# Overview & Scrutiny

## Inner North East London Joint Health Overview and Scrutiny Committee

All Hackney members of the Inner North East London Joint Health Overview and Scrutiny Committee are requested to attend the meeting of the Committee to be held as follows:

**Monday, 17th February, 2014,**

**7.00 pm**
**London Borough Tower Hamlets -Room C1, 1st floor, Mulberry Place, 5 Clove Crescent, East India Dock, E14 2BG**

**Gifty Edila**
**Corporate Director of Legal, Human Resources and Regulatory Services**

Contact:
Jarlath O'Connell
☎ 020 8356 3309
✉ jarlath.oconnell@hackney.gov.uk

**Members:** **Cllr Luke Akehurst, Cllr Ann Munn and Cllr Benzion Papier**

## Agenda

**ALL MEETINGS ARE OPEN TO THE PUBLIC**



Hackney

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The site has excellent bus links which connect it to East and Central London and beyond.

The 277 bus route begins and ends at the site, and the 15 begins and ends a 3 minute walk away at Blackwall Station. There are a number of other bus stops close by.

Most local bus services are listed overleaf and shown on the map, with the closest bus stops clearly marked on the enlarged map below.

## By DLR and Tube

East India and Blackwall DLR Stations are in the immediate vicinity of the Town Hall site, with many other DLR stations within a short walk.

The closest Tube stations are Canning Town or Canary Wharf (both Jubilee Line).

For further information visit www.tfl.gov.uk/journeyplanner

## By Foot

An approximate 20 minute walk from the site is shown by the blue circle (on the map overleaf). Many DLR and both Tube stations are within this zone.

There is pedestrian access to the site from all directions, allowing good access to the surrounding area.

For more information on walking in Tower Hamlets see www.towerhamlets.gov.uk/walking

For walking directions see www.walkit.com

HEALTHY BOROUGH PROGRAMME

tower hamlets becoming a healthy borough

change 4 life

This map has been funded as part of the Tower Hamlets Council Travel Plan which aims to boost the number of staff and visitors travelling to the site by sustainable modes of transport.

Tower Hamlets is one of 9 areas designated as a 'Healthy Town' and has been awarded Government funding to tackle the environmental causes of overweight and obesity. Active Travel (cycling and walking) plays a major role in the programme.

www.towerhamletshealthyborough.co.uk

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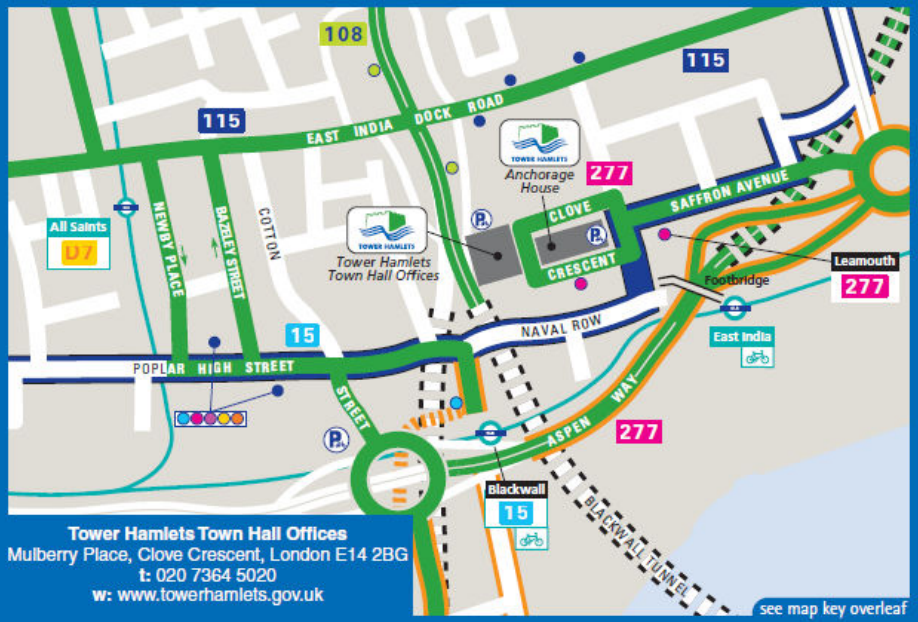


**Tower Hamlets Town Hall Offices**
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t: 020 7364 5020
w: www.towerhamlets.gov.uk

## By Bike

The site is well served by cycle routes, including Cycle Superhighway route 3 opening in 2010.

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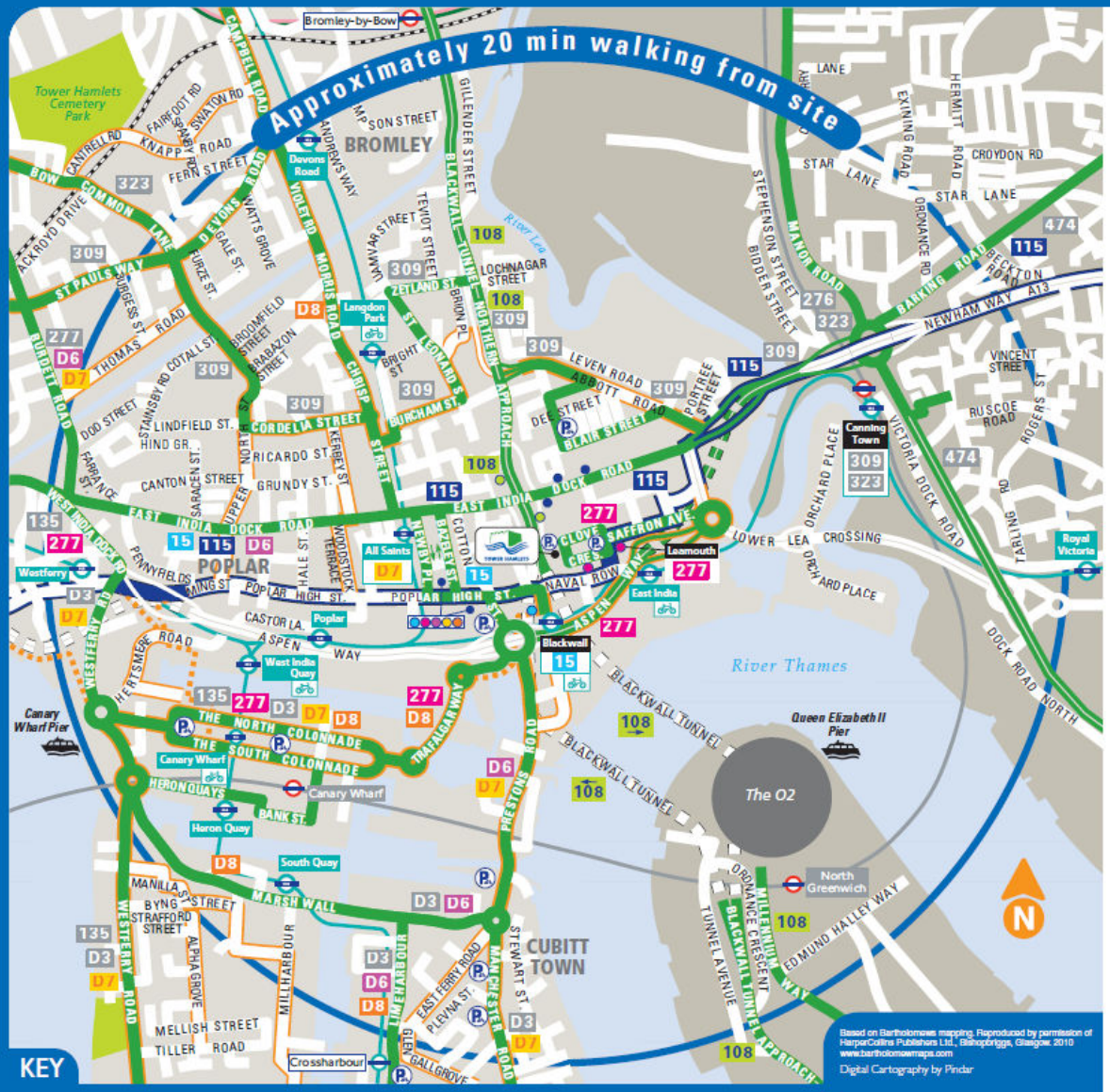
Further information on planning your journey by bike can be found at www.tflgov.uk/cyclejourneyplanner or visit www.towerhamlets.gov.uk/cycling for more information.

Map ▸▸▸




# Bus Frequencies

## 15 Blackwall - Paddington Basin — Daily

Blackwall DLR - All Saints DLR - Limehouse DLR - Aldgate - Fleet Street - Charing Cross - Oxford Circus - Paddington - Paddington Basin

Monday - Friday daytime 6-10 minutes. Saturday daytime 6-10 minutes. Evenings and Sundays 6-10 minutes

Operated by East London

## 108 Lewisham - Stratford — 24 Hour

Lewisham DLR - North Greenwich - Blackwall Tunnel - Bromley-by-Bow - Stratford DLR

Monday - Friday daytime 8-10 minutes. Saturday daytime 10-14 minutes. Evenings and Sundays 20 minutes.

Operated by London General

## 115 East Ham - Aldgate — Daily

East Ham - Upton Park - Plaistow - Canning Town DLR - All Saints DLR - Limehouse DLR - Aldgate

Monday - Friday daytime 5-9 minutes. Saturday daytime 8-12 minutes. Evenings and Sundays 10-12 minutes.

Operated by East London

## 277 Leamouth - Highbury — 24 Hour

Leamouth - Canary Wharf DLR - Westferry DLR - Mile End - Hackney Central - Highbury & Islington

Monday - Friday daytime 5-8 minutes. Saturday daytime 6-10 minutes. Evenings and Sundays 9-12 minutes.

Operated by East London

## D6 Hackney - Crossharbour — Daily

Hackney Central - Cambridge Heath - Bethnal Green - Mile End - All Saints DLR - Crossharbour DLR - Crossharbour ASDA

Monday - Friday daytime 6-10 minutes. Saturday daytime 7-11 minutes. Evenings and Sundays 15 minutes.

Operated by First

## D7 All Saints - Mile End — Daily

All Saints DLR - Island Gardens DLR - Canary Wharf DLR - Westferry DLR - Mile End

Monday - Friday daytime 8-12 minutes. Saturday daytime 7-10 minutes. Evenings and Sundays 15 minutes.

Operated by First

## D8 Crossharbour - Stratford — Daily

Crossharbour - Canary Wharf DLR - All Saints DLR - Bow Church DLR - Stratford DLR

Monday - Friday daytime 9-13 minutes. Saturday daytime 11-12 minutes. Evenings and Sundays 20 minutes.

Operated by First

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**INNER NORTH EAST LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE 2013/2014**

## PARTICIPATING AUTHORITIES

| Authority | Appointed Member |
|---|---|
| City of London Corporation | Common Councilman Wendy Mead |
| London Borough of Hackney | Cllr Luke Akehurst |
| | Cllr Benzion Papier |
| | Cllr Ann Munn |
| London Borough of Newham | Cllr Terence Paul |
| | Cllr Ted Sparrowhawk |
| | Cllr Winston Vaughan |
| London Borough of Tower Hamlets | Cllr David Edgar |
| | Cllr Dr Emma Jones |
| | Cllr Rachael Saunders |

Substitutes:
City of London – Common Councilman Dhruv Patel

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| | |
|---|---|
| **Inner North East London Joint Health Overview and Scrutiny Committee**<br><br>17 February 2014<br><br>**Minutes of the previous meeting** | Item No<br><br>**5** |

**Outline**

Attached are the draft minutes for the previous meeting of INEL JHOSC held on 20 November 2014.

**Action**

The Committee is requested to agree the minutes as a correct record.

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**INNER NORTH EAST LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (INEL JHOSC)**

**Meeting held on 20th November 2013**
**in Assembly Hall 3, Hackney Town Hall, Mare St, London E8 1EA**

| | |
|---|---|
| **Members Present:** | **Councillor Winston Vaughan (Chairman), Councillor Luke Akehurst (Vice Chairman), Common Councilman Wendy Mead, Councillor Ann Munn, Councillor Terence Paul, Councillor Rachael Saunders and Councillor David Edgar** |
| **Member Apologies:** | **Councillor Dr Emma Jones, Councillor Benzion Papier and Councillor Ted Sparrowhawk** |
| **Officers in Attendance:** | **Luke Byron-Davies (Scrutiny Manager, LB Newham, Jarlath O'Connell (Overview and Scrutiny Officer, LB Hackney), Hafsha Ali (Head of Scrutiny, LB Newham), Neal Hounsell (City of London Corporation), Tahir Alam (Strategy Policy and Performance Officer, LB Tower Hamlets), Sarah Barr (Senior Strategy, Policy and Performance Officer, LB Tower Hamlets) and Philippa Sewell (City of London Corporation)** |
| **Also in Attendance:** | **Peter Morris (Chief Executive, Barts Heath), Mark Graver (Head of Stakeholder Relations and Engagement, Barts Health), Mark Cubbon (Executive Director of Delivery, Barts Health), Neil Kennett-Brown (NHS England), John Hines (London Cancer), David Fish (UCL Partners), Muntzer Mughal (UCL Hospitals/London Cancer), Ben O'Brien (Barts Health/UCL Partners), Hilary Ross (UCL Partners), Dr Ash Paul (Consultant, Public Health, LB Hackney), Aidan Keightley (Healthwatch Newham), Michael Vidal (Healthwatch Hackney), Beth Earmington (NHS North and East London Commissioning Support Unit), Ruth Hardy, Stuart Maxwell (Hackney resident), Christopher Sills (Hackney Resident)** |

**The meeting commenced at 7.00 p.m. and closed at 9.00 p.m.**

## 1. WELCOME AND INTRODUCTIONS

1.1 The Chair welcomed everyone to the meeting and stated it had been convened to jointly consider the report on financial turnaround for Barts Health NHS Trust and the consultation on the proposals for specialist cancer and cardiovascular services in North and East London and West Essex.

## 2. MEMBERSHIP OF THE COMMITTEE

2.1 The Committee noted the updated Membership list for Inner North East London Joint Health Overview and Scrutiny Committee. It was noted that Councillor David Edgar had replaced Councillor Lesley Pavitt from the London Borough of Tower Hamlets.

## 3. APOLOGIES FOR ABSENCE AND NOTICE OF ANY SUBSTITUTIONS

3.1 Apologies for absence were received from Councillor Dr Emma Jones from the London Borough of Tower Hamlets, Councillor Benzion Papier from the London Borough of Hackney, and Councillor Ted Sparrowhawk from the London Borough of Newham.

## 4. DECLARATIONS OF INTEREST

4.1 There were none.

## 5. MINUTES OF THE PREVIOUS MEETING

5.1 The Committee gave consideration to the minutes of the meeting held on 29 May 2013.

**RESOLVED –** That the minutes of the meeting of the Committee held on 29 May 2013 be agreed as a correct record.

## 6. ACTIONS AND MATTERS ARISING FROM THE PREVIOUS MEETING

6.1 There was none.

## 7. BARTS HEALTH NHS TRUST - REPORT ON FINANCIAL TURNAROUND

7.1 The Chairman welcomed the following senior officers from Barts Health NHS Trust to the meeting:

Mr Peter Morris, Chief Executive
Mark Cubbon, Executive Director of Delivery
Mark Graver, Head of Stakeholder Relations and Engagement

7.2 At their previous meeting on 29th May 2013, the INEL JHOSC considered the draft Quality Accounts for Barts Health NHS Trust. Mr Morris stated that since then the Trust had begun a financial turnaround programme to improve the quality of patient care, increase speed of delivery and improve efficiency whilst delivering cost savings and productivity improvements.

7.3 As the largest NHS Trust in the country the reduction of the National tariff by 4% would result in a £50m saving to be made per year for Barts. In addition, a further local target of £28m needed to be found as transitional funding had been received previously and would fall away over a 2 year period.

7.4 Mr Morris outlined a three year plan in place to achieve a sustainable long term financial position. In 2013/14 the focus was on stabilising finances via cost reduction and increasing income through Payment by Results. In 2014/15 Mr Morris stated attention would shift to address the underlying financial deficit so that in 2015/16 a financial equilibrium could be achieved.

7.5 Mr Morris highlighted the need to change current operational practices, and advised that this would involve restructuring and unifying the workforce. A review of management, nursing and administrative posts within clinical services had followed a corporate review, and a consultation on staffing levels had been launched in August 2013 with unions, staff and stakeholders to ensure proposed structures and processes were fit for purpose.

7.6 The turnaround and change in practices would require continued support for clinical and corporate functions, along with support for smaller groups within the organisation in order to utilise opportunities for improvement and ensure best practice was shared.

7.7 With regard to income, Mr Morris advised that over the past 12 months they had moved away from block contract payments, and would operate via Payment by Results so that work undertaken would be paid for in full. He also stated that income was a significant consideration in the long term plan.

7.8 Mr Cubbon provided more detail on the process for challenging and scrutinising decisions and ensuring robust practices. Recommendations from the National Audit Office had been implemented to improve quality of care and health and safety: The organisation was split into a number of divisions and each would have assessment levels to scrutinise proposed decisions and plans.

7.9 Senior doctors would present to a panel of officers (i.e. from Finance and HR) on any new plans, giving assurance and taking questions. The scheme would then be accepted or challenged accordingly and go on to be presented to the Chief Nurse and Medical Doctor. The cost implications of each scheme would go to the Trust Board to undergo a further degree of scrutiny.

7.10 With regard to external involvement in the process, an overview of each scheme and the process followed would also be presented to NHS England. An on-going monitoring process would track further financial opportunities, assess how schemes were impacting patients

and service users, and recognise any risks or emerging patterns.

7.11 Mr Cubbon acknowledged that this was an intensive workload, but stated that it was critical in such a large organisation to ensure opportunities were realised and decisions were robust. The Trust had received positive feedback concerning this arrangement.

**Questions and answers**

**7.12 <u>Councillor Ann Munn opened the questioning by asking the officers to give more information concerning the financial predictions for 2014-2016.</u>**

7.13 Mr Morris replied that the end of 2015/16 should see the Trust break even. In 2014/15 the focus would be to reduce and eliminate the underlying financial deficit, which was in the region of £50m, in addition to accommodating the step in Private Finance Initiative (PFI) payments.

**7.14 <u>Wendy Mead queried the effect taking charge of the cardiovascular services at St. Bartholomew's Hospital would have on PFI payments.</u>**

7.15 Mr Morris responded that further to consultation, an application would be made to make changes to the building and the ground prepared for the other hospitals, extensively using the St Bartholomew's site. With regards to PFI, Mr Morris advised Members that the extra patient load would result in extra revenue and that there would be an exercise to determine the cost of changes

**7.16 <u>Councillor Ann Munn asked whether the process for scrutinising decisions would be on-going, and asked for more information regarding Clinical Academic Group (CAG) specific schemes.</u>**

7.17 Mr Cubbon confirmed that the efficiency process would be on-going, and that CAG specific schemes were small, local schemes which built up over time into significant costs.

7.18 Mr Morris added that the numbers concerned were constantly changing, with new schemes being delivered in addition to existing ones. As an example, he spoke about increasing the robustness of theatre scheduling, highlighting that although the target was set at 65%, the aim was to surpass this in 2014/15.

7.19 Mr Cubbon reported that significant resources were being put into the restructure of the work force to understand how it is constructed and that salaries were being paid on an equitable basis. The forthcoming changes to unify the workforce were expected to deliver significant savings as well as improving efficiency. Mr Cubbon stated that £48m of £62m savings for 2013/14 had been delivered so far, with the rest to be

delivered in the next few months.

**7.20 <u>The Chairman queried whether Payment by Results would financially impact CCGs and whether it would be harder to achieve important outcomes.</u>**

7.21 Mr Morris assured Members that the Trust was working closely with CCGs, tracking economics across the system on a monthly basis to ensure a sustainable way could be secured to run care pathways. He added that they were encouraging themselves to do more to reduce waiting times, treating patients close to home wherever possible through an integrated care agenda.

**7.22 <u>With reference to the feedback from staff consultation, Cllr Akehurst declared a non-pecuniary interest by virtue of being a member of Unite. He asked whether any lessons had been learned for future consultations and what steps were in place to increase morale.</u>**

7.23 Mr Morris acknowledged the difficulty in reaching thousands of people and reducing their stress and anxiety but confirmed that support arrangements were in place; downgraded staff were protected against loss of earnings and communication was on-going, particularly with staff reps.

7.24 With regards to lessons learned, Mr Morris stated that allowing sufficient time for comments to be submitted and for feedback to be considered was paramount. Both these timescales had been extended in the consultation, the latter from one to three weeks, and Mr Morris reported that a better set of outcomes had been reached as a result.

**7.25 <u>Cllr Edgar enquired whether benchmarking would be used more generally in the future, and whether the recruitment of staff whilst downsizing the workforce reflected a mismatch of skills?</u>**

7.26 Mr Cubbon responded that as a relatively newly merged organisation it was necessary to get outside expertise. Organisations and services of a similar size had been compared nationally, and showed that the Trust had more staff on higher pay than comparable peers. This comparison was supplemented with benchmarking which compared London against the National nursing skill base. Mr Cubbon reported that staffing levels were not universally reduced, as some areas were being recruited to.

7.27 Mr Morris advised Members that the benchmarking exercise had been tailored to suit the organisation's shape and size which allowed them to be more confident of the relevance and robustness of conclusions drawn. He stated that the Trust came close to benchmarks from Safe Staff Alliance, and had retained a 65:35 mix of trained-to-untrained staff. He added that the Chief Nurse had the power to change the staff

mix in particular areas, and extra monitoring and flexibility would ensure shape and number of staff was fit for purpose.

7.28 Mr Cubbon stated that although recruiting whist downsizing staff might seem counterintuitive, it was necessary to address the mismatch of vacant posts and current skill levels. The Trust wanted to reduce the reliance on temporary staff, with an internal target of achieving 95% of a workforce of 14,500.

**7.29 <u>In light of the CQC reports highlighting problems with staff morale, Cllr Saunders asked how they were being tackled.</u>**

7.30 Mr Morris replied that staffing was an issue in terms of the level of agency staff and morale. A low appraisal rate had been observed previously but now a consistent appraisal system was in place, including team meetings and appraisals which were up to approximately 90%.

7.31 Mr Morris spoke about an annual opinion staff review and a smaller monthly survey (of approximately 2000 staff) carried out to gauge the mood of the organisation. At a request from Councillor Saunders, Mr Morris confirmed he would be happy to share these with the JHOSC.

**7.32 <u>With reference to down-banding, the Chairman queried how staff members were being redeployed and whether patient experience had been affected?</u>**

7.33 Mr Morris explained that any redeployment depended upon which posts would be free and the extent to which individuals were willing to accept posts based elsewhere in the organisation, considering their personal circumstances.

7.34 In response to the Chairman's request for figures estimating redeployment, Mr Morris was not willing to judge what might happen over the next 18 months but undertook to come back with figures at a later date.

7.35 Mr Morris informed Members that, as yet, there was no evidence that redeployment of staff had affected patient experience either positively or negatively. Changes were still being executed and monitoring would continue in order to highlight and address any adverse effect observed.

**7.36 <u>Wendy Mead asked whether the planned movement of staff to St Bartholomew's was part of the redeployment plans.</u>**

7.37 Mr Morris confirmed that the London Trust team would move entirely to the St Bartholomew's site but this would not be part of the redeployment process. With regard to Heart Hospital, work was underway to establish the required workforce, and more detailed preparations would begin in summer 2014.

**7.38 <u>Cllr Paul queried the levels and locations of agency staff compared with benchmarking, and asked whether there was a risk map in place to assess issues of quality and safety concerning temporary staff.</u>**

7.39 Mr Morris assured Members that the reliance on temporary staff would be reduced to more sustainable levels over the next 12 months, but it would take time to iron out the differences in specific sites. 14 additional staff had been recruited in HR to manage this.

7.40 Mr Cubbon added that assessment of risk was part of everyday procedures, and a mitigation plan was in place from Ward level up to the Board.

**7.41 <u>With reference to the CQC report concerning Whipps Cross, Cllr Saunders asked how the issues identified were being addressed.</u>**

7.42 Mr Morris advised Members that numerous housekeeping issues at Whipps Cross had been identified during the inspection, and now the Trust were ensuring the correct mechanics were in place to recognise problems and address them internally. He confirmed that the maternity services at Whipps Cross were safe, secure and effective, but recognised that the maternity patient experience needed to be better. He reported that a culture change within the service was being embarked upon to improve the service of care.

7.43 In response to a follow up question from Councillor Saunders, Mr Morris gave more detail as to the changes made to pick up issues in the future. He stated that a six figure sum had been invested to fix the maintenance issues identified during the inspection, and this provided a visible change to drive further improvements. As other maintenance work was completed, staff were recognising that things were being fixed whenever they were discovered or reported, which encouraged better communication to highlight issues.

7.44 The Chair thanked Mr Morris and the officers for taking the time to attend and answer the Members' questions.

## 8. IMPROVING SPECIALIST CANCER AND CARDIOVASCULAR SERVICES IN NORTH AND EAST LONDON AND WEST ESSEX - CONSULTATION ON CASE FOR CHANGE

8.1 The Chair welcomed the following senior officers to the meeting:

Neil Kennett-Brown, NHS England
John Hines, London Cancer
David Fish, UCL Partners
Muntzer Mughal, UCL Hospitals/London Cancer
Ben O'Brien, Barts Health/UCL Partners

Hilary Ross, UCL Partners

8.2 Mr Kennett-Brown thanked the Chairman, and informed the JHOSC that early engagement to gather feedback on the proposals for improvements to specialist services showed strong support. A leaflet and public events campaign had begun on 28 October and would conclude on 4 December.

8.3 Mr Mughal, from UCL Hospitals and London Cancer, outlined the vision for a world class cancer service with an advanced computer system and the latest treatments. He informed Members that survival rates and patient experience was poor in this part of London, which was a major driver to change and strengthen services. Five centres were proposed for five rare types of cancer: brain, head and neck, urological (bladder, prostate and kidney), acute myeloid leukaemia and oesophago-gastric (upper GI). Focus would be on giving patients access to the best specialist care and to the latest treatments and clinical trials, improving patient experience and holistic care, and utilising the research opportunities.

8.4 Mr O'Brien, from Barts Health and UCL Partners, spoke about the cardiovascular proposals. Although the new building was an enabling factor, the high a number of deaths from cardiovascular illnesses was the real driver for change. Recent innovations in treatment were now being offered, but there was still a high number of cancellations due to organisational issues.

8.5 The proposal would see specialist cardiovascular services currently offered by both University College London Hospital (UCLH) NHS Foundation Trust and Barts Health NHS Trust come together in a single centre for excellence at St Bartholomew's Hospital in late 2014. Services provided at the London Chest Hospital and The Heart Hospital would join the new site, but care would extend beyond the three centres to create an integrated system felt in the community. Academic forces would be linked to ultimately create one centre of excellence that could compete with the world's academic power houses.

8.6 In closing, Mr Kennett-Brown returned to the feedback from the on-going engagement exercise. Support had been received from Clinical Commissioning Groups (CCGs), although the Outer North East London Joint Health and Scrutiny Overview Committee had voiced concerns regarding prostate cancer and the future of oesophago-gastric cancer moving from two to one centre. Travel and access were also important issues, with patients prepared to travel further for better outcomes and the UCLH committing to specific access arrangements (i.e. requesting additional disabled parking bays).

8.7 **Wendy Mead opened the questioning by asking officers why UCLH had been selected over Barts to provide specialist**

**treatment for head and neck cancer, despite the latter treating more patients in 2012/13?**

8.8 Mr Fish, from UCL Partners, responded that the lead for head and neck cancer was an employee from Barts who supported the selection of UCLH. The hospital could offer strong infrastructural support, including the UCLA Ear, Nose and Throat hospital and Postgrad Dental Institute. In addition this was a nationally funded site to develop proton beam therapy, and a support was available from neuro-surgery and neuro-oncology surgery.

8.9 **Wendy Mead queried the robustness of communications planned between the various hospitals and sites?**

8.10 Mr Fish agreed that communications throughout the NHS were inadequate, but advised that having fewer specialist sites would reduce communication difficulty as the complexity of interaction would also be reduced. He assured Members that investment in informatics could link providers of care across the partnership; although the current baseline for communications was low, it was a priority for improvement.

8.11 **Wendy Mead followed up her question, querying how reducing the number of sites would improve patient experience outside of their home territory, which was largely where problems arose?**

8.12 Mr O'Brien replied that wider networking between colleagues would be facilitated to enable better working relationships and improve communication. Patient pathways would be integrated the entire way, to ensure patient experience was consistent and staff communication was continuous.

8.13 Mr Hines, from London Cancer, advised Members that Officers were familiar with the difficulties in moving patients around the system and that it would be easier with fewer places. Doctors and specialists would split their time between the centre and peripheral hospitals to improve communication and patient care, and investments into informatics would ensure GPs were updated at every step of a patient's treatment.

8.14 **With particular reference to prostate cancer, the Chairman asked whether it was wise to proceed with the one centre approach when there were concerns over travelling for treatment.**

8.15 Mr Kennet-Brown advised that all proposals were being evaluated, including single and multi-site options. There was no evidence to show that the current urology service at Barking, Havering and Redbridge University Hospitals NHS Trust (BHRT) was poor, but the aspiration was to become world class, which was why a review was being carried out. Mr Kennet-Brown informed Members that he would be sharing the outcomes of this review with the ONEL JHOSC.

8.16 Mr Hines added to this, stating that statistics showed surgeons who performed complex surgeries on a regular basis achieved better survival outcomes and the complication rate for robotic surgery was halved. Cancer survival statistics for UCLH were comparable to large American centres (which were consistently successful), and it was therefore justifiable from a clinical standpoint that operations should be held centrally with high level surgeons and high level technology. Mr Hines pointed out that patients in North East London have been travelling to the centre for treatment since 2005, though patients coming from outer London would need more consideration.

8.17 **Councillor Munn asked whether follow up care for cardiovascular treatments would be carried out locally.**

8.18 Mr O'Brien responded that there was a wide spectrum of cardiovascular diseases; lesser illnesses would be followed up locally, whilst more complex ones would be treated at the centre. Ms Ross, from UCL Partners, added that staff would be rotated between the centre and peripheral hospitals to ensure a cross site approach for the patient and to establish a robust relationship with outlying hospitals for discharges.

8.19 **With regards to consultation on patient experience, Councillor Paul asked how softer issues would be addressed in the future.**

8.20 Mr Kennet-Brown replied that listening to people was an evaluation criterion, and would be measured through the changes made as a result of feedback received. The 'hub and spokes' model for the centre allowed for an exchange of ideas and information to ensure all hospitals benefitted.

8.21 **Councillor Saunders congratulated officers on their aspiration to create a world class centre for excellence, and queried whether this would mean an increase in private practise and smaller waiting lists?**

8.22 In response Mr Kennet-Brown reported that an increase in private patients would not be detrimental as the income from their treatments would be used to improve the site. He advised Members that the aim was to attract more people in to using the centre through achieving an encouraging reputation.

8.23 **Councillor Edgar asked what the long term implications were.**

8.24 Mr Fish stated that the centre would be held to account permanently by the treatment outcome in the wider population rather than just the results from inside the hospital. Ms Ross advised Members that the current cardiovascular provision was rated excellent, and that twelve Transformation Leaders had been appointed to bring teams together in order to understand what is needed from the new service provision.

8.25 **The Chairman allowed a question from the floor:** Mr Michael Vidal (Board Member, HealthWatch Hackney) **asked whether there had been discussions about the proposals with Monitor?**

8.26 Mr Fish responded that there had been discussions with the relevant agencies and this included Monitor.

8.27 The Chairman thanked the officers for their report, and it was agreed that discussions would continue regarding Members' concerns over the proposals. Mr Kennet-Brown advised the JHOSC that he planned to meet with the Chairmen of the 3 JHOSCs to share and discuss outcomes after 29 November 2013.

## 9. AOB

Councillor Akehurst proposed an amendment to the Committee Procedure Rules for INEL JOSC. This was seconded by Wendy Mead.

**RESOLVED** – That Rule 9.1 be amended to read:

"The lead administrative and research support will be provided by the Health Scrutiny Officer from the borough which holds the Chair with the assistance as required from the officers of the participating boroughs."

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| **Inner North East London Joint Health Overview and Scrutiny Committee**<br><br>17 February 2014<br><br>**Proposed move of Moorfields' Eye Hospital** | Item No<br><br>**6** |
|---|---|

**Outline**

Moorfields' Eye Hospital NHS Foundation Trust proposes to move its main hospital from its existing site in City Road in Islington to a new site in the King's Cross/Euston area.

The Trust is required to consult the relevant local health overview and scrutiny committees as this would constitute a substantial variation. Although the hospital is based in the NCL JHOSC area it takes patients from across London.

The Trust has provided the following data on the referrals relevant to INEL boroughs.

The total referrals by CCG and those who are seen at City Road:

| | Total Referrals 2012-13 | City Road Referrals 2012-13 |
|---|---|---|
| City And Hackney | 5,375 | **4,225** |
| Tower Hamlets | 3,811 | **2,450** |
| Newham | 3,129 | **2,134** |

Attached is their consultation document on the proposed move and attending the meeting to answer Members' questions will be Rob Elek, Director of Strategy and Business Development

**Action**

The Committee is requested to give consideration to proposal.

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Moorfields Eye Hospital NHS
NHS Foundation Trust

# Providing a 21st century facility for Moorfields Eye Hospital

## Involving patients and the public
## Tell us what you think

**Version:** 1
**Published:** November 2013

## Contents

# 1. Introduction

This document outlines a proposal by Moorfields Eye Hospital NHS Foundation Trust to move our main central London hospital from City Road near the Old Street roundabout to more modern facilities in the King's Cross/Euston area. We plan to do this in partnership with our research colleagues at the UCL Institute of Ophthalmology.

We need a new facility for several reasons:

- Our existing buildings in City Road are more than 100 years old and were built at a time when hospital care was provided very differently to how it is now – they are no longer suited to the provision of 21st-century clinical care, research or education
- Our ageing infrastructure is growing increasingly difficult and costly to maintain
- The configuration of our existing buildings offers little scope for true integration between the clinical, research and teaching elements of our work, which will be crucial if we are to achieve our vision for the future (see section 2 below)
- Although intermediate refurbishments go some way to improving the environment for our patients and staff, they are no substitute for purpose-built accommodation

An in-principle decision to focus all our efforts on moving, rather than trying to rebuild on our current campus, was taken by our board of directors in March 2013, following an extensive options appraisal. We are now keen to hear wider views to enable us to develop our plans further. In particular, we want to understand the factors that you consider the most important for us to take into account when we make a final decision about a new site.

In parallel with this engagement exercise, we are working with the local health overview and scrutiny committee and our host commissioners to ensure that we comply with our formal consultation obligations as set out in NHS legislation.

It is very important to stress that this engagement exercise is not about changing the services we currently provide. Wherever we are based, we will continue to offer high quality clinical care, research and education in a central London location, supported by a network of satellite locations in and around the capital, just as we do now.

Once you have read this document, we would be grateful if you could take the time to answer the questions on pages 9 and 10 so that you can tell us what you think.

## 2. Our vision for the new facility

Our aim, in partnership with the UCL Institute of Ophthalmology, is to create a fully integrated and flexible modern facility, enabling us to bring together – for the first time – patient-focused eye research, education and healthcare in a truly coherent way.

By doing this, we will be able to:

- Provide the highest quality clinical care in a modern, supportive environment for both patients and staff
- Enhance significantly our capacity and capability to undertake world-leading research, translating that research rapidly into treatments for patient benefit
- Attract the world's best ophthalmic scientists, educators and clinicians

We plan to pay for the new facility from a variety of sources, including cash reserves, borrowing, a significant contribution from UCL, the proceeds from the sale of the City Road site, and a major fundraising campaign, jointly with UCL, which we anticipate will raise around 25% of the money we need.

## 3. Background to the engagement exercise

Discussions have taken place over many years about the future development and growth of our central London hospital. During this time, we have considered a variety of options, including redevelopment on our existing campus and rebuilding from scratch elsewhere.

These discussions have involved a range of individuals and organisations including Moorfields' board of directors, our membership council (comprising the governors who represent our membership), members themselves, and existing and potential donors to the hospital. We now wish to broaden the discussions by involving many more people who use, or have an interest in, Moorfields' services.

## 4. Why we want to move

During 2012, we completed a detailed analysis of our space requirements in a new building, as well as the costs of moving off-site rather than rebuilding at City Road. These suggested that moving to a new location was likely to be less expensive than staying at City Road.

This is in large part because to redevelop the City Road site at the same time as continuing to provide services there would require us to find and pay for a significant amount of alternative accommodation over an extended period of time. This would not only be extremely expensive, but would also be very disruptive for patients, visitors and staff, and would also take a great deal longer to achieve.

At the same time, our colleagues at the UCL Institute of Ophthalmology have decided that their existing facilities in Bath Street, adjacent to our City Road building, will also require a fundamental redesign and expansion if they are to realise their ambitions for the future.

Taking all of this into account, we conducted an extensive options appraisal which looked at seven different ways of reconfiguring the existing buildings to meet our joint aims, and one to relocate elsewhere in central London. Each option was evaluated on the basis of cost and on a range of qualitative issues as follows:

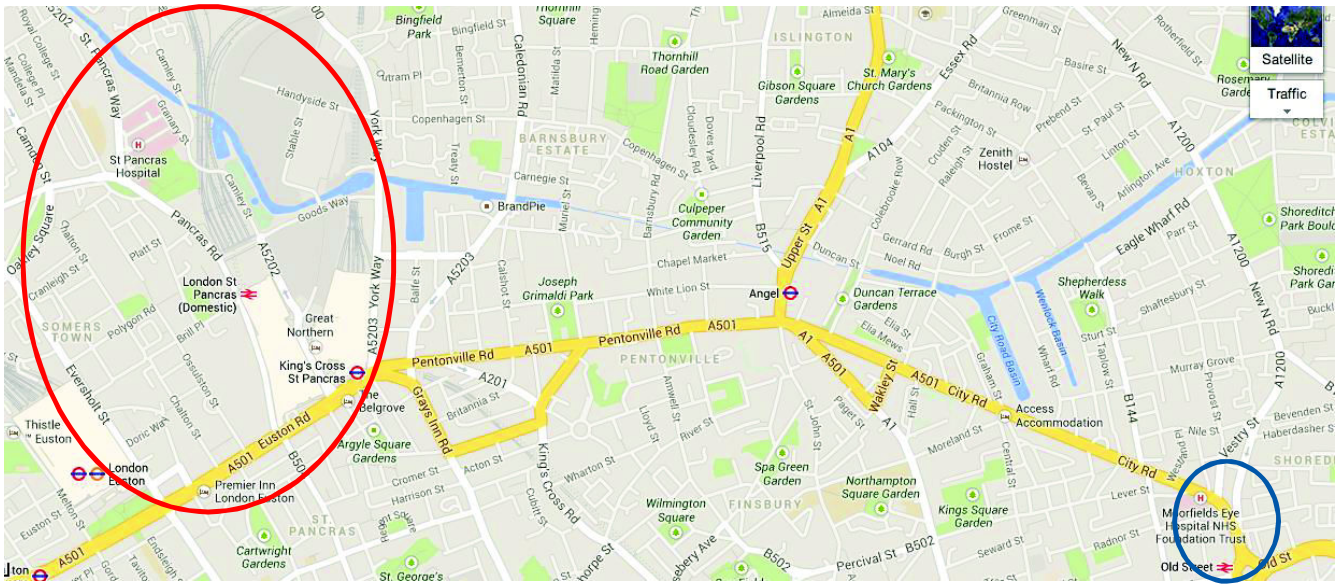
- Accessibility and quality of the surrounding environment
- Ability to realise the best clinical co-locations and patient experience
- Proximity to another acute hospital
- The impact of each option on existing service delivery and patient experience while work takes place
- Future flexibility
- Integration with the Institute of Ophthalmology, research and development and education and teaching capability
- Acceptability
- Brand and reputational impact
- Ability to accommodate additional patient activity

Relocating scored higher than rebuilding at City Road against every qualitative criterion, as well as on financial grounds. On that basis, our board of directors made an in-principle decision in March 2013 that we should focus all our efforts on identifying an alternative site at which to build a new integrated facility.

## 5. Why King's Cross/Euston?

Although we have looked at other parts of central London, King's Cross/Euston is the most attractive proposition for a variety of reasons:

- It is close to our current location (see map below), which will make any move easier for existing patients and staff
- The area is undergoing extensive regeneration, which means that there is land available on which to build, as well as other redevelopment opportunities
- The area is a major transport hub, providing easy access from across London and beyond
- Moving to this area will bring us closer to other important health and health research partners, including University College London Hospital, Great Ormond Street Hospital, UCL, and the new Francis Crick Institute




Please note that the red circle above is intended to show the broad area in which we are focusing our search and its relation to our existing site at City Road – it is not a definitive boundary

## 6. What we are engaging about

We are looking at several potential sites that meet our requirements in the King's Cross/Euston area and now want to hear your views about the most important criteria we need to consider in making a final decision on a new location for our integrated facility.

As part of this exercise, we also need to consider the potential impact of our proposal on people with protected characteristics, in line with the public sector equality duty. Protected characteristics are age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, and sexual orientation. The general equality duty requires us to have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation
- Advance equality of opportunity between different groups
- Foster good relations between different groups

Although we do not think there is likely to be any adverse impact on any group as a result of our proposals, we would like to know if there are any matters which you think we should take into account in this regard.

It is important to understand that this engagement exercise is not about a specific location, or the future of the buildings that make up the existing hospital in City Road. These issues will be the subject of future town planning consultations.

Nor is the exercise related to the services we currently provide. Wherever we are based, we will continue to provide high quality clinical care, research and education in a central London location, supported by a network of satellite locations in and around the capital, just as we do now. In addition, although we might expect more patients to choose to be treated in our satellite locations closer to where they live or work as services at those sites develop, the ultimate choice about whether to be cared for in our main hospital or in one of our satellites will rest with patients themselves.

## 7. How you can have your say

You will find a list of questions on pages 9 and 10 of this document, and we would be grateful if you could answer these and return them to us. There is also a space for you to give us your general views about our proposal to move to a new location.

This engagement exercise runs for 12 weeks from Monday 25 November 2013 to Friday 14 February 2014.

## 8. What happens next?

Once this engagement exercise closes, we will look at all the responses and write a report which will be posted on our website and sent out in hard copy on request. The report will then be used to develop the plans for a new home for Moorfields.

We are also keen to establish a reference group to ensure that patients' views are adequately represented as the project develops. If you would be interested in finding out more about this and what it will involve, please let us know using the contact details below.

## 9. Further information

We hope that this document contains enough useful information to help you contribute and have your say. You can also find a list of frequently asked questions about this project on our website at www.moorfields.nhs.uk.

If you have further specific questions, or need additional copies of this document, response forms or a copy in a different language or format, please contact us as follows:

- By email to projectoriel@moorfields.nhs.uk
- By telephone to 020 7253 3411, ext 4285
- In writing to Elizabeth Smith, Project Oriel project manager, Moorfields Eye Hospital NHS Foundation Trust, City Road, London EC1V 2PD
- By coming along at any time during one of our drop-in sessions: these will be held on **Thursday 5 December 2013** and on **Friday 24 January 2014**; both sessions will run from 10am to 6pm and will take place in the main entrance of Moorfields Eye Hospital, City Road, London EC1V 2PD

## 10. Tell us what you think

To let us have your views on our proposals, please answer the questions listed opposite and on the back page of this document.

Once you have finished, please detach the sheet from this document and send it in an envelope to:

Project Oriel team
FREEPOST NAT9528
Moorfields Eye Hospital NHS Foundation Trust
City Road
London EC1V 2PD

Alternatively, you can email your responses to projectoriel@moorfields.nhs.uk.

Published by Moorfields communications team

1. Do you agree with our proposal to move to the King's Cross/Euston area?

2. Which of the following criteria are most important in making a final decision about which site to choose? (Please rank in order where 1 is the most important and 9 the least important.)

| **Criteria** | **Ranking** |
|---|---|
| Whether Moorfields can afford to pay for the site | |
| Value for money | |
| Accessibility – for example, proximity to a major transport hub and ease of access from that hub to the new facility | |
| Proximity to other hospitals with whom we work closely | |
| Continuity of clinical service delivery during construction works | |
| Future flexibility – to allow us to respond to changes in the way in which eye care is provided, or the demand for it | |
| Ability to integrate fully with the UCL Institute of Ophthalmology, our research partners | |
| Deliverability – for example, likelihood of obtaining planning approvals and ease of construction activity and process, including minimising disruption to staff, patients and neighbours | |
| Other – please specify in question 5 below | |

| |
|---|
| 3. Would moving the hospital to the King's Cross/Euston area affect you in any way – in particular, would it create any significant disadvantages for you? |
| |
| 4. Are there any specific issues for people with protected characteristics (see section 6) in what we are proposing, or which we should take into account in selecting the best location? |
| |
| 5. Do you have any further comments about our proposal? |
| |

Thank you for taking the time to answer these questions.

| | |
|---|---|
| **Inner North East London Joint Health Overview and Scrutiny Committee**<br><br>17 February 2014<br><br>**CQC Report on Barts Health NHS Trust** | Item No<br><br>**7** |

**Outline**

At the previous meeting of INEL JHOSC on 20 November the Committee considered a report on the financial turnaround at Barts Health NHS Trust.

Since then the Trust has undergone a major inspection by the CQC's Chief Inspector of Hospitals.

Attached are the reports of that inspection including a slide presentation from Barts Health giving a summary response.

The CQC inspection report comprises and overall report on the Trust and individual reports on each of the constituent hospitals which form part of the Trust.

Attending the meeting to answer Members' questions will be:

- Rep TBC from Care Quality Commission
- Kay Riley, Chief Nurse, Barts Health
- Mark Graver, Head of Stakeholder Relations and Engagement, Barts Health

**Action**

The Committee is requested to give consideration to the CQC report and Barts Trust's response.

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# Barts Health NHS Trust

## Quality report

Trust Offices, Aneurin Bevan House
81 Commercial Road, London E1 1RD
Telephone: 020 7377 7000
www.bartshealth.nhs.uk

Date of inspection visit: November 2013
Date of publication: January 2014

This report describes our judgement of the overall quality of care provided by this trust. It is based on a combination of inspection findings, information from our 'intelligent monitoring' system, and information given to us from patients, the public and other organisations.

## Overall summary

Barts Health is the largest NHS trust in the country, having been formed by the merger of Barts and the London NHS Trust, Newham University Hospital NHS Trust and Whipps Cross University Hospital NHS Trust on 1 April 2012. Barts Health is a large provider of acute services, serving a population of 2.5 million in North East London.

The trust has three acute hospitals: the Royal London, Whipps Cross University Hospital and Newham University Hospital, and three specialist sites: The London Chest Hospital, St Bartholomew's Hospital and Mile End Hospital – acute rehabilitation site. The trust also has two birthing centres: the Barkantine Birthing Centre and the Barking Birthing Centre.

Barts Health offers a full range of local hospital and community health services from one of the biggest maternity services in the country to end of life care in people's own homes. The trust is also part of UCL partners, Europe's largest academic health science partnership, whose objective is to translate research and innovation into measurable health gains for patients.

The Royal London hosts one of the country's busiest trauma centres with state-of-the-art facilities and a dedicated paediatric accident and emergency (A&E) department. It is also the base of the London Air Ambulance service. Both Whipps Cross and Newham also have A&E departments. St Bartholomew's Hospital has a minor injuries unit.

The trust covers four local authority areas: Tower Hamlets, the City of London, Waltham Forest and Newham. Tower Hamlets is one of the most deprived inner city areas in the country, coming seventh in a list of 326 local authorities. Fifty six per cent of the population of Tower Hamlets come from minority ethnic groups, with 56% coming from the Bangladeshi community. Life expectancy in the borough varies, with those who are most deprived having a life expectancy of 12.3 years lower for men and 4.9 years lower for women than in the least deprived areas.

By comparison, the City of London is more affluent, coming 262nd out of 326 in the Index of Multiple Deprivation. It is less ethnically mixed with 21% of the population coming from minority ethnic groups, the largest group being Asian with 12.7% of the population. Newham is again more deprived coming third out of 326 in the Index of Multiple Deprivation. Eighty per cent of the population of Newham come from minority ethnic backgrounds, with Asian being the largest constituent ethnic group at 43.5% of the population. Life expectancy for both men and women living in Newham is lower than the England average.

# Summary of findings

## Overall summary (continued)

Finally Waltham Forest comes 15th out of 326 with a culturally mixed population. Nearly 48% of the population of Waltham Forest come from minority ethnic communities, with Asian constituting the single largest group at 10% of the population. All four of the local authority areas have young populations, with the majority of residents aged between 20 and 39 and the highest concentration aged 20 to 29.

The purpose of this report is to describe our judgement of the leadership of the trust and its ability to deliver safe, effective, caring, responsive and well-led services at each of its locations. Our judgement will refer to key findings at each location. For a more detailed understanding of the hospital findings, please refer to the relevant location report.

Barts Health was included in the first wave of the Care Quality Commission's (CQC's) new hospital inspection programme, as it had been shown to be at 'high risk' on several indicators in the new 'intelligent monitoring' system – which looks at a wide range of data, including patient and staff surveys, hospital performance information, and the views of the public and local partner organisations. Over recent years the trust has faced significant financial challenges and has been a persistent outlier on some key quality of care indicators, including:

- Poor results on the cancer patient experience survey.
- Non-achievement of the four-hour accident and emergency waiting time standard.
- Poor results on the national staff survey.
- A high number of never events (events so serious they should never happen).
- Non-compliance with regulations recorded on several CQC inspections since it was registered, especially in maternity services and wards caring for older people.

In August 2013 we took enforcement action following an inspection of Whipps Cross University Hospital. We served Warning Notices in two clinical areas: the care of the elderly wards where we found that staff were not adequately supported, and the maternity services were we found the environment to be unclean and equipment not available. During this inspection we checked that the trust had met the requirements of the Warning Notices – they had and so we were able to remove the Warning Notices.

The trust's board is well-established and is committed to improving quality. Quality initiatives have been developed across the trust, although many have only started within the past few months and it is too early to tell if they will deliver the required improvements. New systems are being embedded and the development of site-specific management is a welcome development. All senior nurses work clinically on Friday mornings, and on the first Friday of the month, all Executive Board members visit hospital wards. However, the visibility of the board is variable, with many staff being unaware of the 'First Friday' initiative. Morale across the trust is low, with staff being uncertain of their future with the trust and a perception of a closed culture and bullying. Too many members of staff of all levels and across all sites came to us to express their concerns about being bullied. Many only agreed to speak with us if they could be anonymous. In the 2013 staff survey 32% of staff reported being bullied; the average score for trusts in England was 24%. Staff told us they felt stressed at work and said there were not equal opportunities for career development. This must be addressed urgently if the trust's vision is to be realised.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Are services safe?

Generally services at Barts Health are safe. The hospitals are clean and, on the whole, well maintained and the risk of infection is minimised. There are policies and procedures for practice but not all staff are aware of them. While there is learning from incidents on individual sites, this is rarely the case across the trust. There are risk registers in all departments but on many occasions we found that the risk register was not acted upon and some identified risks were not being dealt with.

Staff levels are variable, however, and this meant that people did not always receive care promptly. Across all sites there is a reliance on agency staff which has an impact on timeliness and quality of care.

Equipment is not always available and this may put patients' safety at risk.

### Are services effective?

The effectiveness of services varies across the trust. In the smaller hospitals, care was consistently effective and guidelines for best practice were followed and monitored. In the larger acute hospitals this was less consistent. Multidisciplinary teams are still establishing themselves and there is ongoing work towards having senior staff available on site at all times.

### Are services caring?

The majority of patients and relatives we spoke to described staff as caring and compassionate. We saw staff treating people with dignity and respect. However, we heard about a number of concerning instances of poor care at our listening events and from people contacting us during the inspection. The trust must ensure that the positive experiences we saw and heard about during the inspection are maintained, and that instances of poor care are minimised and dealt with appropriately.

### Are services responsive to people's needs?

Most people told us that the services they used were responsive their needs. However, in some areas of the trust, people's needs were not being met. There were problems in both the Royal London and Whipps Cross hospitals with patient flow through the hospital, bed occupancy and discharge planning. This was not such a problem in Newham University Hospital.

Young people felt that their needs were not addressed, as there are no dedicated facilities for caring for adolescent patients.

The other area where people felt the trust was not responsive was when they had cause to complain. Across the trust, people we spoke with and who contacted us consistently told us that they were unhappy with the way their complaints had been handled. The Patient Advice and Liaison Service in the trust has recently become centralised and this has been a cause of frustration for people who wish to raise concerns.

We had concerns about written information for patients, both in respect of its general availability and the languages it was available in. This caused anxiety for people who did not want to bother staff.

# Summary of findings

## The five questions we ask about services and what we found (continued)

### Are services well-led?

There is variability in leadership across the hospital. The trust's Executive Team is well-established and cohesive with a clearly shared vision. They are well supported by non-executive directors. However, they are not visible across the trust.

Below board level, some areas were well-led, but others were not and this had an impact on patients' care and treatment. The clinical leadership structure was relatively new. The Clinical Academic Group (CAG) structure was introduced in October 2012 but is not yet embedded across the organisation. The exception to this is the Emergency Care and Acute Medicine (ECAM) CAG.

The CAGs, when embedded, could provide a clear route for board to ward engagement and governance but it needs time to become embedded and effective. The trust recognised this and had taken action to address some shortcomings in the governance structure, such as the introduction of site-level organisational and clinical leadership.

Staff feel disconnected from the trust's Executive and feel undervalued and not supported. The culture was not sufficiently open and some staff felt inhibited in raising concerns. Morale was low across all staffing levels and some staff felt bullied. This must be addressed if the trust's Executive Team's vision is to be successful.

# Summary of findings

## What people who use the trust say

The trust scored below the national average for the NHS Family and Friends Test and in line with, or above, the England national average for A&E but there was also a lower overall response rate. The trust performed within the bottom 20% of trusts in England for 50 out of 64 questions in the 2013 Cancer Patient Experience Survey with information, communication and confidence in the staff all featuring.

Comments posted on the Patient Opinion and NHS Choices websites highlighted that care by doctors and communication by all staff could be improved, although these also featured in positive comments. This was also apparent in our inspection visits where patient opinions of care was polarised, with some telling us of care that went beyond the call of duty and others telling us about very poor care.

People who had cause to complain about their care frequently told us they did not feel listened to and, over the course of this inspection, we were contacted by a number of people who were dissatisfied with the trust's response to their complaints.

## Areas for improvement

**Areas where the trust MUST improve:**

- The trust must ensure that action is taken on identified risks recorded on the risk register.
- The trust must ensure that there are sufficient staff with an appropriate skills mix on all wards to enable them to deliver care and treatment safely and to an appropriate standard.
- The Executive Board must urgently re-engage with staff: they must listen to staff, respond to their concerns and adopt a zero tolerance to bullying.
- Provision must be made for adolescents to be treated in an appropriate environment and not within the general paediatric wards.
- Equipment must be readily available when needed.
- Ensure patients receive nutritious food in sufficient quantities to meet their needs.
- Some parts of the hospital environment do not meet patients' care needs. The hospital environment in the Margaret Centre (at Whipps Cross) and outpatients compromises patients' privacy and dignity.
- Patients are not aware of the complaints process and the hospital does not always learn effectively from complaints.

**Other areas where the trust could improve:**

- Improve the visibility of senior leaders in the trust.
- Address concerns about the implementation of the review of nursing posts and the effects of this on the skills mix of nursing staff.
- Improve the dissemination of 'lessons learned' from serious incident investigations across all clinical academic groups (CAGs).
- Improve access for all staff to suitable IT to enable them to report incidents quickly.
- Consultant cover on site should be 24 hours a day, seven days a week to provide senior medical care and support for patients and staff.
- Provide accessible information for patients who speak English as a second language.
- There should be pain protocols in place for children and children should be seen by the pain team.
- The reasons for waits, and likely length of waits in outpatients should be better communicated to patients.

# Summary of findings

## Good practice

**Our inspection team highlighted the following areas of good practice within the trust:**

- The Royal London's 'EA' (Emergency Assessment) model. A team approach, led by a consultant or registrar, that aims to ensure patients are treated in the most suitable area by the appropriate professional. This includes redirection to GPs when the patient has primary care needs or seeing patients in the urgent care or emergency care area when they require immediate medical intervention, such as patients who have sustained an injury.
- The ready availability of interventional radiology – patients requiring this treatment receive it within an hour of identified need. It is available 24 hours a day, seven days a week.
- The development opportunities available for medical records staff – staff are supported to complete an accredited clinical coding course, which leads to alternative employment opportunities.
- The majority of patients were complementary about the care and compassion of staff.
- Staff were compassionate, caring and committed in all areas of the hospital.
- Palliative care was compassionate and held in high regard by staff, patients and friends and family.
- We saw some good practice in children's services, particularly in relation to education and activities for children while in hospital.
- Internet clinics via Skype for diabetic patients.
- Reminiscence room provided by volunteer service.
- Patients who had had a heart attack received equal treatment, whether admitted during the day or at night.
- There was good support for relatives when patients were in a life-threatening situation or when difficult decisions needed to be made about continuing care.
- There was a dedicated exercise classes for Bengali women following a heart attack.

# Are services safe?

## Summary of findings

Generally services at Barts Health are safe. The hospitals are clean and, on the whole, well maintained and the risk of infection is minimised. There are policies and procedures for practice but not all staff are aware of them. While there is learning from incidents on individual sites, this is rarely the case across the trust. There are risk registers in all departments but on many occasions we found that the risk register was not acted upon and some identified risks were not being dealt with.

Staff levels are variable, however, and this meant that people did not always receive care promptly. Across all sites there is a reliance on agency staff which has an impact on timeliness and quality of care.

Equipment is not always available and this may put patients' safety at risk.

## Our findings

### Safety/incident reporting/never events/ managing risk

Between October 2012 and September 2013, there were 10 'never events' (serious, largely preventable patient safety incidents) at Barts Health. Never events are not acceptable in any circumstances. While it is impossible to directly compare Barts Health with any other trust due to its large size, there is one trust that has almost as many 'bed days' and this trust reported seven never events for the same period. Most of the trust's never events (six) occurred at Newham University Hospital. Learning had been implemented and shared across the trust. Yellow wrist bands were introduced for patients who had swabs left in place following an operation that needed to be removed before the patient was discharged. This system was introduced shortly before our inspection so it is too early to say if this will prevent further never events of this nature. However, in the London Chest Hospital, a yellow wrist band is used to identify a patient who is at risk from falling. Although this has reduced the number of falls at the London Chest Hospital, there is a risk in itself of the same colour wrist band being used to identify different risks.

All trusts are required to submit notifications of incidents to the National Reporting and Learning System – and between October 2012 and September 2013, there were 522 serious incidents at the trust. Forty two per cent of these happened on the wards, with 10% occurring in maternity services. There was clear evidence that learning from incidents is shared across the maternity department.

There is a strong commitment to improving practice through learning from incidents. When incidents occur there are investigations, and in some areas learning from those incidents will be shared in clinical governance meetings. But this is not the case across the trust. There were safety measures in place across the trust to manage risk and to monitor care. In December 2012, the trust was above the English average for the development of new pressure ulcers – that is, more patients than average developed pressure ulcers in Barts Health hospitals. The trust has worked to reduce this and now the rates are close to, and at times lower, than the national average. However, while this information is displayed on some wards, it is not consistent across the trust and so some staff are unaware of this.

Managing risk across the trust presents a mixed picture; on many, but not all, wards there is information displayed about patient safety. The information relates to key risk areas such as pressure ulcers, falls, hospital acquired infection, staffing levels and use of bank (overtime) staff. But this information is not consistently updated and good practice is not widely shared across the trust. The trust's risk register is not used effectively, with many risks being identified but not then addressed. This must be addressed.

### Staffing

Staffing levels are variable across the trust. Some wards had enough nursing staff with the right experience and qualifications to work in the clinical areas they were based in. However, many wards had nursing staff vacancies and, following a review of staffing grades, a number of nursing staff have resigned. Staff told us that it is often difficult to get staff to cover short-notice absences – for example, when people phone in sick at the beginning of a shift – and this can leave patients at risk from unsafe care.

This was not the case in all areas. The Emergency Departments (EDs) across the trust generally had enough staff of all levels on duty, including consultant staff on duty at all times. Junior doctors working in the ED felt supported,

# Are services safe?

as did nursing staff. Although, this was not uniform across other departments within the trust. In the General Medical Council's National Training Survey, completed by junior doctors in training during March to May 2013, junior doctors rated their workload and their clinical supervisor on whether they felt forced to deal with clinical problems beyond their experience and competence; they rated this to be 'within expectations'. In the medical wards, junior doctors reported feeling under pressure and unsupported, particularly at night times and weekends. In surgery there was a similar picture.

### Cleanliness and infection prevention and control

In the 2012 Department of Health NHS Staff Survey, Barts Health came in the bottom 20% of trusts nationally, regarding the proportion of staff stating that hand-washing materials were readily available. On our inspection, we saw that there were adequate hand-washing facilities and we saw staff taking care to wash their hands. There was information about the importance of hand washing and we saw visitors to the hospitals washing their hands before going onto wards.

The trust's infection rates for methicillin-resistant staphylococcus aureus (MRSA) and Clostridium difficile (*C. difficile*) were within a statistically acceptable range.

All the wards we inspected in the eight hospital locations were clean. Some of the buildings are old and the trust has plans to move some services into newer locations; where this has already happened, the facilities themselves were kept clean. We heard patients and visitors comment on the cleanliness.

### Medicines management

Generally medicines were managed well with very few errors in administration. We found incidents across the trust where drug trolleys were left unlocked and drug cupboards were left unlocked or locked but with keys hanging nearby. On each occasion we brought this to the attention to the person in charge of the ward and medicines were secured.

### Environment

Both Newham University Hospital and the Royal London Hospital are new buildings; they are clean and spacious. Whipps Cross is an older building and some of the areas would not be considered appropriate for a modern hospital, although the ED and medical assessment unit are newly built. The London Chest Hospital is due to close in 2014 and the facilities will be moved to a new building on the site of St Bartholomew's Hospital.

### Safeguarding vulnerable adults and protecting children

All staff we spoke with understood the importance of safeguarding vulnerable adults and protecting children. The trust showed us records confirming that staff had received training at the appropriate level for their grade. However, there is no one member of staff at the trust who is the dedicated lead for safeguarding, nor is there a clinical person in each of the hospitals with this responsibility. While it is clear that staff believe safeguarding is the responsibility of all staff, if no one person has oversight, there is a risk that safeguarding concerns may not always be recognised.

### Medical equipment

Throughout the trust, medical equipment was generally clean, serviced and fit for use. There were some instances where this was not the case. However, there were also areas where there were chronic shortages of essential equipment – for example, the older people's wards at Whipps Cross have one bladder scanner between them. Bladder scanners are used to detect urinary retention, which can be a cause of urinary tract infections (UTIs). Between August 2012 and August 2013, the trust's rates for UTIs were consistently above the rate for England for patients both under and over the age of 70. We would recommend that the trust gives consideration to what is the safe level of equipment in departments. In the maternity services at Whipps Cross, we found that there was more equipment available on the wards.

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

## Summary of findings

The effectiveness of services varies across the trust. In the smaller hospitals, care was consistently effective and guidelines for best practice were followed and monitored. In the larger acute hospitals this was less consistent. Multidisciplinary teams are still establishing themselves and there is ongoing work towards having senior staff available on site at all times.

## Our findings

### Mortality rates

Mortality rates across Barts Health are within expected parameters. There have been no mortality outliers for Barts Health in the year to October 2013. Out of 40 mortality rated indicators, as identified by the Information Centre for Health and Social Care Hospital Episode Statistics, Barts Health scored 'tending towards worse' or 'worse than expected' in nine areas. However, statistically this does not make Barts Health an outlier and figures are from 2011.

### NHS Safety Thermometer

The NHS Safety Thermometer is designed to measure a monthly snapshot of four areas of harm: falls; pressure ulcers; catheter related urinary infections; and assessment and treatment of venous thromboembolism (VTE). The number of falls in Barts Health for all patients fluctuates. The trust performed better than the national average in the year from August 2012 to August 2013 and many wards have initiatives to identify and support those at risk from falling. As stated, the trust peaked for the development of new pressure ulcers in December 2012, but since then has been consistently below or the same as the rate in England overall. However, many staff told us about a shortage of readily available pressure-relieving mattresses and this poses a risk for the trust in its continuing effort to reduce the rate of people developing pressure ulcers.

The trust's rates for urinary infections are higher than the national average. The VTE rate has fluctuated either side of the national average. In January 2013, there was a spike in the number of people being treated for a VTE. Throughout the year from August 2012 to August 2013, the numbers of people being treated for VTE has fluctuated.

### National guidelines

Before we inspected the trust, we looked at data we held about Barts Health. For most of the indicators we considered, Barts Health was performing within expected parameters. We knew that in some of the maternity wards the trust performed a higher number of caesarean section operations than expected. We asked the trust to explain this and, although it was able to provide an explanation, it also identified areas of care that could be improved. We saw evidence on all sites that care was delivered according to national guidelines published by the National Institute for Health and Care Excellence (NICE) and by professional bodies. The trust had recently stopped using the Liverpool Care Pathway – the care pathway for delivery of end of life care, in line with guidance from the Department of Health. Although there was other guidance available in the trust, not all staff who may have looked after dying patients were aware of it.

### Clinical audits

We saw that audits were carried out and changes to practice were being implemented to improve patient care. But the audits were not disseminated across the trust, even within CAGs. Departments also participated in national audits and guidance was updated in line with national guidance.

### Collaborative working

The CAG structure has great potential for collaborative working. Some CAGs are better established than others, with staff identifying with being part of Barts Health NHS Trust rather than part of the hospital staff where they are based. However, this is not the case in all CAGs We were impressed with the collaborative working of clinical staff and the levels of support across disciplines.

# Are services caring?

## Summary of findings

The majority of patients and relatives we spoke to described staff as caring and compassionate. We saw staff treating people with dignity and respect. However, we heard about a number of concerning instances of poor care at our listening events and from people contacting us during the inspection. The trust must ensure that the positive experiences we saw and heard about during the inspection are maintained, and that instances of poor care are minimised and dealt with appropriately.

## Our findings

### Patient views and feedback

Barts Health was one of 155 acute NHS trusts to take part in the 2012/13 Cancer Patient Experience Survey. There were 64 questions where Barts Health had enough responses to base findings, and in 50 of these, Barts Health was rated by patients as being in the bottom 20% of all trusts. In the 2012 Adult Inpatient Survey, Barts Health scored 'within the expected range' in nine of the 10 areas. In the NHS Family and Friends Test in August 2013, the combined scores of the trust's hospitals was 59.5, which is above the national average and 93.9% of those who took part in the test that month said they would be 'likely' or 'extremely likely' to recommend the ward they had been on to others.

In August 2013, the trust launched a 'call for action for compassionate care across the trust'. The campaign was called 'Because We Care' and introduced initiatives such as 'hourly chats' with patients and healthcare support workers in A&E. There are posters around the hospitals about the campaign, but not all staff we spoke with were aware of the campaign or their role in it. For instance, one of the wards at Newham Hospital has created the acronym SMILE to describe how they should act: S = Say hello, M = make the person feel at ease, I = introduce yourself, L = look and listen, and E = explain clearly. However, not all staff were able to tell us what the acronym stood for.

### Privacy and dignity

In the annual Patient Environment Action Team (PEAT) assessment, the trust scored 'good' for treating people with privacy and dignity. Staff respected patients' privacy and dignity. During our inspection we saw examples of staff ensuring curtains were closed around patients' beds when care was being delivered. We saw patients being treated respectfully and being spoken to about the care they were about to receive. However, we also saw instances when patients' notes were left on desks on wards, which could potentially breach confidentiality. On a previous inspection of the maternity services in Whipps Cross, we overheard staff speaking in a disrespectful way about patients – we did not overhear any such comments in maternity services on this inspection.

### Food and drink

In the annual PEAT assessment, the trust scored 'good' for food. We heard mixed reviews about the quality of food during this inspection. Generally patients were satisfied with the quality of food they received. Some people told us they would have liked to be able to reheat food but they could not do so as there were no facilities on the wards. We saw people being supported to eat when necessary. We saw that water and other drinks were put close to patients. The trust had protected meal times which meant that, when it was meal time, general care should not be carried out and patients should be assisted to eat and drink if necessary. Many members of staff told us this wasn't always adhered to and we saw some cases of general care continuing at meal times.

### End of life care

In line with the Department of Health's guidance, the Liverpool Care Pathway, the care pathway for delivery of end of life care, is no longer in use. Interim guidance had been introduced, although not all staff were aware of this. There is a purpose-built palliative care unit in the grounds of Whipps Cross hospital and staff from the unit provide support and guidance to the main hospital site. However, at other sites the palliative care team was only available between the hours of 9am and 5pm Monday to Friday.

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

## Summary of findings

Most people told us that the services they used were responsive their needs. However, in some areas of the trust, people's needs were not being met. There were problems in both the Royal London and Whipps Cross hospitals with patient flow through the hospital, bed occupancy and discharge planning. This was not such a problem in Newham University Hospital.

Young people felt that their needs were not addressed, as there are no dedicated facilities for caring for adolescent patients.

The other area where people felt the trust was not responsive was when they had cause to complain. Across the trust, people we spoke with and who contacted us consistently told us that they were unhappy with the way their complaints had been handled. The Patient Advice and Liaison Service in the trust has recently become centralised and this has been a cause of frustration for people who wish to raise concerns.

We had concerns about written information for patients, both in respect of its general availability and the languages it was available in. This caused anxiety for people who did not want to bother staff.

## Our findings

### Responding to patients' needs

The trust performs below the expected national target for waiting time in the A&E department, although this was less likely to happen in Newham University Hospital. The trust also performs below the national average for people leaving A&E without being seen. The CAG for emergency medicine worked to ensure that each of the trust's A&E departments had enough staff with the right skills on duty at all times.

Wards were generally busy and people told us that staff did not seem to have the time to talk with them; rather, they carried out what care was required and then moved onto the next patient. Staff agreed that this was often the case and told us they thought there were not always enough staff on duty.

### Discharge

Discharge planning was mixed. Staff told us that, on medical wards, people who were ready to be discharged sometimes couldn't be, because equipment wasn't available or housing needed to be arranged. There had been a 'bed manager' at the Royal London, although this post no longer exists and staff told us they felt that not having a dedicated person to ensure that beds were available caused a delay in discharging some people. Across all three main hospitals, there was a perception that some patients had delayed discharges because of social issues, such as waiting to be rehoused; the trust should work in conjunction with the local authorities to ensure this is not the case. If patients had a very short life expectancy, of less than three months, there was a 'fast track' process to facilitate funding and ensure that a care package could be put in place speedily. However, nationally the trust was performing similarly to other trusts in response to questions about discharge planning.

### Information

Patients told us they would have liked more written information. They told us that they couldn't always remember what they had been told about their procedures and future plans and didn't like to keep asking. This was a consistent message across all sites. The written information that was available was exclusively in English. All of the hospitals in Barts Health care for people from a number of different ethnic groups, not all of whom speak and/or read English. In the Royal London Hospital, many people told us they found the hospital hard to get around and the lack of signage made this more complicated.

The trust employed a large number of staff from different ethnic groups and staff are willing to translate for patients. Staff may also access a telephone translation service, although patients told us they usually had relatives with them who could translate.

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

### Complaints and feedback

The trust recently restructured the Patient Advice and Liaison Service. This service provided information to patients and helped them with complaints. Until recently, each hospital site had an office with staff. Each of these offices are now closed and there is a central telephone number for people to call instead. People who have concerns or complaints should then be directed to the correct person to speak to. This is a new development and during our inspection we saw that leaflets about the new service were being distributed. However, patients told us that they did not understand how the system worked and when we rang the number, on a number of occasions, there was no response.

During the inspection, we were contacted by a number of people, either directly or at one of our listening events, who told us they had complained about their care or a relative's care and had not been satisfied with the response. In maternity services, it was clear that work had started on learning from complaints in order to improve people's experience, but this was not the case across other departments.

# Are services well-led?

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

## Summary of findings

There is variability in leadership across the hospital. The trust's Executive Team is well-established and cohesive with a clearly shared vision. They are well supported by non-executive directors. However, they are not visible across the trust.

Below board level, some areas were well-led, but others were not and this had an impact on patients' care and treatment. The clinical leadership structure was relatively new. The Clinical Academic Group (CAG) structure was introduced in October 2012 but is not yet embedded across the organisation. The exception to this is the Emergency Care and Acute Medicine (ECAM) CAG.

The CAGs, when embedded, could provide a clear route for board to ward engagement and governance but it needs time to become embedded and effective. The trust recognised this and had taken action to address some shortcomings in the governance structure, such as the introduction of site-level organisational and clinical leadership.

Staff feel disconnected from the trust's Executive and feel undervalued and not supported. The culture was not sufficiently open and some staff felt inhibited in raising concerns. Morale was low across all staffing levels and some staff felt bullied. This must be addressed if the trust's Executive Team's vision is to be successful.

## Our findings

### Leadership and clinical governance structures

Barts Health NHS Trust came into being on 1 April 2012. It was created by a merger of Barts and the London NHS Trust, Whipps Cross University Hospital and Newham University Hospital. In October 2012, the trust introduced a clinical leadership structure (the Clinical Academic Group (CAG)) covering specific specialties, such as emergency medicine or surgery, across all Barts Health sites. There are distinct advantages to this structure: it creates the opportunity to share best practice, make improvements, streamline services and innovate. However, there are also risks, particularly in the way the trust implemented the new structure. Some staff reported difficulties in working across the three main hospitals. They said that it was sometimes difficult to know who was in charge in specific areas. At times, they found that the governance structure prevented issues being addressed. The trust had recognised this and strengthened site level leadership at operational and clinical levels. This had been implemented just before our inspection so its impact could not be assessed. It is, in our view, a positive move.

The CAG structures were not effectively embedded in all areas. The emergency care and acute medicine CAG was the most developed and was working relatively well. The CAG had introduced staff working across all sites and there was effective leadership at all levels in the CAG. This was not the case across other CAGs. The trust is committed to learning from care and participated in 38 out of 39 clinical audits for which it was eligible. Sharing the learning from these audits should ensure care improves.

We found some areas of the hospital were well-led but this was not consistent; we found well-run wards in both surgical and medical departments and outcomes for patients in these wards were better.

The trust's Executive team had a vision for Barts Health and were committed to being highly visible. They were supported by non-executive directors. We were told that the executive team each visit the clinical areas of the hospital on the first Friday of the month. The executive team were confident that staff knew who they were and that they knew about this initiative. Staff, however, were largely unaware of this and said they felt the trust's board was distant and remote.

### Organisational culture

Barts Health does not have an open culture that allows staff to raise concerns without fear of reprisals or bullying. As part of our inspection we held focus groups with staff of all disciplines and all grades. We also interviewed individual members of staff and held drop-in sessions. Consultant medical staff told us that leadership positions were largely given to consultants who had worked in the Royal London rather than Newham or Whipps Cross hospitals.

# Are services well-led?

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

A nursing reorganisation was underway, which will result in some members of nursing staff having their band downgraded; this was having a negative impact on staff morale across all hospitals within the trust. Many nursing staff told us they were considering leaving and doctors told us that they felt their nursing colleagues were not valued.

It was not just nursing staff who felt unsupported and were leaving. We spoke with two acute consultants who had left the trust because of their significant concerns about the infrastructure and safety of practice in the acute admissions unit. We were also contacted by consultant staff who were concerned about medical cover at night time and at weekends. Over the course of the inspection we were contacted by a large number of staff who would only speak with us if we would agree they could be anonymous. They told us they were concerned there would be repercussions and that they felt under pressure not to tell us where there were concerns.

Most staff felt that support and leadership at ward and department level was effective but there was a sense of a disconnect regarding the trust's executive and non-executive teams. Despite this, sickness levels at the trust are better than expected and the trust also scored better than expected on the percentage of staff feeling pressure to return to work while still unwell. In the last NHS Staff Survey, there were concerns about the proportion of staff experiencing abuse from staff, and also about job satisfaction and staff motivation at work.

The General Medical Council's National Training Scheme Survey in 2013 identified a number of areas of concern, including undermining of junior doctors by consultants, teaching, workload, hours of education and trainee compliance. Action plans were in place and these were being monitored, but junior doctors told us that, at times, they felt unsupported – this was particularly the case on medical wards at weekends and overnight.

Although the merger was relatively recent, there is little sense of staff working for Barts Health NHS Trust – staff still related very much to the hospital they were working in than the trust overall or the CAGs.

Barts Health NHS Trust

# The Royal London

## Quality report

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

## Overall summary

The Royal London is a teaching hospital that offers a full range of local and specialist services, including one of the largest children's hospitals in the UK and one of London's busiest children's accident and emergency departments. The hospital is part of Barts Health NHS Trust, which brought together the former Barts and the London NHS Trust, Newham University Hospital NHS Trust and Whipps Cross University Hospital NHS Trust in April 2012.

We chose to inspect Barts Health NHS Trust as one of the Care Quality Commission (CQC) Chief Inspector of Hospital's first new inspections because we were keen to visit a range of different types of hospital, from those considered to be high risk to those where the risk of poor care is likely to be lower. Barts Health NHS Trust was considered to be a high-risk provider.

One of London's oldest hospitals, the Royal London was founded in 1740. To support modern healthcare delivery, the old hospital was recently demolished and replaced by new, state-of-the-art buildings. The new Royal London Hospital opened on 1 March 2012.

CQC has inspected the Royal London Hospital twice since 1 April 2012. On our most recent inspections in November 2012 and June 2013, we issued five compliance actions to the trust. As part of our November 2013 inspection, we did not assess whether the trust had addressed these shortfalls, as the deadlines for completing the trust's action plans had not been reached. These areas will be subject to a further inspection early in 2014.

Our inspection team included CQC inspectors and analysts, doctors, nurses, allied health professionals, patient 'Experts by Experience' and senior NHS managers. We spent three days visiting the hospital. We spoke with patients and their relatives, carers and friends and staff. We observed care and inspected the hospital environment and equipment. We held one listening event in Shadwell and heard directly from people about their experience of care. Before the inspection, we also spoke with local bodies, such as clinical commissioning groups, local councils and Healthwatch.

# Summary of findings

## The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

### Are services safe?

Generally people received safe care. Staff assessed patients' needs and generally provided appropriate care. There were procedures to keep people safe. The hospital was clean and staff adhered to infection control practice.

However, some aspects were unsafe. Staffing levels on some medical and surgical wards were not always safe. Equipment in some parts of the hospital was either unavailable, in short supply, inappropriate or not subject to the appropriate checks, some of which was essential.

The hospital environment was safe, although there were some shortfalls that meant people's needs were not always met.

### Are services effective?

Services within the Royal London Hospital were generally effective, although this is variable. In some cases, multidisciplinary teams did not work effectively together and this had an impact on patients' recovery.

On the whole, staff worked in areas which supported them to gain specialist knowledge and experience and this was beneficial for patients. There is work currently ongoing to ensure that there are senior staff available 24 hours a day.

Patient care and treatment was effective and guidelines for best practice were monitored. We saw effective collaborative working in a number of areas in the hospital – but not all.

### Are services caring?

Feedback from patients, friends and families of patients (including parents of young patients) was overwhelmingly positive about staff attitudes towards them. They said that staff were kind, caring and attentive to their needs. Patients' privacy and dignity was maintained. Patients received appropriate support to eat and drink. During the inspection we saw staff being attentive and caring towards patients.

We have, however, heard – from our listening events and people calling and writing to us – about a number of concerning instances of very poor care. The hospital needs to ensure that the positive experiences we saw and heard about during the inspection are maintained and that instances of poor care are minimised as far as possible.

However, there was frequently not enough written information for people using services and people told us that this would have been helpful in remembering treatment details or what they had been told by staff.

# Summary of findings

## The five questions we ask about hospitals and what we found

**Are services responsive to people's needs?**

Generally services were responsive to people's needs. In some areas of the hospital, patients' needs were not being met. While some improvements had been made in some areas, essential checks on patients did not always happen. There were problems with patient flow through the hospital, bed occupancy and discharge planning. This was having a negative impact on patients' experiences.

The care of adolescents – who are cared for in the paediatric wards for children – is not appropriate as this arrangement did not meet their specific needs.

Where people had complained, they did not always feel that their complaint had been listened to and acted on.

The hospital was difficult to get around and poor signage further complicated this; people told us they often got lost. This is not conducive to providing good care particularly for people with dementia. People also told us they would like more written information about their care and treatment.

**Are services well-led?**

There is variability in leadership across the hospital. Some areas were well-led, but others were not and this had an impact on patients care and treatment. The clinical leadership structure was relatively new and it needs time to become embedded and effective. The trust had recognised this and, to address some shortcomings in the governance structure, action had been taken, such as the introduction of site-level organisational and clinical leadership.

The culture was not sufficiently open and some staff felt inhibited in raising concerns. Morale was low across all staffing levels and some staff felt bullied.

# Summary of findings

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

### Accident and emergency

Patients told us that staff were polite, caring and supported them appropriately. We saw that staff acted in a manner that respected patients' privacy and dignity.

The department had protocols and pathways that ensured most patients received safe and effective care which was responsive to the needs of most patients. Nationally agreed emergency department quality indicators state that 95% of patients should be seen, treated and have either been discharged or admitted within four hours. At the Royal London, 93.9% of patients met this target.

Staff told us that the department was well-led and a good place to work. We saw examples of learning from incidents and changes being made to prevent similar incidents in the future. This included evidence of new protocols being introduced for managing patients with a pulmonary embolism. The department was beginning to work with the trust's other emergency departments to ensure that good practice and learning was shared.

### Medical care (including older people's care)

We found that the quality of care varied between different wards. We saw some examples of good practice on some of the medical wards. However, we found that the quality of care provided on two wards providing care for older people was sometimes compromised by insufficient staffing levels, resulting in some patients being placed at risk of receiving a poor standard of care. Staff did not have enough time, due to their workload, to complete patient records, which meant there was not enough written evidence of what care and treatment was being offered to some of the patients. Staff were also unsure about which recording tools should be used.

# Summary of findings

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

### Surgery

Patients were positive about the care and treatment they received in the surgical department. The transfers between the critical care unit and surgical wards could be improved as patients experienced delays due to limited bed availability and this impacted on their experience.

There were systems and processes in place for pre-operative assessments, which identified any concerns or issues that needed to be resolved prior to the patient being admitted for surgery. This approach reduced the risks to patients and promoted patient safety. However, not all areas where pre-operative assessments took place, such as the cardiac stress testing assessment unit (CPEX) were fit for purpose. The location and the lifts in this area could result in delays if emergency treatment was needed (for example, if a patient collapsed).

There were systems in place for patients to provide comments and complaints about their care and treatment. However, the information regarding how to provide feedback was not readily available. Complaints were logged and a response was provided, however, not all staff were encouraged to participate in resolving the complaint and there was limited evidence of learning from complaints.

Some wards were responsive to patient feedback, and revised the way they delivered services to meet their patients' needs and improve the quality of care, and reduce the impact of long-term treatment on their life style.

There were staffing and equipment issues in theatre and a significant number of cancelled operations. There was reliance on bank (overtime) and agency staff to cover shifts in theatres and on the surgical wards. The use of inexperienced bank and agency staff in theatres was impacting on the department's efficiency.

There was no evidence of a consistent approach to clinical governance in the surgical clinical academic group (CAG). The collection of performance data is incomplete, and data, such as time and reasons for delays in emergency surgery, were not being recorded. Serious incidents were reported and a risk register was completed but there was limited learning from incidents and staff did not routinely receive feedback on incidents they reported.

### Intensive/critical care

There were enough trained and skilled staff to deliver safe, effective care to people in both the Intensive therapy unit (ITU) and high dependency unit (HDU), but many were not up to date with their mandatory training. There was effective multidisciplinary working between the doctors and nurses, who were supported by the matrons, consultants and practice development team.

Performance information was used to improve practice and patient experience. There was culture of reporting, investigating and learning from incidents. Staff made changes to practices in response to incidents to avoid a similar incident in the future.

The majority of ITU patients experienced a delay of over four hours before being transferred to the HDU or a ward. Some of these patients were transferred after 10pm, a time when there may be fewer staff on duty on the wards.

The unit responded to the cultural, linguistic and religious needs of patients. There was the provision of an interpreter service, both face-to-face and through LanguageLine. However, we noted that, on a few occasions, not all staff accessed this service and they tried to communication without an interpreter.

# Summary of findings

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

### Maternity and family planning

At the time of our inspection, the maternity and neonatal intensive care unit (NICU) were providing safe, effective care and were responsive to the needs of people who used the service. Most of the women we spoke with were pleased with the antenatal and maternity care they received. They felt they had been given sufficient information and support. Women were particularly complimentary about the care they had received during labour and from the breastfeeding team. However, we found that some people had had some negative experiences on the postnatal ward.

We found that the Barkantine midwifery-led unit was providing care to low-risk women and transferred patients to the Royal London Hospital if any complications occur. We found that all except five guidelines at the Barkantine centre were out of date. Some had last been updated in 2006 and had no date for review.

Staffing levels were safe and there was sufficient consultant cover. However, some staff told us that there were times when they were stretched and could not provide one-to-one care to women in established labour. Most units were equipped sufficiently, but some staff told us that they had to borrow equipment from other parts of the department.

We found evidence that the maternity service had learned from mistakes. Systems were in place for reporting and reviewing incidents to ensure that appropriate action was taken. Care was delivered in accordance with national guidelines and the service was conducting research studies to improve outcomes for people.

Staff enjoyed working for the service and were positive about the support they received from their line manager. However, changes that were being made to the staffing structure was affecting morale and some staff felt undervalued. They felt lessons to be learned from incidents were shared well, but a shortage of administrative support and poor IT systems were impacting on their delivery of care. At the time of our inspection, the maternity and NICU units were meeting the requirements of the regulation. However, the trust needs to ensure that any changes are sustainable and that the department can continue to provide a good, effective service.

### Children's care

Children were cared for in line with clinical guidelines and by staff trained to work with children. Parents had confidence in the care children received and were positive about staff compassion and communication, although we found a marked lack of written information to help parents and children prepare for a hospital stay. The environment was well maintained and there were toys and activities available for children on the wards and in outpatient clinics.

However, the needs of adolescents were not always met. Teenagers were sometimes nursed in bays alongside much younger children. Staffing levels were adjusted day-to-day to reflect children's needs, but this was not done using a structured dependency tool.

The staffing levels were perceived by nursing staff and parents to be safe but did not always meet national guidelines for staffing in children's services. The quality of the service was monitored by managers and a number of risks to patient care had been identified and escalated to the trust Board. We also saw that a number of improvements had been introduced, for example, the introduction of a new paediatric early warning bedside documentation system. However, it was evident that some aspects of clinical governance and learning from incident reporting was not embedded in the children's services. We identified a significant incident that had not been reported.

# Summary of findings

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

### End of life care

The trust had a specialist palliative care team who supported staff on the wards providing end of life care. Most patients referred to the service were seen promptly, however, some staff were not aware of the trust's interim guidelines relating to end of life care. Because of this, there was a potential risk that some patients may not receive end of life care in a timely manner. While we received positive feedback from the people who used the service and their relatives, we also received mixed comments from the clinical staff about the quality of care provided to end of life patients.

### Outpatients

People were positive about the treatment and advice they received in outpatient settings. Consultations were conducted in private and people had time to ask questions. Some, but not all, clinics were managed efficiently. People routinely waited for over an hour to be seen in some clinics. People's experience of the appointments system was also varied, with appointments for the spinal orthopaedic clinic being particularly problematic. Trust figures showed that most people who needed to be seen urgently were given appointments in line with national standards. The number of patients who failed to attend, and the number of cancelled clinics were above the national average. There was no evidence that the trust had taken steps to identify the reasons for this or take action to address these issues.

The trust sought the views of patients and was in the process of implementing a programme to "transform" outpatient services. We found that staff involved in delivering care in the Royal London Hospital were often unaware of the trust's programme to improve the outpatient experience and were therefore not able to participate or communicate this work effectively to patients.

# Summary of findings

## What people who use the hospital say

Comments and reviews posted via Patient Opinion, NHS Choices and CQC Share Your Experience highlighted that care from doctors and communication could be improved. Positive comments included "nurses give good care" and are "understanding" of patients' needs. Most of the patients we spoke with said that the nursing staff were caring.

## Areas for improvement

**Action the hospital MUST take to improve**

- Ensure that action is taken on identified risks recorded on the risk register.
- Ensure that there are sufficient staff with an appropriate skills mix on all wards to enable them to deliver care and treatment safely and to an appropriate standard.
- Ensure there are sufficient middle-grade medical staff present.
- Actively listen to staff and respond to their concerns.
- Adopt a zero tolerance to bullying by middle managers.
- Ensure that adolescents are treated appropriately and not within the general paediatric wards.
- Ensure that equipment is readily available when requested.

## Good practice

Our inspection team highlighted the following areas of good practice:

- The Royal London's Emergency Assessment (EA) model. This is a team approach, led by a consultant or registrar that aims to ensure that patients are treated in the most suitable area by the appropriate professional. This includes redirection to GPs when the patient has primary care needs, or seeing patients in the urgent care or emergency care departments when they need immediate medical intervention, (for example, patients who have sustained an injury).
- The ready availability of interventional radiology – patients requiring interventional radiology receive this within an hour of the need being identified and this is available 24 hours a day, seven days a week.
- The development opportunities available for medical records staff – staff are supported to complete an accredited clinical coding course which leads to alternative employment opportunities.

# The Royal London

## Detailed Findings

**Services we looked at:** Accident and emergency (A&E), Medical care (including older people's care), Surgery, Intensive/critical care, Maternity and family planning, Children's care, End of life care, Outpatients

## Our inspection team

**Our inspection team for Barts Health NHS Trust was led by:**

**Chair:** Dr Andy Mitchell, Medical Director (London region), NHS England

**Team Leader:** Michele Golden, Compliance Manager, Care Quality Commission

**Our inspection team at the Royal London Hospital was led by:**

**Team Leader:** Fiona Wray, Compliance Manager, Care Quality Commission

Our inspection team included CQC inspectors and analysts, doctors, nurses, midwives, allied health professionals, patient 'experts by experience' and senior NHS managers.

## Why we carried out this inspection

We chose to inspect Barts Health NHS Trust as one of the CQC's Chief Inspector of Hospitals' new in-depth inspections. We are testing our new approach to inspections at 18 NHS trusts. We are keen to visit a range of different types of hospital, from those considered to be high risk to those where the risk of poor care is likely to be lower. After analysing the information that we held about Barts Health NHS Trust using our 'intelligent monitoring' system – which looks at a wide range of date, including patient and staff surveys, hospital performance information, and the views of the public and local partner organisations – we considered the trust to be 'high risk'.

## How we carried out this inspection

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

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

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

- Accident and emergency (A&E)
- Medical care (including older people's care)
- Surgery
- Intensive/Critical care
- Maternity and family planning
- Children's care
- End of life care
- Outpatients

Before visiting, we examined information we held and asked other organisations to share their knowledge of the trust. The information was used to guide the work of the inspection team during the announced inspection on 5, 6 and 7 November 2013. An unannounced inspection was carried out on 15 November 2013.

# Detailed findings

During the inspections we:

- Held six focus groups with different staff members as well representatives of people who used the hospital.
- Held three drop-in sessions for staff.
- Held a listening event specifically for the Royal London Hospital at which people shared their experiences of the hospital.
- Looked at medical records.
- Observed how staff cared for people.
- Spoke with patients, family members and carers.
- Spoke with staff at all levels from ward to board.
- Reviewed information provided by, and requested from, the trust.

The team would like to thank everyone who spoke with us and attended the listening events, focus groups and drop-in sessions. We found everyone to be open and balanced when sharing their experiences and perceptions of the quality of care and treatment at the hospital.

# Are services safe?

## Summary of findings

Generally people received safe care. Staff assessed patients' needs and generally provided appropriate care. There were procedures to keep people safe. The hospital was clean and staff adhered to infection control practice.

However, some aspects were unsafe. Staffing levels on some medical and surgical wards were not always safe. Equipment in some parts of the hospital was either unavailable, in short supply, inappropriate or not subject to the appropriate checks, some of which was essential.

The hospital environment was safe, although there were some shortfalls that meant people's needs were not always met.

## Our findings

### Patient safety

Since January 2013 there have been four Never Events at the Royal London Hospital – Never Events are classified as such because they are so serious they should never happen. The hospital had learned from these events, although some of the new procedures introduced to prevent them happening again had only recently been implemented and so we could not assess how effective they will be. There had also been serious incidents logged by the hospital, with a third of these being pressure ulcers that occurred while people were being cared for at the Royal London. On a previous inspection, CQC found that the Royal London Hospital was not meeting the requirements of the law in some aspects of providing safe care to elderly people, and the hospital is currently working towards changing their practices and ensuring safety.

### Staffing

Staffing levels across the hospital varied. Some wards did not have enough staff, or their staff did not have the right skills for the specialism they were working in. Some aspects of staffing worked well – for instance, the accident and emergency (A&E) department had consultant doctors working at all times so that junior doctors could have access to senior support and expertise. This did not apply in all areas and, on the medical and surgical wards, junior doctors told us they were overstretched, particularly at night time and weekends. The palliative care team worked Monday to Friday from 9am to 5pm, with an on-call system in place outside these hours. However, if a patient required palliative care at the weekend, advice was not always readily available.

There was an ongoing review of nursing staffing levels at the time of this inspection. We were told that the aim of this review was to ensure that staffing levels were determined by the dependency of the patients. Wherever possible, the hospital ensured that agency and bank (overtime) staff had the right skills and expertise to work in the areas they were assigned.

### Learning from incidents

There was a strong commitment to improving practice through learning from incidents. Appropriate investigations took place when an incident occurred. Learning from these investigations was shared at clinical governance meetings that were well attended. But this was not uniform throughout the hospital.

### Equipment

All equipment we saw on this inspection was clean and ready for use. However, across the hospital we were told that equipment wasn't always readily available. We were told that many wards regularly lent and borrowed equipment from other departments. Sometimes equipment was available after a delay and it was not uncommon for there to be delays in getting air flow mattresses for patients. This was not the case in the A&E department which is well equipped.

### Hospital infections and hygiene

Hospital-acquired infections at the Royal London were within expected ranges. People were protected from the risk of infection. There were hand-washing facilities, which we saw staff and visitors use, and in most areas there was hand gel as well. The hospital itself was clean and we heard visitors commenting on this.

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

## Summary of findings

Services within the Royal London Hospital were generally effective, although this is variable. In some cases, multidisciplinary teams did not work effectively together and this had an impact on patients' recovery.

On the whole, staff worked in areas which supported them to gain specialist knowledge and experience and this was beneficial for patients. There is work currently ongoing to ensure that there are senior staff available 24 hours a day.

Patient care and treatment was effective and guidelines for best practice were monitored. We saw effective collaborative working in a number of areas in the hospital – but not all.

## Our findings

### Clinical management

Before we carried out this inspection, we looked at the data we held for the Royal London Hospital. For most of the indicators, CQC considered the hospital was within the expected parameters. We were aware that, in the maternity department, there were more emergency caesarean sections than expected. We had written to the trust before the inspection asking them to explain why this might be and, although they were able to provide an explanation, they also identified some areas where care could be improved. We had also identified that a higher number of women than expected had developed infections after delivery. Although the trust was able to identify that, in many cases, the recorded diagnosis of infection was incorrect, they had implemented a number of changes.

Care was delivered across the hospital according to best practice. However, there were occasions where patients were in the wrong ward – for instance, trauma patients being on the surgical wards because the trauma ward was full. This meant that patients were not always looked after or had their care delivered by the most suitable staff.

In A&E, consultant staff were on duty at all times. This meant that junior staff could seek expert advice at all times but also that patients would be treated by senior and experienced consultant staff when necessary. In the critical care unit this was also the case. Care was supervised by a senior consultant and there was a daily, consultant-led ward round. However, this was not the case throughout the hospital. On medical wards at weekends there was a consultant on duty from 9am to 5pm, but they would only review new patients. This meant that patients admitted on a Friday could potentially not be seen by a consultant until the following Monday, during which time there could be delays in decisions made about suitable treatment for those patients. The palliative care team, which was not based at the Royal London, does not work in the evenings or at weekends.

### Staff skills

In our inspection of June 2013, we had told the senior management team at the Royal London Hospital that staff were not supported adequately and they responded that they would ensure that new systems would be in place across the hospital by December 2013. Nursing staff told us they had been having appraisals and that clinical supervision was planned for the future. Nursing staff in some areas were able to access training, although this was not across all areas. Some nursing staff told us that they could not go to training because there were staff shortages.

Junior doctors also gave a mixed picture: in A&E, critical care and paediatrics, they felt supported; on the medical wards they felt overstretched and less supported.

### Collaborative working

Staff at the Royal London Hospital worked collaboratively and we saw good working relationships across the many different professional groups working there. Staff were respectful towards each other and valued others' opinions.

# Are services caring?

## Summary of findings

Feedback from patients, friends and families of patients (including parents of young patients) was overwhelmingly positive about staff attitudes towards them. They said that staff were kind, caring and attentive to their needs. Patients' privacy and dignity was maintained. Patients received appropriate support to eat and drink. During the inspection we saw staff being attentive and caring towards patients.

We have, however, heard – from our listening events and people calling and writing to us – about a number of concerning instances of very poor care. The hospital needs to ensure that the positive experiences we saw and heard about during the inspection are maintained and that instances of poor care are minimised as far as possible.

However, there was frequently not enough written information for people using services and people told us that this would have been helpful in remembering treatment details or what they had been told by staff.

## Our findings

### Patients' views and feedback

In the 2012 Adult Inpatient Survey, the year before Barts Health NHS Trust existed, Barts and the London Trust performed about the same as other trusts on most questions. There were six questions where the trust did not score as well as other trusts and these were predominantly around nursing interactions. On this inspection, patients overwhelming told us about how caring the staff were at the Royal London Hospital. In the A&E department, where the NHS Friends and Family test has been in use since April 2013, the Royal London scored 56 [possible top score of 100], which is higher than the average score of 52In August 2013, 93.9% of the 1,397 people who completed the Friends and Family test said they would be 'likely' or 'extremely likely' to recommend the A&E department to others. Yet, of the 25 people who have contacted CQC by completing 'Share your experience' forms, 24 have had negative feedback.

On the NHS Choices website, the Royal London Hospital has a score of three stars out of a possible five, based on 79 respondents. Feedback from people using the outpatients department was mixed: many clinics ran late and patients told us they did not receive explanations or apologies for this. Patients found it frustrating not knowing when they would be seen. This had an impact on the whole patient experience and, in some cases, patients formed a negative opinion of the hospital.

### Privacy and dignity

We saw staff treating patients with respect and dignity. Staff were compassionate and caring. Curtains were drawn around beds when staff went to speak with patients or to deliver care. Bays on wards were clearly identified as being for male or female patients and bathrooms were also clearly marked. We saw many instances of patients' notes lying on desks and not being put away securely. This could lead to a breach of a patients' confidentiality.

### Food and drink

Although people were offered choices of food, we received mixed reviews. Some people said they would have liked to be able to reheat food or make toast but there were no kitchen appliances available on the ward. We saw that, where people needed help with eating and drinking, staff were generally available to help them. The hospital had protected meal times which meant general care should not be carried out, and there should not be ward rounds at this time. Staff and patients told us this did not always work in practice and we saw some incidents where nursing and medical staff were continuing with their usual activities at meal times.

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

## Summary of findings

Generally services were responsive to people's needs. In some areas of the hospital, patients' needs were not being met. While some improvements had been made in some areas, essential checks on patients did not always happen. There were problems with patient flow through the hospital, bed occupancy and discharge planning. This was having a negative impact on patients' experiences.

The care of adolescents – who are cared for in the paediatric wards for children – is not appropriate as this arrangement did not meet their specific needs.

Where people had complained, they did not always feel that their complaint had been listened to and acted on.

The hospital was difficult to get around and poor signage further complicated this; people told us they often got lost. This is not conducive to providing good care particularly for people with dementia. People also told us they would like more written information about their care and treatment.

## Our findings

### Patient flow through the hospital

Nationally agreed emergency department quality indicators state that 95% of people attending A&E should be seen, treated and either discharged or admitted within four hours of arriving at the department. The Royal London Hospital meets this timescale for 93.9% of patients and is working towards achieving the target of 95%. However, fewer people leave the department without being seen than in other hospitals. here is a separate children's A&E and staff who work in that department are supported to gain specialist paediatric skills.

Staff on the medical wards told us that, sometimes people who are fit for discharge are unable to leave because they are waiting for services to be arranged. In some cases they may be waiting for equipment to be delivered to their homes or they may be waiting for housing to be found for them. This had an impact on patient flow through the hospital. We were told that there is no longer a bed manager for medical patients. This person had been responsible for ensuring the discharge of patients who were ready to leave. There is a perception among staff that many discharges are now delayed because there is no longer a bed manager on site.

Adult wards were clearly identified as male or female. On the paediatric wards, there are no dedicated adolescent facilities or area. Adolescent patients told us they were unhappy about being treated on a ward with young children and, in some cases, babies.

### Discharge planning

Discharge planning was mixed. We heard of delays in people being discharged from the hospital. In many cases this was because the patient in question had complex medical and/or social needs. Staff told us these discharges were delayed because appropriate care was not always available in the community.

### Information

People using the hospital told us that, while they liked the new building, they found it difficult to find their way around. Many people told us the lack of signs made things more complicated. The signs around the hospital were in English, although a large number of people in the local community do not speak or read English. Staff told us they could access a telephone interpreting service if necessary and could call on staff to interpret too. Some people said they would have liked more written information, as they did not always remember what had been said to them by staff.

### Complaints

Many people we spoke with on this inspection did not know how to make a complaint. CQC also received many emails and telephone calls from people who said they had complained and not had a satisfactory response or, in some cases, a response at all. In some departments, such as A&E, complaints were discussed at departmental clinical governance days to ensure that learning points were identified and discussed.

The Patient Advice and Liaison Service had recently been restructured. Instead of a staffed office on site, people are now given a phone number to call where they can log their concern and a member of staff from the relevant department will call them back. Patients told us they did not always understand how this system worked and, on a number of occasions, our inspection team rang the number but there was no reply.

# Are services well-led?

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

## Summary of findings

There is variability in leadership across the hospital. Some areas were well-led, but others were not and this had an impact on patients care and treatment. The clinical leadership structure was relatively new and it needs time to become embedded and effective. The trust had recognised this and, to address some shortcomings in the governance structure, action had been taken, such as the introduction of site-level organisational and clinical leadership.

The culture was not sufficiently open and some staff felt inhibited in raising concerns. Morale was low across all staffing levels and some staff felt bullied.

## Our findings

### Leadership and clinical governance structures

The Royal London Hospital was part of Barts and The London NHS Trust before it merged with several other hospitals to become Barts Health NHS Trust in April 2012. As such, it is still a relatively new organisation. Following the merger, the trust introduced a clinical leadership structure covering specific specialties, such as emergency medicine or surgery clinical academic groups (CAGs), across all Barts Health sites. There are advantages to this structure, as it creates the opportunity to share best practice, make improvements, streamline services and innovate. However, there are also risks, particularly in the way the trust implemented this structure. Some staff reported difficulties in working across the three main hospitals. They said that it was sometimes difficult to know who was in charge in specific areas. At times, they found that the governance structure prevented issues being addressed. The trust recognised this and strengthened site-level leadership at operational and clinical levels. This had been implemented just prior to our inspection, so its impact could not be assessed.

Staff working in the A&E department felt well supported and told us the department was well-led and non-hierarchical. They felt this had a positive impact on their ability to deliver high-quality care. However, this was not the case across the other clinical academic groups. Not all staff had a good understanding of how their department fit within the hospital and, in many cases, staff told us that changes were introduced to their departments without clear guidance. They said they sometimes received emails about proposed changes that were due to happen soon but there was often not enough detail in the emails.

Generally matrons and consultants were regarded as supportive to junior staff and we saw evidence of good collaborative working at that level. In some areas, staff felt they were encouraged to report incidents as there was a 'no blame' culture, but this was not apparent in all areas.

### Organisational culture and staff morale

Staff of all professionals and grades told us that morale was poor. There was a nursing staff reorganisation underway and staff were concerned at the impact this would have on their grading and salaries. Many staff told us they were considering leaving. Doctors we spoke with also commented on the impact of the nursing restructure on their nursing colleagues.

Many of the staff we spoke with had experienced bullying and spoke with us on the condition of anonymity. CQC was also contacted during the inspection by people wishing to remain anonymous and who identified themselves as 'whistleblowers'.

# Accident and emergency

## Information about the service

The accident and emergency (A&E) department is open 24 hours a day, seven days a week. The department sees about 155,000 patients (adults and children) each year. The department consists of an Urgent Care Centre (UCC), a resuscitation area, an emergency assessment area, cubicles, a clinical decision unit (CDU), and a separate children's A&E.

The department works closely with the provider of the London Air Ambulance and has developed joint administrative pathways for patients to ensure that those who arrive in the air ambulance are seen appropriately. Joint clinical governance and learning sessions are held to ensure that learning can be shared.

## Summary of findings

Patients told us that staff were polite, caring and supported them appropriately. We saw that staff acted in a manner that respected patients' privacy and dignity.

The department had protocols and pathways that ensured most patients received safe and effective care, which was responsive to the needs of most patients. Nationally agreed emergency department quality indicators state that 95% of patients should be seen, treated and have either been discharged or admitted within four hours. At the Royal London 93.9% of patients met this target.

Staff told us that the department was well-led and a good place to work. We saw examples of learning from incidents, and changes being made to prevent similar incidents happening in the future. This included evidence of new protocols being introduced to manage patients with a pulmonary embolism.

The department was beginning to work with the trust's other emergency departments to ensure that good practice and learning was shared.

## Are accident and emergency services safe?

Services were safe and provided in an environment that was appropriate.

### Patient safety

The department's facilities were divided into separate areas, including the resuscitation area, treatment of injuries and emergency assessment area. Staff were allocated to an area at the beginning of each shift and then changed halfway through the shift to an alternative area. This approach ensured that staff were experienced in all parts of the department and did not work in the high-pressure resuscitation area for a full shift. The large and spacious resuscitation room helped to maintain patients' dignity. The room had a separate blood fridge to ensure that blood products were readily available when needed. All areas were tidy and clear of clutter, which made cleaning easier and helped reduce the risk of infection.

Staff felt safe working in the department as the treatment areas could only be accessed through locked doors to prevent access by unauthorised people. The department had badged security staff in the department who could respond to any incidence of violence or aggression.

The department has developed a set of 'how to' guides to provide staff with information to ensure safe care. Staff could easily access this information through a portal on the computer desktop, which we were told was quick and user-friendly. Sections included safeguarding, pharmacy and drugs, and clinical guides.

Patients who arrived at the department were directed by reception staff to see staff in different areas. Those with minor symptoms were directed to the Urgent Care Centre (UCC) where non-clinical staff helped to direct them to other healthcare services, such as a GP. The local clinical commissioning group have commissioned non-clinical navigator staff, who work to a protocol to direct patients to the most appropriate service. This may include facilitating appointments with the individual's GP. While all patients had the option of seeing clinical staff, some patients were leaving the department having only seen these non-clinical staff. This approach presented a potential risk of the patient's condition not being properly identified and appropriate treatment being given in a timely manner.

# Accident and emergency

Following the treatment of a major trauma patient, we observed that the team held a debriefing session, known as a 'code red' debrief, to discuss if there was anything they could improve on for the next patient. We noted that staff identified learning points during this debrief.

There were appropriate infection control systems in place to reduce the risk of cross infection. For example, we saw that cubicle spaces were cleaned between patients using them. Staff were seen to be bare below the elbow, washed their hands and used hand gel dispensers before and after treating patients. We saw that personal protective equipment, such as gloves and aprons, were available and staff used these appropriately.

Recent departmental audits showed that the department had achieved 100% compliance with hand hygiene. However, we noted that the department could benefit from having more hand gel dispensers to ensure that they were more visible and available for patients.

### Caring for children

There was a separate paediatric A&E area for children under the age of 16 years, staffed by appropriately trained and qualified children's nurses. When children and their families arrived at the department, they were directed to this area, which could only be accessed through locked doors, preventing unauthorised access.

Staff had training and understood safeguarding and reporting procedures, including checking to see if the child was on the Child Protection Register to identify those children who were known to social services. This ensured any known 'at risk' children were identified and appropriate action taken.

### Staffing

At the time of the inspection, the department had a vacancy rate of 7% for medical staff and 15% for nursing staff. The nursing vacancies were covered by bank (overtime) and agency staff. During four weeks in October 2013, the department booked 2,992 hours of agency nursing staff, which would equate to around nine shifts a day being covered. Some staff told us that using large number of agency staff placed additional pressure on the permanent staff as the agency personnel were not familiar with the department. To mitigate the risk associated with using agency staff, the department aimed to use the same agency nurses, who were trained in accident and emergency. Also, all agency staff received an orientation on arrival in the department for the first time.

The department had 18 consultants who provided cover in the department 24 hours a day, seven days a week. This arrangement ensured that junior staff always had access to consultant advice and support. Medical staff told us they felt well supported by senior colleagues and that if they needed advice and support this would be available. The department had clear protocols for the supervision of junior medical staff. For example, foundation year 2 (FY2) junior doctors cannot discharge patients without senior review in the first six to eight weeks of their placements, and they cannot treat patients in the resuscitation area without senior support.

Nursing staff told us that they felt the staffing levels in the department were appropriate and that they felt well supported. On the day of our visit, there were 20 members of nursing staff working in the adult areas and four in the paediatric area. There were also separate staff in the UCC.

### Equipment

The department has dedicated scanners, radiology staff and point-of-care machines, meaning that patients had quick access to appropriate diagnostics and treatment. In July 2012, the department was audited as part of the London Health Programmes, which showed that critical patients had access to interventional radiology within one hour, 24 hours a day, seven days a week. The department was using point-of-care machines that allowed diagnostic investigations, such as blood gases tests, to be done immediately. This approach ensured patients received treatment without delay.

### Learning from incidents

The department demonstrated a strong commitment to improving practice through learning from incidents. It had a high level of incident reporting. Since 1 October 2012, 908 incidents had been reported in the department. Staff told us this was reflective of the open learning culture of the department. Incidents were reviewed by senior staff in the department to identify any learning that needed to be implemented. Staff we spoke with were able to clearly describe learning points that had been identified from recent incidents and how these were being actioned

# Accident and emergency

to prevent similar things happening again. We were told that when an incident was reported, an e-mail was automatically sent to other staff in the department so they were aware of the incident and any safety implications.

We saw an example of this during a serious incident investigation into the management of a patient with a pulmonary embolism. The learning from this incident, which took place at another of the trust's hospitals, had been identified and new protocols for managing such patients had been put in place across the trust.

The trust's three emergency departments held quarterly joint clinical governance days to share learning and discuss improvements. We saw that a range of nursing and medical staff had attended the recent clinical governance day. Discussions had included a session on learning from recent serious incidents.

## Are accident and emergency services effective?

Patients were seen and treated effectively by appropriate staff.

### Clinical management/guidelines

The department had clear procedures and pathways in place to support patients when they arrived at A&E. New patients were directed to the injury assessment area, where they were usually seen by an emergency nurse practitioner. This meant that they were seen directly by a member of staff with the seniority to make decisions about the investigations required and the initial treatment to be provided. Those patients arriving with major trauma were sent directly to the emergency assessment area where medical staff made decisions about their treatment. There were dedicated staff for the resuscitation area and patients could be fast-tracked from here into theatres if necessary. There was a blood bank on the unit and extra blood products were available to ensure patients received treatment in a timely manner.

The department was in the process of developing a number of 'care bundles' for set conditions. Conditions for which bundles had already been developed included radial fractures, fractured neck of femur (hip joint) and renal colic. This project aimed to take national guidelines and use them to develop key standards that the department would aim to meet. It would also look at how best to ensure that these standards were delivered and performance audited on an ongoing basis. We saw the example of a new patient information page that was being used for patients who arrived with a fractured neck of femur. This information sheet included key stages to be completed within timescales, such as delivery of analgesia. A formal audit was being undertaken of the quality of care for patients with this type of fracture and staff were confident it would show an improvement in care.

The clinical decision unit (CDU) delivered care to those patients on specific care pathways and aimed for a length of stay for most conditions of under 12 hours. When we visited, we saw three patients who had been on the unit for more than 24 hours. The ward environment was not appropriate for such long stays. Staff told us that patients may be on the unit longer than the set times, due to lack of beds elsewhere in the trust. The staffing levels and environment of the unit were not appropriate to meet the needs of patients who required care for longer than 12 hours. It was unclear what action was being taken to address the issue of delayed discharges from this unit.

### Communication

The twice-daily handover between medical staff was carried out in a formal and appropriate manner. We also saw that communication and briefing meetings took place twice a day. At these meetings, staff discussed the general situation in the department, patients in resuscitation, the situation with beds in the hospital and the upcoming communications diary. This information-sharing provided staff in the department with an awareness of patients and any specific issues that needed to be resolved.

### Staff development

Junior doctors told us they felt they were well supported in the department and had good access to training. The rosters for medical staff that we looked at showed that protected time was allocated for teaching.

Nursing staff told us they felt the team structure ensured they were clear who they needed to contact to get support. Most of the staff we spoke with told us they had received an appraisal or had one planned. We saw a log of appraisals which showed this was the case. Staff told us they had access to training and we saw evidence that 95.8% of nursing staff had completed all their mandatory training.

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The department had a dedicated practice development nurse whose role was to develop the skills of nurses in the department. Staff at band 5 were able to access the department's 'Foundation in emergency medicine' course, which formalised the development and education of nursing staff in emergency department skills. There were plans to provide this course at the trust's other emergency departments in 2014 but, at the time of our visit, this had not yet been implemented.

### Links with local GPs

The department is currently working on a project to ensure that GP information, for example, information about medications and allergies, was available electronically in the department. This information would enable medical staff to deliver care more promptly as they would have the necessary information to make decisions.

## Are accident and emergency services caring?

Patients received safe care from staff that were kind and caring. However, we found the signage and information available did not always meet people's needs.

### Patients' views and feedback

During our visit we spoke with 11 patients and five relatives, as well as patients in the acute assessment unit who had received care in A&E. They were mostly extremely positive about the care they had received. They told us they had found the staff to be very caring and responsive to any questions. They told us they had been seen by staff and received pain relief promptly.

Patients told us that, "nurses go the extra mile", "All the staff know what they are doing"., and, "[I feel] incredibly well looked after". Patients were spending longer than expected in the CDU, but this was not impacting negatively on their experience. They told us "[I have received] constant good care day and night".

The department was gathering patients' opinion through the NHS Friends and Family test. No other formal method was being used to collect patient feedback. Since April 2013, patients attending hospital wards and A&E departments have been asked: 'how likely are you to recommend our ward/A&E department to friends and family if they needed similar care or treatment?' Their responses to this are used to calculate a score about satisfaction with the service. So far, the A&E department has received an overall score of 56 out of a possible top score of 100, which is better than the A&E average for England which is 52.

### Privacy and dignity

We observed that staff spoke in a kind and respectful manner to patients. For example, we saw staff walking around the department stopping and taking time to answer questions for patients who were waiting. We also saw that call bells were being answered promptly and people's needs were met in a timely manner. During all our visits, we observed that the department was being managed in a calm manner.

When patients were receiving support from staff their privacy and dignity was respected. We noted that curtains or doors were closed. The size of the department meant that there was space to enable discussions to take place in private.

We noted that patients in CDU who were staying longer than expected did not have access to any magazines or television. This left them with nothing to do on the unit unless their family or friends brought in magazines or newspapers. The department had volunteer 'befrienders' working most days to help patients complete the Friends and Family test and also to spend time sitting and talking with patients.

### Food and drink

Patients received adequate nutrition and hydration while they were in the department. Drinks and snacks were available and these were being offered to people. The patients we spoke with on the CDU told us they had been offered sandwiches and hot meals.

### Information availability

When we visited the department we noted there was little information available to patients. For example, we did not see any information on how to complain or contact the Patient Advice and Liaison Service. While the department's new building was not complete, we found the signage difficult to follow and potentially confusing to patients. The department serves a local population with a high percentage of people who do not speak English as a first language. Signage in other languages was not available. We were told that, if required, translation services could be accessed through language.

# Accident and emergency

## Are accident and emergency services responsive to people's needs?

Services were responsive to patients and were actively monitoring performance to ensure patients received timely care, treatment and discharge.

### Waiting times

Nationally agreed emergency department quality indicators state that 95% of patients should be seen, treated, discharged or admitted within four hours. Data showed that, for the financial year to date, the trust was meeting the timescale for 93.9% of patients.

On the day we visited, the department had 426 attendances; of these 10 patients had breached the four-hour timescale. The reasons for these breaches were being recorded and monitored. They included: waits for pathology results, lack of available beds, and time taken to undertake psychiatric assessments. Staff told us that the main reasons for not meeting the target included: delays in admitting patients because of lack of available beds in the trust; and delays in discharging patients from the department because staff prioritised their time to manage major trauma patients.

In response, the department's performance, and specific agreed action, was being monitored by the trust's board. The integrated performance report for November 2013 noted that the trust had moved its acute assessment to an alternative area to enable eight more beds to be opened in the unit.

We noted that, of the patients attending the department, 2.7% left the department without being seen. This figure is below the national target that less than 5% of patients leave the department without being seen.

### Pathway of care

When patients arrived at the department with an injury they were directed to be seen in the injury assessment area, where they were usually seen by an emergency nurse practitioner. This meant they were seen directly by a member of staff with the seniority to make decisions about the investigations and initial treatment they required. Other patients were sent directly to the emergency assessment area where medical staff made decisions on the most appropriate treatment for the individual.

The department had its own dedicated scanners and radiology staff available at all times of the week. This ensured that clinical decisions could be taken quickly and, when patients needed scans, they could receive these promptly.

### Responding to the needs of children

The department had a separate paediatric area, so when children arrived at the department they were directed to a separate waiting area. Dedicated paediatric staff provided care in this area, including four consultants who had a paediatric sub-specialisation and specific skills that enabled them to identify the needs of children and provide appropriate supervision and support for other medical staff. Consultant cover was provided in the paediatric area from 9am to 6pm on weekdays.

At the time of our visit, the children's A&E department was not always staffed by nurses who had paediatric skills to meet the needs of children attending. While this was the department's aim, we were told that it had proved difficult to recruit to some nursing roles requiring paediatric trained staff. In response to this, the department was looking to support staff from within the department to develop their paediatric nursing skills, but this had not yet occurred.

The department had toys for children to play with and there was a play assistant to work with staff to ensure the as far as possible, children's experience of care was not distressing. For example, they would play with children in the waiting areas and help to distract children when they were having treatment.

There was no separate paediatric waiting area in the radiology department. Therefore, children waiting for x-rays did so in an open bay to the side of the main adult waiting room.

### Caring for people with mental health needs

The department had a dedicated 'place of safety' room for people who arrived under section 136 of the Mental Health Act 1983 or those who may have mental health needs. There were plans to develop a second, 'ligature-

# Accident and emergency

free' room to decrease the risk of self-harm for patients with mental health problems. Members of staff from the local mental health trust were situated on the department 24 hours a day. The team gave patients access to medical staff, mental health nurses and approved mental health professionals. This arrangement facilitated the prompt mental health assessment. Staff told us they felt they had a good working relationship with the wider department.

### Working with the ambulance service

The department had systems and processes in place to ensure quick and efficient handovers between A&E staff and ambulance staff. Paramedics who had brought patients into the department told us that they found the process for handing patients over in the department to be effective. They said they appreciated that department staff wore name tags on their uniforms as it made it clear who they were handing over to. We observed that the handover between ambulance staff and the department staff was undertaken in a discreet and thorough manner.

The trust's data regarding the time between the ambulance arriving at the hospital and the clinical and patient handovers showed that, in the financial year to date, the trust was meeting its targets. Eighty six per cent of handovers had been completed in less than 15 minutes, against a target of 85%, and 99.1% of handovers had been completed in less than 30 minutes, against a target of 95%. There had been no 'black breaches', where patients had waited over an hour for handover to be completed.

### Paperless department

Patients' notes were electronic, and this paperless system meant that when a patient who had visited the department previously was admitted, staff did not have immediate access to their notes and were unable to access information collected in the department promptly.

### Complaints

Complaints were being managed within the department and any learning points were identified for discussion at departmental clinical governance days. Appropriate changes were made.

## Are accident and emergency services well-led?

The emergency department and service was generally well-led and there was sharing of practice across the other emergency departments in the trust.

The department was jointly managed with the emergency departments at the trust's other hospitals. We saw evidence that, following the trust merger in 2012, the departments had begun to work more closely together. We were told that recent cross-department appointments had been made, with consultants employed to work in all the trust's A&E departments.

There were other initiatives, such as the 'how to' guides which were being shared across all A&E departments in the trust. Clinical leads were working clinically and managerially across all A&E departments. However, staff we spoke with acknowledged that it would take time to develop this relationship to its full extent.

All the staff we spoke with were positive about their experiences of working in the department. Many told us that the department was the best place they had ever worked. They told us they felt the department was well-led. Staff from all levels told us that they found the department to be non-hierarchical, and that this was important in being able to deliver quality care to patients.

# Medical care (including older people's care)

## Information about the service

The Royal London hospital has 18 wards offering general and specialist medical care to patients, such as people who have had a stroke, people with respiratory illnesses or diabetes and frail, older people.

We made both announced and unannounced visits as part of our inspection of these wards. We visited the acute assessment unit (AAU), often the first ward for patients admitted through A&E, and 15 other medical wards. We visited the discharge lounge where some patients waited for transport to take them home.

We talked to patients, relatives and friends, and staff, including registered nurses, healthcare assistants, ward managers, doctors, consultants and receptionists.

## Summary of findings

We found that the quality of care varied between different wards. We saw some examples of good practice on some of the medical wards. However, we also found that the quality of care provided on two wards providing care for older people was sometimes compromised by insufficient staffing levels. This placed some patients at risk of receiving a poor standard of care. Staff did not have enough time to always complete patient records, which meant there was not enough written evidence about what care and treatment was being offered to some patients. Staff were also unsure which recording tools should be used.

### Are medical care services safe?

Services were generally safe but there were issues around safe levels of staffing to meet patient dependency and ensure patient care records were completed.

#### Patient safety

In most cases, patients' medical needs were assessed appropriately on the AAU and this reduced the risk of unsafe or inappropriate care. Records were fully completed and risks clearly identified, including those relating to malnutrition, pressure damage to skin, falls, and moving and using medical equipment.

Due to the shortages of beds on medical wards, patients were not always admitted to an appropriate specialist ward. These patients, called 'medical outliers', were being treated on surgical wards. During our inspection we were told that there were about 10 older people in the hospital who were not being treated on the specialist care of the elderly wards, due to lack of beds on these wards. Patients were at increased risk of their needs not being met if they are not admitted to an appropriate ward or were moved between wards. One relative told us their relative had been cared for on four wards in five days. They commented, "so many changes in just five days. Lots of new faces. Very stressful for both patients and relatives". Staff told us that, because some patient records were not fully completed, there were potential risks to people's safety.

During our visit to the acute assessment unit, staff told us that some patients needed to have a venous thromboembolism (VTE) – or blood clot – risk assessment completed to ensure that they received the correct care, such as specific medications. Information on display in the ward showed that the ward safety thermometer tool, which measures harm and the proportion of patients who are 'harm free', had been completed for 69% of patients. In August this figure was 60%, which is lower than the national target of 95%. We were told that this data had been produced from a computer system were the assessment information had been recorded in line with the trust's policy. Good practice indicates that the assessment should also be recorded on the medication chart. Of the 14 medication charts we looked at, only six had a record that the assessment had been completed.

Medical staff told us there was an issue with the trust's picture archiving and communication system crashing for up to half an hour about every two weeks. If the system was down, medical staff were unable to look at diagnostic images without contacting the radiology staff, resulting in delays in diagnosis and inefficient working.

We noted that the resuscitation trolley on ward 11D had a record that it had been checked daily. All the equipment and drugs listed on the checklist were present and fit for use. This ensured that, in the event of an emergency, treatment could be provided without delay.

The wards were using safety briefing books, these were updated at each staff handover and recorded the beds of patients with specific needs, such as those requiring

support with eating, or those at risk of falls. They were also used to record any problems with equipment. We noted that these books had been completed and that, on each shift, 'safety briefings' were held where staff discussed these issues.

'Patient at risk' scores were being calculated on the medical wards. The nurses we spoke with were able to explain how they would calculate the score, what it meant and how they would respond.

The trust had a plan to deal with emergency pressures over the winter. For example, it had recently opened a new ward, funded by the winter planning budget. This facilitated the admission of patients without delays, ensuring they received care and treatment that met their needs.

On the two care of the elderly wards we found that there were no written integrated nursing care plans in place. This meant that staff had to look in different parts of patients' records to find information about the proposed care and treatment plans. Staff told us that not having an integrated care plan made their job more difficult and could result in information being overlooked. We also noted that some care records were incomplete. Staff also told us that they did not always manage to complete patient records, because of staff shortages.

### Staffing

There were not always sufficient numbers of nursing staff on the medical wards. The trust was in the process of reviewing nursing staffing levels and we were told that the new staffing structure would be put in place by the end of December 2013. Senior nurses told us that staffing levels were based on the patients' dependency needs. However, there was no formal assessment tool in place to allow nurses to assess patients' level of dependency. Senior nurses told us that any additional nursing staff had to be authorised by one of the senior managers. Staff said that sometimes there were delays in approving additional staff, which meant that some of the shifts remained uncovered. Nursing staff on the medical wards told us that sometimes there were not enough staff on duty to enable them to deliver good and safe care.

All patients on the AAU were reviewed by a consultant daily during the week. At weekends, consultant cover was provided from 9am to 5pm, but they only reviewed all new patients, with no routine review of existing patients. This meant that a patient admitted on a Friday may not be seen by a consultant until the following Monday. This may lead to delays in care management decisions, patient discharges or admissions to other wards.

Staff told us there were fewer senior medical staff on duty at nights and weekends and this was affecting the quality of medical decisions. Junior doctors reported they were very stretched with the amount and intensity of work covering medical wards. Most of the wards we visited confirmed that they did not experience difficulties in accessing clinicians out of hours or at weekends. Staff on some wards did tell us, however, that it was more difficult to access clinicians at weekends. They said they did not feel that patient safety or wellbeing was compromised, but stated that there were, for example, delays in obtaining people's death certificates because of staff not being able to contact doctors.

Information was shared between shifts to facilitate continuous care. We observed some formal, structured and safe medical handovers on one of the stroke units. Staff communicated information about patient care in a professional and respectful manner. Ward staff worked in partnership with other professionals to make sure patients received appropriate care and support. They worked with dieticians, physiotherapists, palliative care team and mental health professionals. The multidisciplinary meetings and staff handovers we observed on three medical wards, showed that patients were discussed in detail, including their treatment and discharge plans. Patient safety was treated as a priority and any issues were openly discussed and addressed.

### Managing risks

Patient records showed that the risk of developing blood clots, pressure sores, catheter and urinary tract infections were managed in most cases. However, due to staff shortages on some of the wards, documents were not always being completed, therefore there was not always a record of how these risks had been managed. The trust had 'intentional rounding' in place, a system where staff walk around the ward or clinical area to check on the welfare of patients at a minimum of every two hours. Patients' files we looked at showed that staff did not always complete each person's chart. This meant that there was no written evidence that two-hourly checks were being carried out. One of the ward managers told

us that staff did not always see the value of completing documentation, however, efforts were being made to ensure that staff understood the purpose of recording all types of care offered and care delivered, as well as any refusals by the patients. We noted that records of two-hour intentional rounding on the AAU were being completed.

Staff assessed patients at the point of admission to find out if they were at risk of developing pressure sores. There was a tissue viability nurse specialist who supported the ward and monitored and reported on pressure sores throughout the hospital. Staff told us that pressure-relieving equipment was available when needed, however, there were sometimes delays in obtaining it. The trust had recently introduced new documentation for recording information relating to pressure sore management called SKIN Bundle. Staff told us that, although they were expected to use this new document, they had not been given any training on how the documents should be completed. They were also unsure of whether they were expected to continue recording information on the existing forms. Therefore, some staff spent more time completing duplicate records than spending time with patients.

### Hospital infections

Patients were protected from the risk of infection. The environment on medical wards was clean and safe. We observed visitors making comments about how clean the hospital was. There was hand hygiene gel available in all medical ward areas for patients, staff and visitors to use. We observed staff wearing gloves when needed. We also saw them washing hands between attending to patients. Patients with infections that could easily be spread to other patients were treated in side rooms. Information on how to prevent infections was available to patients and visitors. Each ward carried out infection control audits. The medical care wards' hand-washing audit for September 2013 recorded 97.5% compliance.

### Safeguarding procedures

Staff had an understanding of how to protect patients from abuse and restrictive practices, such as deprivation of liberty. They gave us examples of the types of abuse to be alert to and knew how to report any safeguarding concerns. Some of the wards had notices in nurses' stations, which displayed contact details of the safeguarding team. Staff said they were confident that concerns would be appropriately dealt with to ensure patients were protected.

### Patient records

We found some gaps in people's medical files. For example, we saw that some records had not been fully completed. Most of the incomplete records were on the wards caring for older people, where staff had not completed people's initial admission assessments and/or the records relating to pressure sore management and nutritional needs.

Staff told us that the hospital computer system was often unreliable, which meant that staff did not always have instant access to patient information, resulting in delays in delivering care or treatment.

### Medical equipment

Medical equipment was well maintained and had been regularly checked and serviced to ensure that it continued to be safe to use. Patients had been provided with the specialised equipment they needed. However, some staff told us that there were delays of up to 48 hours in obtaining equipment, such as air flow mattresses.

## Are medical care services effective?

Services were generally effective, but we found learning and changes in practice arising from serious patient safety incidents was not widely shared across the trust.

### Staff skills

Staff had appropriate skills and training. On each of the wards we visited, staff were professional and competent in their interactions with patients. Staff told us that training opportunities were "good". They said they had recently received annual appraisals, although clinical supervision was still not taking place due to staff shortages. In June 2013, we issued a compliance action in relation to supporting staff. The trust provided us with their action plan and told us they would become compliant by the end of December 2013. Therefore, at the time of our visit, not all actions in this plan had been completed.

# Medical care (including older people's care)

### Learning from past incidents

Most of the staff we spoke with about learning from past incidents were not aware of any systems in place, which allowed staff to learn from and improve their practices as a result of recommendations from past incidents. For example, medical staff were not aware of any protocol in place to assess correct placement of nasogastric tubes, despite several never events (serious patient safety incidents) that had taken place within the trust. Because of this, junior medical staff told us they did not feel confident in assessing the correct location of these tubes.

## Are medical care services caring?

Services were generally caring and patients recognised that the majority of staff were kind and caring. There were some issues about the quality and variety of food available.

### Patient feedback

All six patients we spoke with on the acute assessment unit, reported a swift pathway through A&E and good support with pain relief. They told us they thought that the care had been "very good". Some of the comments made were: "the care has been marvellous", "care good 24 hours a day", and, "caring nurses."

There was no trolley service on the unit, so people could not easily buy magazines or other items. One person reported that they had not been able to brush their teeth as the ward was unable to supply them with a toothbrush.

### Patient treatment

Staff treated patients with dignity and respect and, on the medical ward, we noted that their interactions with patients were kind, professional and patient. Staff assisted patients in a discreet and dignified manner. Patients told us they were treated with respect. We saw examples of staff being very kind to people: for example, calming down a confused person. All areas we visited were single-sex with bathing facilities clearly identified. All call bells were within each patient's reach to allow them to call for assistance.

### Food and drink

We received mixed comments about food offered in the hospital. Some patients told us they were unhappy that there were no microwave ovens or toasters on the wards. This meant that meals brought in by relatives could not be reheated. Also, people told us that if a patient was not on the ward during meal times, they would not be able to be served a warm meal.

We found that the records of food and fluid intake on both care of the elderly wards were not fully maintained. Therefore, it was not possible to establish what kind of food people were offered and whether patients at risk of malnutrition received enough food. Also, staff did not always record when patients refused to eat meals and what action had been taken by staff in such cases. Records of people's weight were also not always completed. Therefore, there was a risk of patients not receiving adequate and sufficient meals and fluids and some patients could be at risk of malnutrition.

On one of the care of the elderly wards, we found catering staff were not aware of one patient requiring a gluten-free diet. The person told us they found it very frustrating that they were being offered food they could not have. We brought this to the attention of the person in charge of the ward, who ensured that the patient received food suitable for their diet and that staff were aware of the person's dietary needs.

During lunch on the ward on the AAU, we saw that, when patients had red trays, they received help from staff if needed.

The dietician we spoke with told us that the hospital operated protected meal times. This allowed patients to have their meal without being interrupted by medical staff. However, the person told us that staff did not always observe this rule.

## Are medical care services responsive to people's needs?

Services were usually responsive to people's needs but some patients felt isolated because of the ward layout and signage did not always meet people's needs.

### Management of flows

Some nursing staff told us that some beds were being occupied by patients who were physically fit for discharge, but were staying in the hospital because they were waiting for arranged services, such as packages of care, or for

suitable housing. As some of the patients did not live in the local area, there was a risk that delays may occur because of the complexity of dealing with different local authorities.

The trust no longer employed a bed manager for medical patients. We were told that this meant that the flow of patients into medical wards could be delayed because this role was not available to facilitate the admission to medical wards once a bed became available.

### Patients with dementia

There were no specialist dementia wards in the hospital. Patients with dementia were cared for on general medical wards. Staff told us that, because of the restrictions in how the premises could be decorated, there were very few signs that would help people with dementia to orientate themselves around each ward. Staff were able to access dementia awareness training and had the skills and knowledge to deliver care to these patients.

### Ward environment

The ward environment was appropriate for patients. All wards had single-sex bays and side rooms so that patients with more complex needs could be appropriately cared for. Some of the patients using one of the bays on ward 11F complained that it was very cold. We were told that the sister had reported this issue but it had not been rectified.

Some people told us that, because of the layout of the ward, they felt isolated, especially if occupying side rooms. Staff also told us that the layout sometimes made it difficult for them to spend as much time with these patients as they would like to.

At our listening events people told us they found the lifts complicated and difficult to use.

### Accessible information

Information for patients was available in some ward areas but most of it was in English. Patients and relatives whose first language was not English told us they found it difficult to move around the hospital building, as all the signs were in English only. We were told that it was difficult to arrange adequate signage in different languages because the building was new and there were restrictions on putting up additional signage. It was unclear if alternative arrangements had been explored to address these issues.

Staff told us they used LanguageLine, a telephone translating service for patients and relatives who did not speak English. Interpreters could be booked, however, there were sometimes reported delays in making bookings and using interpreters. For example, an interpreter had been booked for the family of an unconscious patient so that medical staff could discuss treatment options and other issues with the person's family, however, there was a delay in arranging the meeting. We were also told that some staff working in the hospital would translate on behalf of patients.

Staff told us that some information could be translated into other formats or languages, but that would mean delays for people whose first language was not English. We found that staff on one unit (HIV and immunology) used information produced by other organisations to provide information in different languages for their patients.

## Are medical care services well-led?

Services were fairly well led locally but some staff reported bullying and harassment by their line manager. The implementation of changes in practice and the monitoring of quality was not well understood by all staff.

### Leadership

Most of the staff who spoke with us told us they were satisfied with the way they were managed by their line manager. They told us they found their line managers supportive and approachable. However, some staff said that they had experienced bullying and harassment from their line manager.

We found that not all staff understood the performance or changes made to practices in their departments. Staff gave us examples of receiving emails telling them about new ways of working being introduced, however, they felt there was very little information being passed on about how these systems should be used and how they would be reviewed. This lead to staff not being sure which documents to use and to some duplication and inconsistencies in which documents were being completed.

Monitoring of the quality of care varied between different wards. For example, staff working on the care of the elderly wards told us that, because of staff shortages, they did not always have time to complete quality assurance documents. Staff also said that staff shortages and their heavy workload meant they did not always receive clinical supervision.

# Medical care (including older people's care)

### Staff morale

The nursing staff we spoke with on the AAU were very positive about working on the unit. They all told us that they found it a good place to work and felt they were well supported. They felt there were enough staff for them to be able to deliver care. A recently qualified nurse explained to us that they were supernumerary for two weeks and were on a preceptorship programme of practical experience and training. Prior to working on the ward, they had to complete a drugs assessment with the sister to ensure that they were safe to deliver medications.

Staff told us they had good access to training, although it was noted that this sometimes had to be completed in their own time. A training session on sepsis was being run on the day of the inspection. We were told that, because of staff shortages, some nurses were unable to have an induction to their new job.

We were told by a junior sister that a the reorganisation of nursing staff was taking place and some sister-level posts would be lost in the reorganisation, while other nursing staff across the trust would have to apply for their roles. They said this reorganisation was causing difficulties and low morale in the department, as staff were not sure if they would have jobs or whether they would keep their current grades.

# Surgery

## Information about the service

Surgery at The Royal London Hospital consists of nine surgical wards and 17 theatres. The hospital has plastic surgery, orthopaedic and general surgical specialties.

We talked to patients, relatives and staff, including nurses, doctors, consultants, volunteers, senior managers, therapists and support staff. We observed care and treatment and looked at care records. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

## Summary of findings

Patients were positive about the care and treatment they received in the surgical department. But patients' experiences were impeded by the transfers between the critical care unit and delays experienced on surgical wards due to limited bed availability.

There are systems and processes in place for pre-operative assessments, which identify any concerns or issues that need to be resolved prior to patients being admitted for surgery. This approach reduced the risks to patients and promotes patient safety. However, not all areas where pre-operative assessments take place, such as the cardiac stress testing assessment unit (CPEX) are fit for purpose. The location and the lifts in this area could result in delays in emergency treatment being provided if a patient collapsed.

There are systems in place for patients to provide comments and complaints about their care and treatment. However, the information regarding how to make a comment or compliant was not readily available. Complaints were logged and a response was provided, but not all staff were encouraged to participate in resolving the complaint and there was limited evidence of learning from complaints.

Some wards were responsive to patient feedback, and revised the way they delivered services to meet their patients' needs and improve the quality of care, and reduce the impact of long-term treatment on their life style.

There were staffing and equipment issues in theatre and a significant number of cancelled operations. There was reliance on bank (overtime) and agency staff to cover shifts in both theatres and on the surgical wards. They were sometimes inexperienced and this was impacting on the department's efficiency

There was no evidence of a consistent approach to clinical governance in the surgical clinical academic groups (CAGs). The collection of performance data was incomplete, and data such as time and reason for delays in emergency surgery were not being recorded. Serious incidents were reported and a risk register completed but there was limited learning from incidents and staff did not routinely receive feedback on incidents they reported.

## Are surgery services safe?

Services were not always safe. There were issues around safe levels and the availability of suitable equipment in theatres.

### Patient safety

Some surgical wards had a number of 'escalation' beds, which could be opened when additional capacity was required. For example, on Ward 3F, there were six beds where funding had not been agreed in advance – if there were patients in these beds the trust used agency nurses. These beds all had equipment that promoted patients' privacy, dignity and safety, such as call bells, oxygen and curtains.

The high risks associated with the management of pre-operative patients were not always effectively managed. The surgical wards used standard criteria to identify high-risk patients. Once identified, these patients, about 10% of all surgical patients, were all seen by consultant

anaesthetists pre-operatively to ensure they were fit for surgery. However, it was identified that high risk cardiac patients, who could deteriorate while undergoing their pre-operative assessment – for example, undergoing a stress test – could not be safely transferred to the A&E or Coronary Care Unit CCU if their condition became unstable. While some staff had completed resuscitation training, the lift linking the two departments was inadequate as it could not safely accommodate a patient trolley. The arrangement of undertaking these tests on the second floor placed patients at risk in the event of an emergency.

Patients were not always protected from avoidable harm during surgery. We noted that the World Health Organisation (WHO) checklist was not always completed before surgery in some specialities, for example orthopaedic. We were told that sometimes these were completed later in the day or post-surgery by the theatre coordinator. They were not routinely being reviewed but some were spot checked by the theatre sisters or matron. There was no evidence provided to demonstrate the findings of these spot checks or the action that had been taken to address identified issues.

There was a trust-wide strategy for the management of pressure ulcers that included specific roles and responsibilities, such as a dedicated Tissue Viability Nurse (TVN) team. We were told that the number of patients coming into hospital with a pressure ulcer and those acquiring one while in hospital was increasing. Some patients told us that they had acquired a pressure ulcer during their stay in hospital. Staff said that they requested specific equipment such as a pressure-relief mattress, but there weren't enough available which resulted in delays delivering this equipment to the ward.

Patients were regularly monitored but not all changes in their condition were responded to in a timely manner. There were insufficient numbers of junior doctors on some surgical wards, which resulted in patients not being seen by a doctor in a timely manner. For example, we saw that a junior doctor on one surgical ward was the only doctor present. We observed that he failed to attend to a patient, despite being asked twice to do so by the ward sister.

We were informed that, because some staff spoke limited English, communication was difficult and could place patients at risk. For example, in an emergency situation, a healthcare assistant was asked to contact an anaesthetist. However, because this person was not fluent in English, they did not understand what was meant by the term 'anaesthetist'. This placed the patient at risk as support was not obtained in a timely manner.

### Managing risks and incidents

We saw that medication in four anaesthetic rooms was stored and administrated safety. All drugs were in date and fit for purpose. We noted that staff had accounted for and signed when controlled drugs had been used.

Risks associated with delays in emergency theatres were not effectively managed. Staff routinely recorded these delays as incidents and there was no monitoring system in place in the theatre department to record the number and length of delays, despite the potential impact on patient care. We noted that delays for patients requiring emergency surgery were recorded on the department's risk register with an action for staff to escalate delays to the management or clinical lead. However, when we asked for this information, the manager told us that no records of these incidents, or how they had been dealt with, had been kept. Therefore, we were unable to confirm that these delays had been managed effectively and the impact on patients minimised.

We were informed that not all surgical outcomes were recorded. For example, the trust undertakes a large number of orthopaedic surgical procedures, but the outcomes of these were not recorded. This was identified as a risk and recorded on the department's risk register, which stated that a clinical database system was being developed in January 2013. However, the surgical junior doctors and orthopaedic ward sisters had no knowledge of the database and were therefore unable to provide any data from it.

The trust uses the NHS Safety Thermometer to identify risks to patients and how these were being managed. The NHS Safety Thermometer is designed to measure a monthly snapshot of four areas of harm: falls, pressure

ulcers, catheter related urinary infections and assessment and treatment of venous thromboembolism (VTE). To promote safe and effective practice, some wards have introduced link nurses for specific areas such as catheter care and pressure sores. These members of staff support their peers, cascade trust guidance and promote best practice. Some wards were provided with information and data on the management and prevention of meticillin-resistant staphylococcus aureus (MRSA), pressure ulcers and falls. Staff told us that several areas had been identified as 'red'; these included pressure sores at grade 2 or higher, falls resulting in harm, medical incidents and high number of bank and agency staff requests. It was stated that these issues were investigated by the matron, however, it was unclear what action had been taken to address them.

### Equipment

Specialist surgical equipment was not always available. The sister in the neurosurgical theatre stated that specialist equipment used for neurological procedures was not always readily available. We were told that stereotactic image equipment was available, but this was rarely used due to surgical preference for stealth surgery, a newer technique. However, we were told that two new spinal orthopaedic surgeons had been appointed and had been told they would have the necessary spinal surgical equipment to carry out procedures. This equipment was not available when they started in post, therefore they had used the neurosurgical spinal surgery sets. Although they carried out the spinal surgery, it meant that there was limited equipment available for neurosurgery procedures. This could result in delays for patients requiring neurosurgery and place them at risk of infections such as Creutzfeldt–Jakob disease (CJD).

We also found that the theatre department did not have sufficient paediatric bronchoscopy equipment; this placed children at risk of airway damage if adult equipment was used inappropriately or meant delaying their treatment if their procedure was cancelled. We saw that staff had raised this lack of paediatric equipment as an issue and it was on the department's risk register, but the issue had not been resolved.

Surgical equipment was not always repaired or cleaned in a timely manner. For example, we were told that one neurosurgical spinal surgery set was out of service due to technical faults, leaving only two sets that were being used by the spinal orthopaedic and neurosurgical teams. There were also reported difficulties with getting surgical equipment cleaned rapidly as the theatre sister had to process this request through managers, who were not available out of hours. Delays in getting surgical equipment cleaned resulted in surgeons using alternatives rather than the specific instruments required for procedures in emergency situations.

There were resuscitation trolleys in all three recovery areas. These were checked to ensure that all equipment and emergency drugs were available and in date.

### Hospital infections and hygiene

Patients were protected from the risk of infection. The trust's infection control rates for *Clostridium difficile (C.difficile)* and MRSA were within the expected range. However, there was a lack of information for patients and visitors on how to prevent infections and we noted that there was limited hand hygiene gel in all surgical ward areas for patients, staff and visitors.

Patients were cared for in a clean environment. They told us, and we observed, that the wards were clean. During our inspection we saw staff from theatres wearing their theatre scrubs and blood-stained clogs in the canteen used by staff and relatives, which could place others at risk of cross infection.

### Staffing

There were not always appropriate numbers of skilled theatre staff to provide safe care in theatres. We were told that the lack of permanent nursing staff in theatre was impacting on patient care, as a high number of agency staff (in some cases inexperienced) in specialist surgery theatres were being used to cover vacancies and staff absences. This arrangement was reported to be very stressful in emergency situations when teams had to rely on agency staff who may not know where to find equipment that was needed. In specialist surgical theatres this was also reported to be leading to delays in

surgery and in setting up equipment as these staff was unfamiliar with the specialist surgical equipment. This resulted in patients' operations taking longer than they would if permanent staff were present. This inappropriate additional time in theatre was unnecessary and, at times, reduced theatre capacity. The staffing rotas that we saw confirmed that a high number of bank and agency staff had been used and there were several unfilled shifts. For example, on 10 October 2013, there were six unfilled staff nurse shifts. Staff in theatres had escalated this issue and we noted that it was included on the department's risk register.

Most surgical wards had appropriate numbers of nursing staff to deliver care in a timely manner. However, we did note in some specialities, including orthopaedics, trauma and plastic surgery, that not all nursing shifts were covered on night duty. For example, one ward only had two of the four qualified nurses required. There were insufficient numbers of junior doctors on some surgical wards, which resulted in patients not being seen by a doctor. The General Medical Council's national survey for 2013 rated the neurosurgical trainee workload as 'red', meaning that the workload was very high. There were also insufficient numbers of registrars, which resulted in some junior doctors carrying the registrar pager as well as their own on-call pager. This lack of middle-grade doctors placed additional pressure on the junior doctor as they were often the only doctor covering the wards. We were also told that junior doctors were also frequently requested to go to the trust's other hospitals to cover clinics. This left the ward without a doctor, which impacted on patient care. It was unclear from the evidence provided to us what action had been taken to address the doctors' work load issues.

We were told that some locum doctors were refusing to cover shifts on the wards and in theatres as there were delays in payment for shifts. They therefore chose to work in other trusts who paid them within the agreed timescales. These unmanned shifts placed additional pressure on medical staff and could compromise patient safety. Some middle-grade doctors were offering to cover the shifts, which could mean they were working 24 hours on call, followed by their regular shift without any time off. Medical staff stated "we just about get by". We were told the issue had been raised with the manager and the human resources department, but no action had been taken.

## Are surgery services effective?

Services were generally safe but there were issues around staff being up to date with their training in all areas.

### Clinical management

There was a multidisciplinary approach to delivering surgical patient care, including planning and delivering care. Some areas, such as the trauma ward had multidisciplinary documentation which provided a holistic view of the care delivered and the progress the patient had made. We were told that some surgical specialities experienced issues with discharging patients from acute surgical wards to rehabilitation wards, due to bed shortages. The short stay surgical unit was often used for trauma patients, resulting in elective surgical cases being cancelled at short notice. This had an impact on patients' experience. For example, during our visit to the short stay ward we noted that 15 of the 32 short stay surgical beds were occupied by trauma patients who could not be accommodated on the trauma ward. Placing trauma patients on alternative wards resulted in operations being cancelled and patients being cared for by staff who may not have the specialist trauma skills required to deliver effective care.

Managers told us that National Institute for Health and Care Excellence (NICE) and other professional guidelines had been implemented. However, they were unable to provide evidence of assurance that NICE guidance had being implemented.

### Staff skills

Not all surgical staff had completed mandatory training relevant to their role. The mandatory training record we saw showed that, on some wards, 60% of staff were up to date with their mandatory training, while in other wards this figure was 94%. Staff had access to a range of in-house training provided by internal and external staff. This included specific equipment training and other training. Some wards held monthly meetings which included regular feedback to nursing staff on any complaints received. Staff who were unable to attend received the updates through email and information in the ward folder.

# Surgery

## Are surgery services caring?

Services were generally caring but there were issues in meeting patient's care needs in a timely manner.

### Patient treatment and feedback

Patients received care from staff who were focused on the delivery of high-quality care. Many clinical staff we spoke with were committed to delivering care that met patients' needs. Most patients were happy with the care they received and praised the nursing staff. They said, "I feel like I am in a private hospital. Ten out of ten", and, "I am in the best hospital, with the best consultant and the best treatment in Britain". Patients did report that the wards were busy and short-staffed but they were calm and tried not to compromise patient care. However, at times, care was compromised – for example, some patients reported long waits for pain relief, while others stated that they had received poor communication in relation to their post-operative care.

### Patients' privacy and rights

Patients' privacy and dignity were maintained. We observed that staff respected people's right to make choices about their care. The patients we spoke with said that they were kept informed about their treatment. Clinical staff were seen to interact with patients in a compassionate and caring manner.

### Patients on the 'wrong' ward

There were a number of 'outlier' patients on the wards when we visited. For example, medical patients temporarily on the surgical wards because a medical bed was not available.

## Are surgery services responsive to people's needs?

Services were generally responsive to people's needs but there were issues about delays in discharging people and the signage in the hospital.

### Patients' feedback and complaints

Patients' experiences and complaints were used to improve the service and the effectiveness of treatment. Some matrons we spoke with were clear about the trust's complaints procedure and were able to provide examples of how they had responded to patient feedback. For example, extending the opening hours of the infusions service for neurology, meaning that patients could go into work for half of a day then to go and have their infusions, losing half a day rather than a whole day's wage.

Many patients and their families found the new hospital "lovely" but sometimes not patient friendly. They found the signage an issue – signs were colour-coded but it was not clear what the colours related to, making it difficult for people to find their ways to appointments at times. We noted that none of the signs were in Braille, making it impossible for blind people to navigate the hospital. They also said that some of the lifts were confusing and difficult to operate, placing additional stress on families as they tried to get to the floor their relatives' ward was on. Reception staff were very helpful when patients or their relatives asked for support or directions to departments.

There were systems in place to monitor cancelled operations and any delays in elective theatre lists. This included identifying the reason for cancellations. We found that, in the last six months, the majority had been cancelled several days before the patient's scheduled surgery. However, 17% of cancellations happened on the same day: 8% for clinical reasons; and 9% for non-clinical reasons. It was unclear if action had been taken to reduce the number of same-day cancellations. Staff told us that, for half a day each month, all staff attended the pre-operative audit but, as this coincided with the surgical audit day, the emergency theatre was operational for only half a day, with no elective work undertaken during that time.

### Responding to patients' needs

Most patients' specific needs were met. For example, on wards providing care to people who may have self-harmed, or taken a drug overdose there were also mental health nurses employed or staff had easy access to the mental health team. This ensured both their physical and mental health needs were met.

# Surgery

Nursing staff we spoke with were clear about how to escalate concerns regarding sick patients, including contacting the junior doctor or Critical Care Outreach Team, to obtain support and advice although we did see one incident where a doctor did not respond when approached about a patient.

### Discharge of patients

Some patients, particularly those with rehabilitation needs, were not discharged on time. Staff reported numerous delayed discharges from the neurosurgical ward to the rehabilitation units. Also, those patients who required social service support post-discharge sometimes experienced delays while they waited for appropriate support in the community. This meant that these patients were receiving care in an acute ward longer than needed and their recovery could be delayed. This also limited the availability of surgical beds.

We were told that patients needing medication to take home did not delay discharges as the pharmacy service operated until 8pm and the pharmacy team were involved in patients' discharge planning. Unexpected discharges were sometime delayed as the ward staff would need to contact the out-of-hours team.

### Accessible information

Patients and their families had access to translation services, either face-to-face or via LanguageLine. We were told how interpretation services had been reviewed with increased use of LanguageLine, and that staff and patients did not raise any concerns about these changes. We were told that pre-operatively staff frequently used the multi-lingual patient advocates based in the hospital to provide a translation service. It was difficult to assess if, when patient's consent to surgery was sought through an interpreter, the patient understood the risks and benefits of surgery and therefore gave their informed consent. There was also trust-wide generic information regarding surgery and how to make a complaint or comment. This information was available only in English and was not easily accessible in the ward area.

## Are surgery services well-led?

Services were generally well led locally and there was effective team working in some areas. Some clinical staff told us they experienced bullying from managers.

### Leadership

Staff in surgery told us that they felt well supported by the matron and consultants. Ward staff in many areas felt their wards were well managed by the ward sister, for example, ensuring there were always some permanent staff on duty to supervise and work with the agency staff. There was effective team working between the nursing and medical staff who worked well together and supported each other. However, we did witness an incident of bullying in theatre when an individual's behaviour towards a junior member of staff was unacceptable. We were also informed of incidents of bullying of clinical staff by middle managers.

Most staff we spoke with had completed an annual appraisal that identified their professional development needs. We were told that some management teams are not supportive of innovation and professional development. This included the development of interventions that could result in better patient outcomes. Staff felt their feedback was listened to and led to changes being implemented, including changes to the management of surgery and theatres, when it was identified that the workload for one person was too great and an additional matron had not been appointed to manage theatres.

The trust is currently in consultation with nursing staff regarding the re-banding of some clinical posts. Nursing and medical staff raised concerns about the impact on patient care of these changes and, while they had had an opportunity to comment on the proposal, they did not feel listened to and had no confidence that the managers would take their views into account. Staff felt disempowered and demoralised by these changes, stating that for some posts, several nurses were competing for the same post, the trust was using online assessments rather

than face-to-face interviews. Staff felt this approach was unfair. Some staff groups, for example, the laboratory and nursing staff, reported a lack of promotional opportunities. Some students told us this would influence their decision about if they would apply for a post in the trust when they qualified. While others were very keen to secure a post in wards they had worked in because they stated the ward was well-led and they felt valued.

### Managing quality and performance

Monthly integrated performance reports for the surgical group, including numbers of serious incidents, complaints falls and waiting times. These provided in graph for the entire surgical service, not hospital specific. It was not clear what action had been taken on the issues raised in the report or how this was shared with clinical staff. We were told safety and quality of care was monitored and all serious incidents and complaints were discussed at the weekly surgical CAG meeting. We saw examples in surgery of staff being actively involved in the complaint's process. For example, staff were given an opportunity to respond to the complaint, providing their view of what had occurred before the response was sent out to the complainant. The trust had a complaints policy and procedure in place. However, we were informed by the staff we spoke with that they were not aware that there was a trust-wide protocol for managing and responding to complaints or agreement about which complaints were escalated to executive team level. This resulted in an inconsistent approach to complaints management.

The governance structures were not embedded. While some teams reported an open and transparent approach to learning from performance management, others said there were no service-specific clinical governance meetings, and were unable to identify any shared learning across the CAGs.

# Intensive/critical care

## Information about the service

The critical care service at the Royal London has 20 intensive therapy unit (ITU) beds and 20 high dependency unit (HDU) beds, for patients who are too ill to be cared for on a general ward. However, on the day of our inspection, two HDU and two ITU beds were closed due to staff shortages. A Critical Care Outreach Team assists in the management of critically ill patients on wards across the hospital.

We talked to staff including nurses, doctors, consultants and senior managers. We observed care and treatment and looked at care records. We received comments from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

## Summary of findings

There were enough trained and skilled staff to deliver safe, effective care to people in both the ITU and HDU, but many were not up to date with their mandatory training. There was effective multidisciplinary working between the doctors and nurses, who were supported by the matrons, consultants and practice development team.

Performance information was used to improve practice and patient experience. There was a culture of reporting, investigating and learning from incidents. Staff made changes to practices in response to incidents to prevent a recurrence.

The majority of ITU patients experienced a delay of over four hours before being transferred to the HDU or a ward. Some of these patients were transferred after 10pm, a time when there may be fewer staff on duty on the wards.

The unit responded to the cultural, linguistic and religious needs of patients. An interpreter service was provided, both face-to-face and through the LanguageLine service. However, we noted on a few occasions that not all staff accessed this service and tried to communicate without an interpreter.

## Are intensive/critical services safe?

Services were generally safe but there were issues about the timely discharge of patients and medical staff adherence to hand hygiene measures.

### Patient safety

The service was focused on safety. Staff reported incidents, which were investigated and the findings were fed back. Staff we spoke with were able to describe action that had been taken to reduce the risk of similar incidents recurring. For example, when issues were identified with ventilators, the air values were changed to mitigate the risk. It was not clear if this learning had been shared with the other critical care units and other departments in the trust.

The critical care risk register included an identified risk that patients were not always discharged from the unit in a timely manner due to beds on the wards not being available. This resulted in delays in admitting critically ill patients into the unit and a large number of out-of-hours discharges from the wards. This issue had been identified and recorded on the risk register for over 12 months without any clear action being taken. There are also other risks documented on the risk register that have been rated as a high risk for over two years without being resolved or de-escalated as action had been taken to mitigate the risk.

### Critical Care Outreach Team

The Critical Care Outreach Team responded promptly to requests for telephone support and attended wards when requested. Patients are reviewed using an early warning system that assists in identifying those patients who need to be transferred to the HDU or ITU. The team were available daily between 8am and 8pm and always saw those patients transferred from HDU or ITU to the wards the following day, post-discharge, to monitor their progress and support ward staff.

### Staffing

The unit had completed a quality and safety audit in July 2012, which found that there were enough qualified medical and nursing staff available to meet patients' needs. However, during our inspection, we noted that there were not always enough appropriately trained staff to meet patients' specialist needs. The critical care unit

# Intensive/critical care

had reduced their vacancy rate from 25% to 11%, which had reduced the unit's need to cover vacant posts with agency staff, who may not be familiar with the unit layout and patients' needs.

Agency staff we spoke with all said they had received an induction when they commenced work in the unit and all felt well-supported by permanent members of staff. Medical staff provided a service seven days a week that ensured that any changes in the patient's condition or needs were responded to in a timely manner. We noted that patients were closely monitored by nursing staff, however, not all level 3 (critically ill) patients were provided with one-to-one nursing at all times. We were told that all these patients should have one-to-one care but we observed that, on some occasions, two nurses provided care to three patients.

### The environment

The environment in ITU ensured the safety of patients and staff. In response to several aggressive incidents in the unit, CCTV has been installed in the corridors and at the entrance to the unit. This ensured that security staff were aware of and could respond to any incident in a timely manner. Staff we spoke with told us they had completed conflict resolution training that assisted them in de-escalating incidents.

### Hospital infections and hygiene

Patients were not always protected against the risk of infection. Hand-washing facilities were available but not clearly signposted. Nurses were seen to wash their hands before and after providing care to patients. However, we noted that the consultant was the only doctor who washed their hands on the ward round. The saving lives audit data for September 2013 showed 50% hand-washing levels. Saving Lives is a self-assessment audit tool which helps hospitals ensure compliance with the Hygiene Code. It was unclear from the evidence provided what action had been taken to improve these levels.

### Medical equipment

Equipment was checked, labelled and cleaned to ensure it was fit for purpose. However, during our inspection, problems with computer access to images during the morning ward round on ITU were reported. This resulted in staff being unable to review images which could result in delays to treatment. We were told that the trust-wide equipment database was not up to date; this could cause delays in obtaining essential equipment.

## Are intensive/critical services effective?

Services were generally effective and followed national guidelines.

### Clinical management and guidelines

Patients received care and treatment according to national guidelines. However, we noted that there was no head injury protocol in the notes of those patients who had sustained a head injury.

Care was supervised by a consultant who was available 24 hours a day, undertaking daily ward rounds to ensure any changes were identified in a timely manner. We noted that a daily structured proforma was used for ward rounds which included structured input from the nursing staff. Nurses we spoke with reported they work well with the medical team and are listened to by the doctors, saying it was not a "them and us" culture.

Consultant-to-consultant referrals for ITU were not always being initiated, by the referring physicians/surgeon consultants These referrals were frequently made by junior medical staff and therefore referrals were sometimes inappropriate. However, the ITU consultant reviewed all patients before a decision was made to transfer patients in. Data collected by the unit showed that a high number of patients were transferred after 10pm and high numbers of readmissions to the unit.

Diagnostic equipment was readily available, for example a portable head CT scanner. However, as staff qualified to operate the machine were not always available, this sometimes resulted in investigations not being undertaken in a timely manner. We were told that the unit did not experience any problems getting radiological imaging out of hours; these were undertaken and reported on in a timely manner which ensured treatment was commenced without delay.

### Patient mortality

A national independent survey by the Intensive Care National Audit &Research Centre (ICNARC) highlighted that the numbers of unplanned readmission was relatively low. The comparative figures showed that the Royal London unit had a higher number of delayed discharges and out-of-hours (after 10pm) transfers to the wards. A similar number of people died in ITU than would be

# Intensive/critical care

expected, given the area, age and health of the population the hospital serves. A monthly mortality meeting with medical and nursing staff took place to monitor and understand why people might die on the ward so improvements could be made.

### Staff skills

Staff had appropriate training to provide effective care and confirmed that training and skills development opportunities were available. However, the mandatory training database was not up to date and therefore we could not confirm that all staff had received training in areas such as incident reporting, infection control or complaints handling. Staff we spoke with stated that they received support from the practice development nurses who facilitated learning and development.

## Are intensive/critical services caring?

Services were caring and patients were treated with dignity and respect but there was an issue with patient records potentially not being protected from unauthorised access.

### Feedback from patients and relatives

Patients' relatives we spoke with told us their family member had received excellent care, stating, "it is the best hospital they could have come to". Families told us that staff had kept them informed when they had called the unit to check on their relative's progress but they found it difficult to access the hospital, and locate the ITU when they visited.

Relatives told us they were encouraged to stay at the bedside and staff explained the treatment that was being provided.

### Patients' privacy and rights

Patients were cared for in a calm environment with telephones being answered promptly to avoid unnecessary noise. Patients were treated with privacy and dignity was maintained. We observed that staff used clips to ensure curtains around the patient's bed remained closed or the shades on doors to patients' rooms were closed when they were delivering care.

We observed that patient notes were left open by the patient's bedside during the ward round. This could result in unauthorised people accessing the patient's information.

## Are intensive/critical services responsive to people's needs?

Services were responsive to patients needs and used patient feedback to make changes.

### Patients' welfare

The unit responded to the changes needed to keep people safe. We saw that action was taken when pseudomonas was identified in the unit.

The service monitored the safety and quality of care and action was taken to address identified concerns. For example, data on pressure sores, methicillin-resistant staphylococcus aureus (MRSA) rates, falls and Clostridium difficile (C.difficile) was collected and analysed. Feedback was disseminated to staff via notices and bulletins on staff noticeboards. Monthly or bimonthly consultant directorate meeting took place, where covering a range of topics, including the dissemination of ICNARC concerns.

The unit responded to the cultural, linguistic and religious needs of patients. Patients and their families had access to religious support from a range of faith leaders, Translation and interpreter services were available, however, with the increased use of LanguageLine as an alternative to face-to-face translation, it was not clear which provision was meeting the needs of patients and their families.

### Complaints

Complaints were discussed at the unit's monthly governance meeting, which was attended by members of the multidisciplinary team. However, it was not clear from the evidence provided how feedback about complaints, or learning from investigations were communicated to staff.

## Are intensive/critical services well-led?

The service was well-led but there was an issue that risks identified on the risk register were not updated or removed when action was taken.

### Leadership

The critical care unit was well-led. Senior managers and clinicians had a good understanding of the performance of their department. Staff we spoke with stated that there was effective team working which promoted a team

approach to care delivery. The unit held weekly consultant meetings to discuss mortality. Nurses were encouraged to attend these meetings and their opinions were sought.

Staff were encouraged to report incidents and they felt able to do so as there was a 'no blame' culture in the unit. Concerns raised by staff were documented on the risk register but this document was not up to date and included identified risks that had been logged for several months without any evidence of the action taken.

# Maternity and family planning

## Information about the service

The Royal London Hospital maternity service delivers over 6,000 babies annually. The maternity unit includes a maternal fetal assessment unit (MFAU), an antenatal clinic, triage rooms, five dedicated induction of labour rooms and a labour and postnatal ward. The labour ward was divided into low-risk pregnancy and high-risk pregnancy delivery rooms. There are two dedicated obstetric operating theatres adjacent to the labour ward, three maternal high-dependency beds and a neonatal intensive care unit (NICU) on site. The NICU is a level 3 unit, which means that it has the capabilities to care for the most premature and unwell babies.

We talked to 12 women, their partners and 30 staff, including care assistants, midwives, nurses, doctors, consultants and senior managers. We observed care and treatment and looked at 13 care records. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

We also inspected the Barkantine Birthing Centre, which is a midwife-led unit that delivers over 350 babies annually. It has five birthing rooms and transfers any women or babies with complications to the Royal London Hospital. We spoke to two staff, looked at three records and at policies and guidelines. We reviewed performance information about the trust from both internal and external sources and compared it against national guidelines. On the day of our visit there were no women at the unit and so we are not publishing a separate report.

## Summary of findings

At the time of our inspection, the maternity and NICU were providing safe, effective care and were responsive to the needs of people who used the service. Most of the women we spoke with were pleased with the antenatal and maternity care they received. They felt they had been given sufficient information and support. Women were particularly complimentary about the care they had received during labour and from the breastfeeding team. However, we found that some people had had some negative experiences on the postnatal ward.

We found that the Barkantine midwifery-led unit was providing care to low-risk women and transferred patients to the Royal London Hospital if any complications occur. We found that all except five guidelines at the Barkantine centre were out of date. Some had last been updated in 2006 and had no date for review.

Staffing levels were safe and there was sufficient consultant cover. However, some staff told us that there were times when they were stretched and could not provide one-to-one care to women in established labour. Most units were equipped sufficiently, but some staff told us that they would benefit from having more cardiotocograph fetal heart monitors (CTGs) and sometimes had to borrow equipment from elsewhere in the department.

We found evidence that the maternity service had learned from mistakes. Systems were in place for reporting and reviewing incidents to ensure that appropriate action was taken. Care was delivered in accordance with national guidelines and the service was conducting research studies to improve outcomes for people.

Staff enjoyed working for the service and were positive about the support they received from their line manager. However, changes that were being made to the staffing structure were affecting morale and some staff felt undervalued. They felt lessons to be learned from incidents were shared well, but a shortage of administrative support and poor IT systems were impacting on their delivery of care. At the time of our inspection, NICU and the maternity unit were meeting the requirements of the regulation. However, the trust needs to ensure that any changes are sustainable and that the department can continue to provide a good, effective service.

# Maternity and family planning

## Are maternity and family planning services safe?

At the time of our inspection, we found that people were receiving safe care. The women we spoke to were positive about the care they had received and felt their needs had been met.

### Patient welfare and safety

The service was focused on safety. Expectant mothers were assessed for any risks to themselves or their unborn child at their antenatal appointments. These included both health and social risks, such as diabetes or their vulnerability to abuse. Where particular risks had been identified, there were 'care bundles' (additional assessment and monitoring documents) to ensure each identified risk was managed appropriately. If any medical concerns were identified after the first 17 weeks of a pregnancy, the mother was referred for observation to the MFAU which was open seven days a week. Expectant mothers could also rapidly access the service through a dedicated maternity triage, which was open 24 hours a day.

We observed the obstetric theatre team at the service. People were protected from avoidable harm through the use of the World Health Organisation (WHO) safety checklist to ensure that the necessary checks were completed before, during and after surgery.

There were systems in place to deal with medical emergencies. The service used specific obstetric and neonatal observational charts to ensure that mothers or new born babies who may be becoming unwell were quickly identified and their condition prioritised for care. These were the nationally recognised Modified Obstetric Early warning Score and Neonatal Early Warning Score (NEWS) observation charts. We were told that all women were placed on a chart post-delivery. Babies were placed on a NEWS chart where there were concerns about their medical condition. However, we found examples where these observation charts had not been fully completed or where the observations were illegible. If a baby's condition deteriorated, a team from the NICU attended the ward to examine them. They were then either admitted to NICU or cared for on the ward if they did not meet the criteria for admission, but were reviewed daily by the NICU team.

### Equipment

We found the NICU was spacious and well equipped. We also found that the MFAU was well-equipped. However, some staff on the other maternity wards felt there was not always enough equipment available. Staff on both the labour and postnatal wards told us more CTG monitors were needed and that they often had to borrow them from other areas. Staff on the NICU confirmed that they did lend equipment to other areas of the hospital, but there was a system in place to ensure it was returned promptly.

In the Barkantine Birth Centre resuscitation equipment was in date and checked daily, although we found gaps in the completed lists. Reporting of faulty equipment was inconsistent as some staff recorded this in the handover book while others used the equipment folder. It was not always clear when the faulty equipment had been returned to the department or if it had been followed up.

The home birth equipment book was not checked regularly. We found that checks were made up to April 2013 then minimal checks up to 23 October 2013 when regular checks recommenced.

### Safeguarding

There was a lead midwife for safeguarding as well as a dedicated safeguarding team for maternity called Gateway, which was accessible to staff 24 hours a day. It consisted of eight midwives who worked with the hospital team and community services to provide an integrated approach to managing patients where there were safeguarding concerns. They were also involved in providing level 3 safeguarding training to staff working for the hospital's maternity service. Staff told us Gateway responded quickly when a referral was made and that they would attend the wards regularly to provide support and advice.

### Managing risk

Staff we spoke with were able to describe the system for reporting incidents. Staff of all levels told us they felt that any lessons to be learned from incidents were disseminated well by management. Monthly "hot topic" newsletters were issued and included details of incidents and any subsequent changes to policies and procedures. These were also discussed at team meetings and, where necessary, training was provided.

# Maternity and family planning

There was evidence that the service was learning from mistakes. Two never events (largely preventable patient safety incidents) had occurred in the maternity unit in the last 12 months. These incidents involved swabs being left inside the patient following discharge. An investigation by the trust found that the errors were not being made in theatre, but when patients received medical interventions on the ward. An action plan was developed to prevent recurrence. This included placing a yellow risk band on patients who had internal swabs to prompt staff. While the new system had only been in place for two weeks prior to our inspection, the provider may find it useful to note that we looked at the care records of five patients who had required retained swabs and two of them had no second staff signature. We observed staff being reminded of the process during staff handover on two wards.

In 2012 the trust was an outlier for the number of emergency caesarean sections, meaning there were more being undertaken than expected. While the outlier alert specifically related to their maternity services at Newham University Hospital, a review of medical records identified that delays in the induction of labour was a contributory factor in some cases. As a result, five induction of labour rooms were opened a Royal London Hospital and an audit tool was introduced to enable ongoing analysis of emergency caesarean sections. Every quarter a consultant and a midwife reviewed 30 emergency caesarean cases to determine whether they could have been prevented. The results of these audits were discussed at risk and quality meetings.

### Infection control

During our inspection we observed that the environment was clean. Hand hygiene gel and personal protective equipment (such as gloves and aprons) were available throughout the maternity unit. Hand hygiene and infection control audits were carried out at ward level monthly and submitted to the trust's infection control team. During our inspection we observed good infection control practice. However, we observed one member of staff on the postnatal ward not washing their hands between patients.

### Staffing levels

At the time of our inspection, there were sufficient staff to meet the needs of women on the unit. However, some staff raised concerns about capacity to cope at busy times, especially when there were unexpected absences. We were told that there was a directive not to use agency staff, but shifts could not always be covered by the services' internal bank staff. The trust's midwife-to-birth ratio was one midwife for every 32 births, which was fewer than national recommendation of 1:28. Staff told us there were times when they were unable to provide one-to-one care to women in established labour.

Consultants were available on the labour ward 60 hours a week, including weekends, as recommended by the Royal College of Obstetricians and Gynaecologists. They were also on call during nights. The consultants were also supported by a team of doctors during the day and out of hours. During the day there was a dedicated consultant anaesthetist for the labour ward. There was an additional consultant anaesthetist three days a week when elective caesarean sections were being undertaken. The service also had access to an on-call anaesthetist out-of-hours.

There were two obstetric theatres and two dedicated theatre teams during the day. However, at night there was only one theatre team and staff told us that, if a patient required an emergency caesarean section, it was a challenge to get a second. This was a potential risk to patient safety.

## Are maternity and family planning services effective?

The maternity service at Royal London Hospital provided effective treatment to the majority of people using the service. Where there had been shortcomings in care provided, risks had been identified and responded to. However, inadequate IT systems and changes to staffing structures were impacting on the ability of staff to consistently provide effective care.

# Maternity and family planning

The maternity service at Barkantine provided effective treatment to the majority of people using the service. However, record keeping and updating and adhering to national guidance needed to be improved.

### Benchmarking and national guidelines

The service's mortality rates were within expected ranges and the number of births that were classified as a "normal delivery" was similar to the national average. The trust's elective caesarean rate was 9.1%, which was below the England average of 10.6%. However, the trust's emergency caesarean rate was high at 19.1% compared to the England average of 14.5%. This led to an outlier alert for the trust. As a result, the service allocated five delivery rooms to induction of labour to improve the process for women and to attempt to reduce the number of emergency caesarean sections. The maternity service had three high dependency unit (HDU) beds for women who required more intensive nursing and had prevented women from being transferred to the general intensive care wards.

The service's policies and protocols were accessible to all staff via the trust's intranet. We saw that these had all been written in accordance with professional best practice clinical guidelines. According to the unit's September 2013 performance dashboard, 97.3% of women were risk assessed for venous thromboembolism (VTE). In addition, the World Health Organisation's (WHO) checklist was used as part of surgical checks.

There was a programme of clinical audit, which incorporated National Institute for Health and Care Excellence (NICE) guidelines, national audits and locally identified risks to ensure the service was providing effective care for people. The outcomes of these audits were shared with staff and training was provided where necessary. For example, an audit of CTG interpretations found that staff were not reviewing all CTG results every hour, as per NICE guidelines. Therefore, scenario-based CTG interpretation training was provided every Monday morning.

At the Barkantine centre we found that National Institute for Health and Care Excellence (NICE) Guidance 2007 for fetal monitoring in the first stage of labour was not always followed. Forms for venous thromboembolism (VTE) – blood clots – were partially completed and the 24-hour review was not always completed.

### Research

At the time of our inspection, there were four research projects being conducted in the maternity service by a research team consisting of consultants and midwives. One study was examining the best treatment for women who experienced blood loss during a caesarean.

### Collaborative working

We observed a staff handover on the labour ward and postnatal ward. Both were well attended. On the high-risk labour ward, handover was attended by consultants and doctors in addition to the midwives. NICU and maternity, including fetal medicine, worked closely together to ensure that any potential admissions to NICU were identified as earlier as possible. At the time of our inspection MCAs were excluded from handover on the postnatal ward. We were told that this was so they could clean the ward. The provider may find it useful to note that some of the MCAs we spoke with told us this was a challenge as it meant that they did not know what the women under their care might need unless a midwife told them.

There were a variety of specialist midwives and specialist teams to improve the effectiveness of the service. For example, there was a dedicated safeguarding team for maternity, a specialist midwife to provide advice on babies requiring transitional care and a breast feeding team to support women in hospital and in the community. According to the service's September 2013 performance dashboard, about 90% of women were breastfeeding their babies within 48 hours of delivery. These teams provided a link to community services and we found evidence of good collaborative working.

At the Barkantine Centre there was a clear referral protocol to the Royal London Hospital. We found from reviewing the transfer book that women were referred to the Royal London appropriately for issues such as meconium stained liquor, prolonged first or second stage of labour, and maternal collapse in pregnancy.

### Staff skills

Midwives had statutory supervision of their practice and access to a supervisor of midwives for advice and met them formally on an annual basis. Midwives told us the service provided good development opportunities and that they were supported to attend mandatory training.

# Maternity and family planning

Midwives rotated throughout the service to prevent their skills from becoming limited to one area. The provider may find it useful to note that some maternity care assistants (MCA) we spoke with felt they had a lot of responsibility. While they confirmed they had received appropriate training to carry out tasks, they felt it was beyond their salary grade.

Staff working on the NICU were all trained in intensive care and there was good skills mix, including advanced neonatal practitioners (nurses or midwives that provide additional neonatal advice and support to parents and staff).

In the Barkantine Birth Centre there was always a midwife and a maternity assistant rostered to be on duty. Numbers could be increased depending on the number of women in labour. Midwives told us that they worked one week at the birth centre then the rest of the month in the community in order to retain their skills.

### IT and administrative support

Some staff we spoke with told us the service's IT systems were not fit for purpose and work was being duplicated through having to record information on multiple databases that did not "speak to each other". In addition, there had been a reduction in administrative support, so staff were having to spend more time on administrative tasks which was affecting their ability to provide effective care.

## Are maternity and family planning services caring?

Maternity services at the Royal London Hospital were caring.

Women we spoke with told us that they felt they had been well cared for. We received positive feedback from women on their experiences during labour, but there was some negative feedback about the attitude of individual staff on the postnatal ward. We also looked at a feedback survey that had been completed in May 2013. Comments included: "When it got really scary you helped me to do well"; "I wanted to breastfeed and I cannot thank you enough for the lovely nurses who came into help me". People we spoke with told us that they had felt involved in their care; they had been given sufficient information and knew what to expect.

We spoke to some parents whose baby was being cared for in NICU. They were complimentary about the quality of care being provided. They felt they had been well supported by staff and involved in their baby's care. There was "home from home" accommodation available to parents through a charity linked with the hospital.

### Privacy and dignity

All delivery rooms on the labour ward were private with en suite toilet and shower facilities. On the postnatal ward there was a mixture of shared bays and private rooms, which women could pay privately for. We were told that these rooms would be used if there was a lack of beds, but women would be advised that they may have to be moved if a person who had paid for the room arrived. However, we were told by one new mother that she had had to sit in the waiting area on the postnatal ward as the only bed available was a private room which she would have to pay for. Therefore, not all staff were acting in accordance with the trust's policy.

We observed staff knocking on doors before entering and drawing curtains round beds for privacy. There was one four-bed bay on the postnatal ward, which we were told were antenatal beds. However, if the unit was busy, they often had to use them for postnatal women. At the time of our inspection there was a mix of antenatal and postnatal women in this bay. This meant it could be upsetting or worrying for those who had not yet delivered their baby.

We observed staff speaking to women and their partners in a kind and supportive manner. While most people were positive about the attitude of staff, two people we spoke with told us there had been individual staff who had not spoken to them in a professional or caring way. Both of these staff were on the postnatal ward.

There were two dedicated rooms for bereaved families where people could spend the night if they wished. There were systems in place to provide psychological support, including consultant-led counselling. At the time of our inspection there was no dedicated bereavement midwife. While the trust was attempting to recruit to this post, consultants were concerned that the service was not being as effective or caring as it could be.

# Maternity and family planning

## Are maternity and family planning services responsive to people's needs?

Maternity services at Royal London Hospital were planned to meet the needs of the local population. Some midwives had specialist areas of expertise to meet the diverse needs of patients, including mental health, substance misuse, breastfeeding, safeguarding and diabetes.

### Accessible services

People felt that their needs had been met at each stage of their pregnancy and no concerns were raised about accessing the service. The MFAU was open seven days a week and there was a maternity triage operating 24 hours a day. In response to a high number of emergency caesareans, the service had allocated five delivery rooms to induction of labour procedures to improve the process for women. There was also an "early labour lounge" for people who were in the early stages of labour and did not need to be admitted, but who felt anxious about returning home. There was a good flow of women through the maternity pathway and we found no evidence of delayed discharges. In the year preceding our inspection, services had been suspended twice due to bed shortages. We were told that this was a result of other services in the area having to close and their patients being transferred to Royal London Hospital.

The hospital was linked to the Barkantine birthing centre, a midwife led service in the community, to which women self-referred or were referred by their midwife. Women's choice was respected, depended on the risk factors involved in individual cases. However, if complications arose during labour there was an escalation procedure in place to transfer them rapidly to the labour ward at Royal London Hospital. There was a home birth service available, which was provided by the community midwife team. We were told that historically uptake was poor, but according to the service's September 2013 performance dashboard, there had been a gradual increase.

Women and babies were not discharged from the hospital until they were well enough and with the right support in place. There was a specialist breastfeeding team who visited mothers on the wards and held group classes to provide support. Babies were not discharged from NICU until a discharge checklist had been completed. This included ensuring that parents had received training on how to care for their baby's specific needs, including medication, bathing and how to respond to a medical emergency. Parents' competencies were checked over a period of time before discharge. Their progress against the checklist was on display in the unit using a traffic light system (red, amber, green), which was done in collaboration with the parents to engage and involve them in the process.

### Accessible information

There were a variety of information leaflets available on various topics, including tests and screening, breastfeeding and how to make a complaint. All written information, with the exception of how to make a complaint, was only available in English. We were told that there had not been a demand for information in other languages. There was a Bengali interpreter based on site and the service had access to an translation service. We observed staff using communication cards with people prior to the arrival of an interpreter. The women we spoke to felt they had been given sufficient information and told us that staff had explained things in a way that they could understand.

Women kept hold of their medical notes in relation to their pregnancy up until they delivered their baby. We saw that their antenatal notes included information on who they should contact if they were concerned about anything.

### Continuity of care

Following a previous CQC inspection, concerns were raised around a lack of continuity of care for women. It was reported that women were seeing a different midwife at each appointment. As a result, the service now assigned to a team of 12 midwives. Within that team, two midwives were assigned to each GP practice covered by the service, to improve continuity for women. The women we spoke to told us that they had usually been seen by a different midwife, but they did not feel this had impacted on their care.

# Maternity and family planning

### Patients' feedback and complaints

Women's experiences of care were used to improve the service through patient surveys, complaints, comments and encouraging involvement in quarterly meetings regarding service delivery. In response to negative feedback concerning poor communication, the service had launched a one-year project, Great Expectations, designed to improve women's experiences. We were told that work had targeted areas where concerns had been highlighted, such as the attitudes of night staff.

All staff we spoke with were able to explain the complaints policy and procedure. Staff told us that if someone made a verbal complaint they would attempt to resolve this at the time. All complaints were escalated to the ward manager or matron.

## Are maternity and family planning services well-led?

Maternity Services at The Royal London Hospital were well-led at unit level. Changes to the staffing structure were causing anxieties amongst staff at all levels. They felt well supported as far as leadership on the unit itself was concerned, but confidence in management beyond that was uncertain. The trust needs to involve staff at all levels to a greater degree in the proposed changes.

Although staff at the Barkantine Centre felt information was shared appropriately between the centre and The Royal London, governance and quality monitoring could be improved to ensure the birth centre was using up-to-date guidelines.

### Leadership

The maternity services had been subject to changes. At the time of our inspection, the staffing structure, including some leadership, was under development. There was a new head of midwifery post for the hospital, but this was not yet in operation. Some doctors, midwives and maternity care assistants we spoke with were anxious about the changes and were uncertain of how the governance structure would work. However, some staff felt that there was a lack of consultation or staff involvement regarding proposed changes. They reported messages were shared with staff once decisions had already been made by senior management.

### Service culture

During our inspection we observed good, collaborative team work with medical staff engaging positively with nursing staff. Staff we spoke with told us they enjoyed working for the service as they felt part of a supportive team. Staff felt able to report incidents and raise concerns with their line manager. Multidisciplinary team meetings were held monthly and staff were encouraged to attend training. The trust was in the process of making changes to the nursing structure and some staff we spoke with felt this had had a detrimental effect on staff morale. Some staff told us they felt undervalued and that it was a "stressful time".

### Managing quality and performance

The service monitored the quality and safety of care. The service was part of the women's and children's clinical academic group (CAG), which was responsible for the service. Each CAG was assigned a lead for risk and clinical governance who was responsible for monitoring progress along with ward management. Risks specific to the service had been identified and action plans put in place. There was a performance dashboard for the service produced monthly and included indicators such as, delivery rates, complaints and staffing levels. We found evidence that lessons were learned from audits and root cause analyses following incidents, which were shared with staff effectively. However, the risk register for the women's and children's directorate, which had not been updated since July 2013, did not easily identify risks associated with maternity and did not include the trust's high level or emergency caesarean sections.

We saw that there were up-to-date policies and guidelines, which were available to staff on the trust's intranet. However with regards to printed guidelines available at the Barkantine Birth Centre, all except five guidelines were out of date (some dating back to 2006). The guidelines for transfer were last updated in 2009 and did not make any reference to postnatal transfer. They mainly related to neonatal care being required. Staff could not access any guidelines relevant to the birthing centre on the intranet.

# Children's care

## Information about the service

The Royal London Hospital children's service includes a small critical care unit, neonatal intensive and special care facilities, four inpatient wards, an assessment and short stay ward and outpatient services and therapies. The hospital undertakes inpatient and day case surgery on children and there is a children's accident and emergency department.

We talked to 18 parents (or relatives) and children and 20 staff, including nurses, doctors, therapists, play support specialists, senior managers and administrative staff. We observed the inpatient and outpatient environments and looked at selected care records and other documentation. We received comments from our listening event and from people and staff who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

## Summary of findings

Children were cared for in line with clinical guidelines and by staff trained to work with children. Parents had confidence in the care children received and were positive about staff compassion and communication, although we found a marked lack of written information to help parents and children prepare for a hospital stay. The environment was well maintained and there were toys and activities available for children on the wards and in outpatient clinics.

However, the needs of adolescents were not always met. Teenagers were sometimes nursed in bays alongside much younger children. Staffing levels were adjusted day to day to reflect children's needs, but this was not done using a structured dependency tool.

The staffing levels were perceived by nursing staff and parents to be safe but did not always meet national guidelines for staffing in children's services. The quality of the service was monitored by managers and a number of risks to patient care had been identified and escalated to the trust Board. We also saw that a number of improvements had been introduced, for example, the introduction of a new paediatric early warning bedside documentation system. However, some aspects of clinical governance and learning from incident reporting did not seem well embedded in the children's services. We came across a significant incident that had not been reported.

# Children's care

## Are children's care services safe?

Services were generally safe but there were issues about secure storage of confidential patient records and the availability of hand hygiene gel.

### Managing risks

Children who were admitted to the hospital were assessed on admission and their health and care was monitored throughout their stay. We reviewed a number of patient records and these were complete, legible, up-to-date and included regular observations, medical notes and relevant risk assessments. The trust had recently introduced a new Paediatric Early Warning Score (PEWS) system to the children's wards. This had been piloted and the nurses trained on its use before the documentation was rolled out. Nurses consistently told us that they thought the new PEWS was a significant improvement and the tool was sensitive to change. The nursing staff were confident that they would quickly identify any child whose condition was beginning to deteriorate.

Staff told us they had access to the equipment they needed on the wards and to more senior or specialist colleagues when required. Staff members we spoke with were familiar with the emergency call procedures. The resuscitation equipment on each of the wards was clearly labelled and had been checked daily by staff.

### Communication and handover

We observed one handover session between nursing shifts and saw a number of ward rounds taking place. The shift handover included a detailed discussion about each patient. Nurses were present for the entire handover which meant that they were made aware of patients' needs and any risks beyond their own allocated patients. The handover meeting was also used to communicate other immediate issues or important updates. One junior nurse told us it would be helpful to know which patients they were to be allocated before the handover discussion, as it was easy to miss some details over the course of the full meeting. However, they also told us that they always felt able to ask colleagues if they were unsure of anything. Doctors and nurses consistently told us that clinical communication was good.

### Critical care

The hospital had facilities to care for children needing critical care. The critical care unit included two short-stay intensive care beds and four high dependency beds. The critical care unit was appropriately staffed. Children requiring longer periods of intensive care, over 48 hours, were usually transferred to another hospital in line with regionally agreed protocols. However, staff told us it was sometimes clinically appropriate for a child to remain in intensive care at the Royal London without transfer. The responsible doctor consulted intensive care specialists at the other hospital before any decision was made to extend a child's stay in the unit.

Staff on the unit raised more general concerns about regional arrangements for the retrieval and transfer of critically ill children in London. Several staff members independently raised this as a safety concern with us. The trust Board was aware of the issue and had included it on the trust's risk register as a priority for follow-up action but to date the issue had not been resolved.

### Staffing

The children's wards were generally appropriately staffed with a minimum 70:30 ratio of qualified to unqualified children's nurses. Children requiring intensive care received one-to-one nursing. Children needing high dependency care were nursed on a ratio of one nurse to two beds. The critical care unit was staffed by three consultant paediatric intensivists which was fewer than national guidelines recommended for the size of critical care unit. The trust was aware of the issue which had been escalated to the board, although it was not clear what, if any, action had been proposed to address this issue.

We were initially told that nurse staffing levels met the Royal College of Nursing's national standards for staffing levels for children's services. However, we saw that one ward manager was permanently covering two wards contrary to these guidelines. The trust had plans to reduce the number of band 6 nurses to levels below the guidelines. When asked, senior nurses explained that the trust would address any risks introduced by these staffing changes, by expecting the band 5 nurses to "step up" or "become more assertive". Nurses also described a number of additional factors which contributed to their workload

# Children's care

being challenging at times. These included the number of different specialties and teams working on the surgical ward; the challenges of caring for children and families who were long-term inpatients and the physical layout of the wards which were spacious but had limited sightlines in places.

Children were sometimes transferred from the critical care unit to other children's wards while still requiring high dependency care. We were told that staffing levels on the wards were adjusted when this occurred to take account of their higher needs. A number of healthcare assistants on the wards had been trained to provide care children following a tracheostomy. This meant that the assistants were able to provide one-to-one support and observation for a period. Nursing staff on the inpatient wards confirmed they would only accept a child with high dependency needs if they could obtain sufficient staffing to provide safe care. Even so, nurses expressed differing levels of disquiet about the practice and the impact on other aspects of care.

We found that the senior nurses did not use a structured acuity or dependency scoring tool to help decide on appropriate staffing levels day to day, instead relying on their experience and professional judgement. The trust had plans to reduce the number of senior nursing managers covering children's services. In this context, practices such as transferring children with high dependency needs to the general children's wards and the lack of dependency scoring increase the risk of unsafe care through a lack of appropriate staffing.

The service covered unplanned staff absence with bank or agency nurses. Temporary nurses were only allocated to the children's service if they were appropriately qualified to work with children. Senior nurses said they sometimes had difficulty obtaining authorisation to cover absence at very short notice. They said the requirement to obtain central authorisation occasionally resulted in understaffed shifts without proper consideration of risk.

### Safeguarding children

Parents were able to stay on the wards with their children including overnight. Staff had been trained on safeguarding children and were able to tell us how they would raise any concerns about child abuse. The trust had a dedicated safeguarding children's team and staff on the paediatric ward were positive about the support and advice they received from this team. Children known to be at risk of abuse were identified on admission and staff said they were alerted before a child in this situation arrived on the ward.

The service had recently cared for some young patients whose immigration status was unclear. The trust was able to demonstrate that clinical decisions, for example, about the timing of discharge, took into account the patients' wider social circumstances and they were not discharged until this could be achieved safely. Staff were able to demonstrate good liaison with social services professionals in these cases.

### Hygiene

All areas in the children's unit were visibly clean. Equipment was cleaned and labelled with a green sticker which was removed when the equipment was next used. Hand-washing audits and other audits of infection control were carried out and the results displayed in the wards. Children's play areas were also cleaned daily and toys were thrown away and replaced as required. All the toys we saw were clean and in good condition.

The children's wards did not have hand washing gels or information about the importance of hand washing located near to the entry and exit to the wards. Hand-washing gels were located outside patient rooms and bays although they were not always well signposted. Over the course of the inspection we observed a number of visitors entering the ward and visiting patient areas without cleaning their hands. Some parents also commented on the lack of hand cleaning facilities. On one occasion, staff requested that members of the inspection team wash their hands with soap and water before entering the ward. This is a reasonable request when children are at particular risk of infection, but there were no sink facilities nearby by which to do this.

# Children's care

### Security

The children's wards received a high number of visitors. The doors to the wards were locked with entry via an intercom system. However, this was hard to enforce with visitors frequently being able to follow others into the ward without necessarily being observed. Security was a recognised problem and there had been a number of thefts from the wards, for example of parents' food from the fridge and alcohol gel dispensers. Several parents we spoke with had experienced their food being stolen from the kitchen.

We saw that confidential patient records were stored in an open trolley on the wards near the nurses' station. The station was not continuously manned and the records were not properly secure. Staff told us they had reported their concerns about the lack of lockable storage for patient records but this had not yet been addressed.

## Are children's care services effective?

Services were effective and parents and children had confidence in the quality of care provided.

### Clinical management and guidelines

Nearly all the parents and children we talked with had confidence in the quality of care they were receiving at the hospital. One parent said, "This is exactly what [my child] needs – to get the treatment they require at exactly the right time". Staff said they were proud of the service and the care they provided. Every child had a named nurse. Parents and children said their named nurse introduced themselves at the start of their shift.

Children received care according to professional best practice clinical guidelines. For example, there were pain management ward rounds. We saw a child with sickle cell anaemia being assessed and observed appropriately. Staff made sure that adequate pain control was achieved for this child while also ensuring they had the ability to cough and participate in their physiotherapy. We spoke with a consultant anaesthetist who was developing a written pain information leaflet for families. This had been developed with the involvement of parents.

There were clear arrangements for children to transfer to another NHS trust or to community teams for certain types of specialist care, for example, for planned end of life care.

The trust supplied us with their clinical audit plans for children's services which outlined their arrangements for ensuring that NICE and other professional guidelines were implemented. Each audit was led by a named clinical lead.

We found that few children admitted to the assessment and short stay unit had been admitted directly by their GP for observation and monitoring. All the children who were staying on the unit when we visited had been admitted through the accident and emergency department. We were told this was normal at this hospital. It was unclear if local GPs were aware of the facility.

### Staff skills and support

Children were cared for by staff specially trained to care for and treat children. Services were provided by nurses, doctors, surgeons, and anaesthetists who specialised in paediatrics. We spoke with several junior doctors and registrars covering a range of paediatric specialties including anaesthetics, critical care and orthopaedics. The registrars told us they had protected time to undertake clinical audit and teaching. Junior doctors said they were well supported by their consultants and were positive about the training they were receiving.

Staffing shift patterns, particularly the day shifts for doctors, did not always match the peak times of demand in children's services.

## Are children's care services caring?

Parents and children said the service was caring and their needs were generally met but there was very little written information available for parents and children to help prepare them for surgery.

### Patient feedback

Parents and children said the staff were kind. One parent said, "they are compassionate, they really want to help get [my child] better and well". Another said, "It's been a really positive experience". Most parents told us communication was good, and their child's treatment was explained to them in a way they could understand and they were kept informed. One parent said, "We were

# Children's care

encouraged to ask questions, as many as we needed and to repeat them if necessary". Another parent whose child had been in hospital for some time said, "Staff listen and ask for my observations. I have become part of the team". Parents of children with longer-term conditions consistently said they worked "in partnership" with the hospital staff.

However, there were times when some parents said they did not have enough information when they needed it. In one case this occurred following surgery when the family found it difficult to obtain information from the surgical team. In another case, parents said they had not had enough information prior to discharge and their child had to be readmitted a few days later. Another parent thought there had been a medication error with their child and, although this had been mentioned to them, they had not received a proper explanation about how it had occurred.

We found that the trust provided very little written information to families about what to expect in hospital and how to prepare, for example, for surgery. There was also little information that would be helpful to parents and young people on the trust's website. Parents said they relied on the verbal communication they had with staff. We were told that the trust had invested in new display boards for the wards but these had not been installed yet.

There were arrangements to ensure children felt comfortable, and less anxious about being in hospital. Parents were able to stay with their child overnight. The trust employed play workers and specialists who ran play sessions but also discussed children's individual preferences for activities with them and their families. Toys, books, and other forms of entertainment were available for children of different ages. Children had access to education and could attend the school room, if they were able, or receive bedside tuition if appropriate during term time.

Parents and children were generally positive about the facilities at the hospital. There were a range of spaces that families and children could use. The recently created garden was an imaginatively designed area for use in warmer weather.

## Are children's care services responsive to people's needs?

Services were responsive to people's needs but there were issues about facilities for teenagers.

### Facilities for children and young people

We found that the provision for adolescents did not always meet their needs. At times, older children were allocated beds in bays with younger children, babies and with boys and girls together. One young person told us they had not been able to sleep because of the younger children in the neighbouring beds. They said they needed to keep the curtains closed around their bed all the time to maintain enough privacy. Another young person who had experienced care in a number of hospitals said, "It's not like a children's ward here. I made friends with staff much quicker at [another hospital]…If I had a magic wand I would improve the overall look of the ward – it's not friendly. Some of the nurses don't seem as though they are used to working with teenagers".

We also saw that there was insufficient storage space alongside the beds for parents who were staying on the ward overnight. The trust provided care to some children over long periods and to families who did not live locally. Parents and relatives in this situation were able to stay in a separate house close to the hospital. This facility was greatly appreciated by parents who had used it.

Parents and children were encouraged to complete short feedback questionnaires. Staff were not always clear on how this information was going to be used. We were told that the results would be analysed centrally before being reported back. However, staff were able to give us examples of how they had responded to parents' recent concerns, for example, by making the staff fridge available to parents following a number of thefts from the parents' kitchen.

### Accessible information

There was virtually no written information about care and treatment available on the wards, in any language. There was also a lack of information about how to make a complaint or raise concerns about care. We found one leaflet about this on one ward.

# Children's care

The trust served a diverse population. When families needed an interpreter this was documented in children's care plans. Staff told us they were able to use interpreters when children and their families were not fluent in English. We saw evidence in care plans that interpreters or advocates were booked when required and the nurses we spoke with knew how to arrange this.

## Are children's care services well-led?

Services were well-led and safety and quality measures were in place but there were issues that incidents were not always reported formally.

### Leadership

Paediatric services are part of the women's and children's CAG which was still under development. The senior managers and paediatric matrons from all the hospital sites within the trust met monthly to review quality and performance and we saw the notes of recent meetings. Quality issues were communicated to staff through a variety of methods, including handover meetings and 'purple folders' which were available on every ward and unit. Some of the nursing staff said they would like to have more opportunities to meet as a team and discuss ideas for improvement.

There was generally effective operational leadership on the wards and departments. Staff showed enthusiasm for their work and the service was developed around the needs of children. Staff worked together as a team and there was good communication between the surgical, medical and ward staff.

Senior managers within the children's service had an understanding of some of the main risks facing the service. These concerns were documented in the trust's risk register and escalated, although it was not always clear how risks were being addressed and to what timescale.

### Managing quality and performance

Safety and quality of care was monitored and action taken to respond to concerns. Incidents, complaints and patient feedback were monitored at both board and directorate level. We saw evidence of action being taken to reduce the recurrence of incidents in children's services. For example, we were shown how medicine charts had been amended to highlight common antibiotic allergies and saw some evidence that this had reduced the number of related incidents.

However, there did not seem to be a universal reporting culture in the children's service. For example, we were initially told by ward managers that there had been no recent Never Events or serious incidents on the paediatric wards. We subsequently discovered that there had been a Never Event involving a misplaced nasogastric tube in previous months. Staff we spoke with were not aware of this event and the measures in place to prevent any recurrence. We also discovered that a child had experienced a cardiac arrest on one of the children's wards in recent weeks. The ward nursing staff had concerns about admitting this child to the ward before the arrest. The child had subsequently recovered. We were told that, although the incident had been discussed by staff and local ward managers, it had not been formally reported as an incident. The trust is at risk of missing opportunities for learning and improvement if incident reporting and feedback is incomplete.

# End of life care

## Information about the service

The end of life care services were provided by a palliative care team, which operates across Barts Health NHS Trust. The team consisted of one palliative care consultant and four palliative care nurses.

We spoke with members of the palliative care team, relatives of two people who were receiving end of life care. We looked at records and spoke with clinical staff working at the Royal London to find out more about how the hospital provided care and treatment to patients.

## Summary of findings

The trust had a specialist palliative care team who supported staff on the wards providing end of life care. Most patients referred to the service were seen promptly, however, some staff were not aware of the trust's interim guidelines relating to end of life care. Because of this there was a potential risk that some patients may not receive end of life care in a timely manner. While we received positive feedback from the people who used the service/or their relatives, we also received mixed comments from the clinical staff about the quality of care provided to end of life patients.

## Are end of life care services safe?

Patients received safe end of life care.

### Patient safety

The records of two patients who were receiving palliative care or end of life care on the elderly care and medical wards showed that they were being appropriately treated for their condition. Pain relief, nutrition and hydration were provided according to their needs. Their wishes for their end of life care were also clearly documented.

Staff told us that most patients were discharged safely with the right care and support. In some cases people were able to use services of the local hospice. Two members of staff told us that some staff, including consultants and registrar doctors, were not fully aware of what end of life care meant.

### Patient records and end of life decisions

Important information in relation to end of life care was fully documented. The sample of records on the medical wards we looked at included evidence of 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms being in place and consultant doctors recording how or if a decision had been reached and who was consulted as part of this process. Additional information was also recorded in individual patient's notes. There were systems in places for nurses to be know which patients had DNA CPR orders in place. All the nurses we spoke with were aware of this system and were able to identify how many order were in place on each ward at any time.

### Staffing

The palliative care service worked from Monday to Friday, 9am to 5pm. The staff who spoke with us felt that the team was "understaffed".

## Are end of life care services effective?

Patients' end of life care was managed effectively but not all staff were aware of the interim guidance.

### Clinical management and guidelines

Patients received effective support from a multidisciplinary palliative care team. Staff told us that the palliative care team responded quickly to any referrals so that patients received an effective service. The team included four nurses, led by a consultant who worked five days a week and was based at another hospital managed by the trust. There had previously been an end of life facilitator, who was based at the Royal London Hospital, but, due to funding, this post was no longer available. Clinical staff told us they missed having access to someone within the hospital who they could approach with any questions relating to end of life care.

People were able have access to spiritual support, volunteers and a bereavement coordinator who, following a patient's death in hospital, made sure families received their personal belongings and essential documents. They also provided information and support about bereavement services.

# End of life care

Staff told us that the trust was not providing any training in palliative care and of life care. Therefore, staff may not have the skills or knowledge to effectively provide care and support to patients and their families at this time in their life.

The end of life care followed government guidelines. The trust had, as requested by the Department of Health, undertaken an immediate clinical review of patients on end of life care pathways, in response to the national independent review *More Care, Less Pathway: A Review of the Liverpool Care Pathway* published in July 2013. The trust had an interim policy on end of life care which replaced the Liverpool Care Pathway, as per national guidance. Although all the staff we spoke with were aware that the Liverpool Care Pathway was no longer used, only some were aware of the interim guidelines. This meant that there could be delays in people receiving appropriate end of life care.

## Are end of life care services caring?

The palliative care services were generally supportive and usually enabled staff to provide patients with dignified end of life care.

### Patient feedback and support

The two relatives who we spoke with told us that they were satisfied with the quality of care offered by the staff. One person told us that medical staff explained the process and they felt involved in the decision-making process. One of the relatives told us, "We are quite happy with the care provided and we are happy with the hospital. Staff are very welcoming. I can see there are shortages of staff, I can't fault them though. The doctor came to discuss what was happening and explained everything, including medication, to me".

The trust produced a booklet for relatives called What to do when someone close to you dies. It included practical information as well as information about support services available, including local and national charities.

Patients' spiritual needs were met by a multi-faith chaplain, volunteers and staff. Staff were aware of how to work with people from different cultures and religions and were aware of religious customs and traditions. They gave us examples of how they supported people from different cultures and religions, so that each person's needs were being met.

Patients at end of life care were seen by specialists as soon as possible. Medical staff told us that the palliative care team responded to all urgent referrals without delay. They talked to patients and families to explain end of life care, options available, pain control. They also discussed and recorded people's preferences for where they spent their final days.

### Staff feedback

The staff who spoke with us gave us mixed views about how the quality of end of life care. One member of staff told us that the quality of care depended on which ward the patient was cared for, the leadership of the ward and existing staffing levels. Another member of staff described the care provided to patients as "variable" and they said this lead to people having a lack of confidence in care. The same person told us that the quality of care offered varied from "excellent" to "shocking". They said that because the Liverpool Care Pathway was no longer used, staff were less able to be assertive and empowered to take responsibility. This meant that the quality of care was not provided to the highest standard to each patient.

## Are end of life care services responsive to people's needs?

Services were responsive to people's needs and involved them in decisions about their care. There were issues that important information related to people's end of life care was not documented.

### Patients' rights and wishes

Most staff told us that patients received flexible care and support and were able to make choices about their end of life care. Their needs and wishes were fully discussed at multidisciplinary meetings, handovers and ward rounds. Staff showed compassion for ensuring patients' wishes were fully discussed and, where possible, discharges to either hospice care, home or nursing home was facilitated within 24 hours. The relative of one of the patients told us that staff respected their relative's wishes and were also very accommodation to their needs.

# End of life care

Staff told us they had a good working relationship with the local hospice and, because of this, patients were able to access the service without delays, if they so wished.

### Patient records and end of life decisions

Important information regarding end of life care was not always fully documented. However, we noted that information concerning if a patient was to receive resuscitation was always documented appropriately.

The two bereavement officers we spoke with told us that, following a patient's death, they made sure families received their personal belongings and essential documents. They also provided information and support about bereavement services. They told us that, in some cases, there were delays in obtaining people's death certificates. This was usually for two to three days and happened mainly during weekends or when there were changes in doctors' teams. This meant that patients who were Muslim or Jewish were not always able to be buried in line with their religious belief that they should be buried within 24 hours of death.

### Patient information

The palliative care consultant told us they were in the process of producing a leaflet about end of life services. At the time of the inspection, this was not available.

Staff showed us the route which a deceased patient took to the mortuary and the equipment on which they were transported. The process was carried out with dignity and care. Facilities were available for families and friends to view the deceased person. The staff explained the process and showed us around the area were viewings take place. Staff were aware of cultural religious customs of the diverse range of people the hospital provided its services to.

## Are end of life care services well-led?

The palliative care service was well-led and worked across services to benefit patients.

### Leadership

The palliative care team were well-led by specialists who understood their role and were passionate about ensuring good care outcomes for patients at the end of their life. The team was not fully staffed and there were consultant vacancies. The service had one consultant lead who worked five days a week.

The team had recently had its palliative care coordinator removed due to budget cuts. This meant that no teaching was currently offered by the team to any of the staff working in the Royal London Hospital.

### Managing quality and performance

The palliative care team was attached to the cancer clinical advisory group and performance was therefore managed by this team.

# Outpatients

## Information about the service

The Royal London Hospital provides a wide range of outpatient clinics for adults and children. A number of clinics currently operate in the older part of the hospital and these are due to move to the main hospital building in coming months.

We talked to 28 patients and relatives and 15 staff including department managers, booking and clerking staff, qualified nurses, healthcare assistants, doctors and consultant staff. We also interviewed the trust's outpatients services manager and the service development director with responsibility for outpatients. We observed waiting areas and spoke to people before and after their consultations and tests. We received comments from our listening event, from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

## Summary of findings

People were positive about the treatment and advice they received in outpatient settings. Consultations were conducted in private and people had time to ask questions. Some, but not all, clinics were managed efficiently. People routinely waited for over an hour to be seen in some clinics. People's experience of the appointments system also varied with appointments for the spinal orthopaedic clinic being particularly problematic. trust figures showed that most people who needed to be seen urgently were given appointments in line with national standards. The number of patients who failed to attend and the number of cancelled clinics were above the national average. The trust sought the views of patients and was part way through a programme to "transform" outpatient services. We found that staff involved in delivering care in the Royal London Hospital were often unaware of the trust's programme to improve the outpatient experience and were therefore not able to participate or communicate this work effectively to patients.

## Are outpatients services safe?

Patients received safe and appropriate care.

### Patient safety

Patients received safe care. Patients experienced consultation, diagnostic tests and assessment and consultations with appropriately qualified staff and advice was sought from other healthcare professionals where necessary. Staff knew what to do in the event of an emergency and the departments we visited had accessible emergency equipment which was regularly checked.

### Safeguarding patients

Staff understood their responsibilities in safeguarding children and vulnerable adults from the risk of abuse. Staff knew what to do if they needed to raise an alert. Staff we spoke with said training on safeguarding children and vulnerable adults was included in the trust's mandatory training workbook. Staff knew how to access relevant policies and procedures and how to contact their safeguarding lead.

### Hygiene and the environment

Outpatient services were provided in a number of departments across the hospital. Clinics were clean and hygienic. We observed that hand hygiene gels were obvious and available in most, but not all, departments. Clinics were accessible to patients with mobility difficulties. There were wheelchairs at the front of the main outpatient entrance for patients to use if needed. A porter or staff from outpatients would escort or use a wheelchair to assist frail or disabled patients who attended without support from family or friends. Parts of the older outpatients building were no longer in use. The signage to these areas was confusing and risked misdirecting patients to unused and unstaffed areas.

# Outpatients

## Are outpatients services effective?

Patients told us the outpatient services were generally effective.

### Clinical management

Patients told us they were allocated sufficient time with staff when they attended clinics. They said they were encouraged to ask questions, were involved in making decisions about their care and able to give their informed consent if required.

Many patients told us that the outpatient service was effective. "For endocrinology, you couldn't ask for better. The consultant really cares and he knows what he is doing. I feel I am in safe hands and my condition is slowly getting better." Another patient told us, "The doctor always checks I understand what they are doing, tests and follow-ups, everyone is so caring here. I never have a problem".

### Staff skills

Staff received training, support and supervision to enable them to provide a caring environment in the outpatients department. Staff told us that they were given an induction when they started work which covered patient focus and included competence testing. The trust had recently introduced a written workbook covering mandatory training. Staff had mixed views about the effectiveness of given scenarios for outpatient settings but said they had been given protected time to work through the book and training. Nursing staff also attended meetings to review the team's performance, although we were told no written notes were taken. All the staff we spoke with, except for one nurse who was relatively new, had received an annual appraisal.

## Are outpatients services caring?

Outpatient services were generally caring but there were issues with contacting the service to make or change appointments.

### Patient feedback

Patients had mixed experience of outpatients. Performance reports showed that reported problems about appointment times had fallen to 4% for the trust overall in 2012.

People were often positive about the advice and care they received during their consultation or the course of diagnostic tests. However, some people told us they waited a long time to receive an appointment. This particularly affected the spinal fracture clinic with six of seven patients we spoke with reporting problems accessing the clinic. Staff told us this was an ongoing problem with this service. Senior outpatient managers were aware of the issues and said they worked with each clinical team to identify the root cause of problems.

Difficulty accessing appointments greatly affected people's experience of the hospital. One person had received a brief telephone message with an appointment at short notice and no information about how to contact the department to arrange an alternative time. Two other people told us that the problems in accessing the service were so difficult they had experienced anxiety and depression.

We did find good practice. One parent in children's outpatients had been able to arrange the appointment at Royal London after their child received care at another hospital. They had found the outpatients service friendly and helpful. We saw that the service for some clinics was very positive, for example, we saw a number of written compliments from patients with Behçet's syndrome, (a rare condition that causes swelling of the blood vessels), praising the way this service had responded to individual needs and concerns. Patients attending the gastro-intestinal clinic told us they were very happy with the service and it "could not be faulted".

Some patients had to wait in the clinics before being seen. In this case, staff displayed the length of the expected waits on a board. These boards were supposed to, but did not always, display a reason for the delay. In one example we saw, the reason given was, "busy". However, we did see staff taking time to find individual patients who were waiting and explain any further delays. Patients told us that, even when they knew from past experience there was likely to be a delay, they did not want to arrive late in case they missed their appointment. One person told us they had lost their job partly because of the amount of working time they had lost through waiting in outpatients.

# Outpatients

### Patients' privacy

Staff respected patients' privacy and dignity. We saw that patients had consultations in private rooms and clinic doors were closed during clinical examinations. Staff on reception generally spoke with patients quietly, although sometimes the reception desks were located close to waiting areas and this was difficult to achieve, for example, if people had hearing difficulties.

## Are outpatients services responsive to people's needs?

The outpatients service was generally responsive to people's needs but there were issues with long waits in some clinics due to double booking.

### Patients' feedback

Patients were asked to complete comment cards with their views and experiences and outpatients had recently been included in the NHS Friends and Family feedback exercise across the trust to see which services people would recommend to others. There was no information displayed for patients or relatives summarising the results.

### Waiting times

Trust performance reports showed that patients who need to be seen urgently usually received an appointment quickly and within the nationally agreed timescales. Most cancer patients referred by their GP were given an outpatient appointment within the national standard of two weeks and patients requiring diagnostic tests were given these within six weeks.

Most patients were followed up and monitored according to national guidelines. The trust monitored outpatient services according to national specialty guidelines and had appropriate follow-up for patients. Some specialties, however, were performing below service standards. The trust had taken action to improve this but the capacity to provide outpatient care in adult orthopaedics, for example, was an issue.

Patients and staff told us that, although patients were given timed appointments, it was quite common for people to have to wait for more than two hours to be seen in some clinics. We were told that orthopaedics, urology and dermatology routinely had long waiting times and we observed this to be the case during the inspection. Some clinics routinely "double booked" patients into appointments which created delays from the start of the session. Senior managers told us the incidence of "double booking" had been reduced and remained a focus for improvement but was sometimes in place to ensure patients received urgent appointments within the agreed timescales.

Medical records were usually available and the trust aims to have 100% of records available in clinic. This ensured that staff had access to the patient's history and previous treatment.

### Meeting patients' needs

Outpatient services were responsive to patient's needs. Appointments were booked from a central office, but patients could change the date and time if notice was given. Patients who used patient transport were offered morning appointments, and patients with mobility difficulties were offered transport to attend clinics.

The trust had systems in place to identify patients who required urgent appointments and patients attending for the first time. However, the system did not flag patients who had experienced cancelled clinics as a priority. One administrator told us they had spoken to a patient who had experienced multiple cancellations who contacted the hospital in tears and this had distressed staff as well.

### Accessible information

Information leaflets were available in the outpatient area to help patients understand their condition and treatment options. There was also information about how to make a complaint. The trust had "advocates" who spoke the languages common in the local community. We saw that this service was used to ensure that people understood their care and were able to give informed consent. Staff had access to a wider range of languages through the LanguageLine telephone interpreting service.

# Outpatients

## Are outpatients services well-led?

Services were generally well-led although there were issues with staff involvement in the programme to transform outpatient services.

### Leadership

The trust sought the views of patients and was part way through a long-term programme to "transform" outpatient services. Senior managers told us they had board-level support and focus on outpatient care. This was being done by reviewing individual service pathways to identify areas for improvement and using a "one-stop-shop" model for outpatient clinics where patients might undergo a range of diagnostic tests. Nursing staff were able to identify which clinics had been redesigned and said they thought patient experience was improving in these areas. However, many of the nurses and healthcare assistants we spoke with were unaware of the trust's wider programme to improve the outpatient experience and so were therefore not able to participate or communicate this work effectively to patients.

### Managing quality and performance

The quality of outpatient services was monitored. The trust collected data on outpatient activity, including the number of patients who missed clinics and the number of cancelled clinics which were higher than the national average. The trust had undertaken a major patient feedback exercise in 2011 and had used this data to inform changes. It was unclear to what extent current feedback was being analysed and used for improvement. Managers explained a range of practical actions and initiatives they were taking to improve the service. This included work with local GPs to reduce problems accessing appointments and work with individual clinical teams to reduce the number of cancelled clinics and 'double bookings'.

# Good practice and areas for improvement

## Areas of good practice

Our inspection team highlighted the following areas of good practice:

- The Royal London's Emergency Assessment (EA) model. This is a team approach, led by a consultant or registrar that aims to ensure that patients are treated in the most suitable area by the appropriate professional. This includes redirection to GPs when the patient has primary care needs, or seeing patients in the urgent care or emergency care departments when they need immediate medical intervention, (for example, patients who have sustained an injury).
- The ready availability of interventional radiology – patients requiring interventional radiology receive this within an hour of the need being identified and this is available 24 hours a day, seven days a week.
- The development opportunities available for medical records staff – staff are supported to complete an accredited clinical coding course which leads to alternative employment opportunities.

## Areas for improvement

**Action the hospital MUST take to improve**

- Ensure that action is taken on identified risks recorded on the risk register.
- Ensure that there are sufficient staff with an appropriate skills mix on all wards to enable them to deliver care and treatment safely and to an appropriate standard.
- Ensure there are sufficient medical staff available.
- Actively listen to staff and respond to their concerns.
- Adopt a zero tolerance to bullying by middle managers.
- Ensure that adolescents are treated appropriately and not within the general paediatric wards.
- Ensure that equipment is readily available when requested.

This section is primarily information for the provider.

# Compliance actions

## Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury. | Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing.<br>The registered person must take appropriate steps to ensure that, at all times there are sufficient numbers of suitably qualified, skilled and experienced persons to safeguard the health, safety and welfare of patients. Regulation 22. |

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury. | Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records.<br>The registered person must ensure patients are protected against the risks of unsafe or inappropriate care and treatment by maintaining an accurate record of the care and treatment provided to patients. Regulation 20. |

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury. | Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment.<br>The registered person must protect patients who may be at risk from the use of unsafe equipment by ensuring equipment is properly maintained, suitable for use and available in sufficient quantities to meet patient need. Regulation 16 (1)(a)(2). |

This section is primarily information for the provider.

# Compliance actions

| Regulated activity | Regulation |
| --- | --- |
| Treatment of disease, disorder or injury. | Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services.<br>Patients were not protected from the risks of receiving care or treatment that is inappropriate or unsafe in such a way as to reflect published good practice guidance from professional and expert bodies. Regulation 9(b)(iii). |

| Regulated activity | Regulation |
| --- | --- |
| Surgical procedures | Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services.<br>The provider did not have an effective system to regularly assess and monitor the quality of service that people receive and did not always implemented the required changes to ensure improvements were made (Regulation 10 (2)(c)(i)(ii)). |

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Barts Health NHS Trust

# Newham University Hospital

## Quality report

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Date of inspection visit:
5-6, 11 and 14 November 2013
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## Overall summary

Newham University Hospital is in Plaistow, East London, and serves the people of Newham and other areas. It provides a full range of inpatient, outpatient and day care services as well as maternity and accident and emergency departments. It also has a dedicated stroke unit for rehabilitation following initial urgent treatment. The area the hospital serves has the third most deprived local authority (out of 326 local authorities) and has been identified as one of the top 50 most deprived areas in the country.

Newham University Hospital is part of Barts Health NHS Trust (the trust). Barts Health is the largest NHS trust in England. It has a turnover of £1.25 billion, serves 2.5 million people and employs over 14,000 staff. The trust comprises 11 registered Care Quality Commission (CQC) locations, including six primary hospital sites in east and north east London (Mile End Hospital, Newham University Hospital, St Bartholomew's Hospital, the London Chest Hospital, the Royal London Hospital and Whipps Cross University Hospital) as well as five other smaller locations.

CQC has inspected Newham University Hospital twice since it became part of Barts Health on 1 April 2012.

Our most recent inspection was in June 2013, when we visited the stroke ward and an elderly ward to check that the trust had taken action to address issues identified in August 2012. We issued two compliance actions and asked the trust to provide us with an action plan showing how they would address the shortfalls. As part of this November 2013 inspection, we assessed whether the trust had addressed the shortfalls, and we took a broader look at the quality of care and treatment in a number of departments to see if the hospital was safe, effective, caring, responsive to people's needs and well-led.

Our inspection team included CQC inspectors and analysts, doctors, nurses, midwives, allied health professionals, patient 'Experts by Experience' and senior NHS managers. We spent two days visiting the hospital. We spoke with patients and their relatives, carers and friends and staff. We observed care and inspected the hospital environment and equipment. We held a listening event in Stratford Town Hall to hear directly from people about their experiences of care. Prior to the inspection, we also spoke with local bodies, such as clinical commissioning groups, local councils and Healthwatch.

# Summary of findings

## The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

### Are services safe?

Patients were protected from the risk of infection and the hospital was clean. There was an emerging focus on safety and quality, and on developing a more robust safety culture across the organisation. However, governance systems were not embedded through the clinical academic group (CAG) structures in all clinical areas.

There were concerns that patients' needs may not be met due to the hospital's reliance on bank staff (hospital staff working overtime) and agency staff in some areas.

Improvements are needed as medicines were not being stored safely.

Risks may be increased for patients when staffing levels were not maintained and senior staff not available on site. There is also a potential increased risk to patients following the introduction of yellow wrist bands to identify two different risks: the presence of a swab to prevent bleeding following a surgical procedure, as well as a patient who is at risk of falls.

### Are services effective?

National guidelines and best practice were followed but not always consistently and in full. Patient pathways followed national guidance but on-site consultant support out of hours and at weekends did not follow professional guidance. The trust had taken steps to ensure departments were staffed appropriately and there was no evidence of an impact on patient care as a direct consequence. Junior staff in most specialities felt they were supported sufficiently by consultants.

We had concerns that children having orthopaedic surgery did not have input from the paediatric team and emergency surgical procedures on children under 10 were being carried out only occasionally. There were no pain protocols in use and children were not seen by the pain team.

Senior staff in medical services and surgical services were not available at weekends or at night in the Emergency Department, which could impact on decisions about patient care and treatment.

### Are services caring?

We saw that staff were polite, kind and caring in their interactions with patients, visitors and colleagues. The majority of patients told us staff were caring and compassionate and they were treated with dignity and respect.

### Are services responsive to people's needs?

Patients told us that services in the hospital had usually responded to their needs. We had concerns about the lack of information for patients about being transferred between surgical wards and about discharge arrangements. Information for the public was provided in English and not available in other formats, but there was good access to translation services.

### Are services well-led?

We saw there was good local leadership and staff were committed to providing safe and effective services. The trust had established a clinical management structure and governance arrangements. However, we were concerned about a lack of visible leadership and adequate communication from the trust's board with staff to achieve effective working in clinical academic groups (CAGs) and communication upwards to the board.

The implementation and monitoring of safety and quality systems was not embedded and sufficiently effective through the management structures and needed to improve in some areas.

# Summary of findings

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

### Accident and emergency

The majority of people were seen and treated within the national waiting time limit of four hours. Treatment plans were put in place for either discharge or transfer to inpatient services for further care and treatment. Senior nursing staff had specialist qualifications in treating adults and children within an emergency department setting. There were not enough consultants to provide night-time cover and this was managed via an on-call consultant rota. However, there was always senior medical cover provided by experienced doctors throughout the night.

People who walked into the department were initially seen by reception staff who referred them to either the emergency department (ED) or Urgent Care Centre (UCC) using set guidelines. This may present a risk as patients referred to the ED or UCC were not always seen within 15 minutes of arrival for further assessment. The assessment was completed by a registered nurse or doctor.

### Medical care (including older people's care)

Overall care was safe and effective, and staff worked hard to ensure patient safety. The majority of patients were complimentary about their care and told us that most staff were kind and caring. There were concerns that nursing staff were sometimes unable to meet people's needs due to staff absence and bank staff (hospital staff working overtime in the trust) or agency staff cover could not be provided. Senior medical support to junior doctors at weekends was by a consultant on-call system and did not meet current professional guidance standards.

Quality and safety monitoring systems were in place and there was evidence that staff received some local feedback and escalated incidents appropriately. Staff were not aware of shared learning from incidents/investigations across the trust, which showed that the dissemination of learning across the organisation was not effective.

Staff were supported by their line managers and had mandatory training and annual appraisals. Staff morale was low following a recent staffing review but we were impressed that staff of all grades remained committed to providing good services to patients at Newham Hospital.

### Surgery

Patients were treated in accordance with national guidance – for example, for joint replacement surgery. Risk management processes were in place and staff were aware of how to report incidents. Staff were aware of learning in their own area but they were not aware of learning from incidents across the wider trust.

We saw that safety checks in theatres followed the World Health Organisation (WHO) checklist. However, we observed that not all surgeons participated in the safety checks at appropriate times in the patient pathway of care in theatres. We also noted there was a lack of consultant engagement in theatre planning meetings and in CAG management and leadership roles. We found there was no consultant presence on site out of hours and at weekends. Patients were transferred to other wards and junior staff covered 'outliers' (patients on wards that are not the correct specialty for their needs) around the hospital which created additional workload and patient care and discharge could be adversely affected.

There were sufficient staff available to provide care to patients, but they did not always have the skills to meet all types of surgical needs on the inpatient ward.

# Summary of findings

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

### Intensive/critical care

Patients received appropriate care and treatment in accordance with national guidelines. The critical care service performed as well as similar units across the country.

There were sufficient numbers of staff on duty to provide 24-hour care, however, this was only achieved with overtime (bank) or agency staff. There were five unfilled nursing vacancies on the unit. Out of hours and at weekends there was no specialist critical care consultant cover and a consultant anaesthetist provided support to the unit.

There were delays in discharges from the unit due to the availability of beds elsewhere in the hospital. The unit was small and lacked facilities and storage. Patient privacy could be compromised due to the close proximity of the beds.

### Maternity and family planning

The unit was refurbished two years ago and was bright, spacious and clean. The use of colour-coded signs helped people find their way around. There had been a number of 'never events' in the last year; these are events that are so serious they should never happen. The trust had undertaken much work on incident reporting, investigation, learning lessons and changing practice to prevent a recurrence.

There were a significant number of vacancies for midwives within the maternity service. Steps had been taken to address this, but staff expressed feeling "burnt out".

There were appropriate arrangements for obtaining medicines but management, storage, prescription and administration of these did not protect women against unsafe use. Although most staff were caring and respectful towards the women in their care, there were examples of women who had not consistently been treated with consideration and respect.

The service responded to patients' needs and was well-led.

### Children's care

We had some concerns about the safety of children's care. The orthopaedic surgeons were operating on children without input from the paediatric team. Emergency surgical procedures on children aged under 10 were being carried out only occasionally. Medicines were not being stored safely.

Children's care was not always effective. We had some concerns that there were no pain protocols in place and the pain service did not see children.

Staff were caring and responded to children's needs but there were no specific facilities for teenagers and the temporary accommodation used for children's outpatients did not met the needs of the service.

We found the service was well-led. We were concerned that the trust only had one children's governance manager and there was no liaison with other governance managers across the trust

# Summary of findings

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

### End of life care

Staff were supported to provide safe and effective palliative and end of life care by the specialist palliative care team. Patients and relatives were supported during this phase of care and their wishes were taken into account and respected. There was good use of the 'do not attempt resuscitation' (DNAR) documentation and decisions were reviewed regularly. Interim guidance was available to replace the Liverpool Care Pathway (for delivery of end of life care) following its removal from use in 2013 according to national guidance.

### Outpatients

The Outpatients department provided safe and effective care. However, the consultation, assessment and treatment process in clinics were not regularly monitored by the trust.

Staff were caring and responded to patients' needs. We had some concerns about the leadership of the department. There was no evidence that performance was being checked on a daily basis and staff sometimes felt unsupported by their line manager.

# Summary of findings

## What people who use the hospital say

Newham University Hospital scored highly in the 'Friends and Family' test on the NHS Choices website with 291 out of 311 people who used the hospital being 'likely' or 'extremely likely' to recommend the hospital. However, individual comments on the same website suggest that the staff in maternity services are uncaring and rude. People who spoke to us during the inspection were broadly satisfied with most aspects of the care they received.

## Areas for improvement

**Action the trust MUST take to improve**

- Ensure medicines and fluids for infusion are stored securely.
- Ensure that members of staff follow national guidance for the management of children undergoing surgery and that they do this sufficiently to maintain their expertise.
- To promote a safety culture, the hospital must improve the visibility of management and embed clinical academic group structures and processes.

**Other areas where the trust could improve**

- Consultant cover on site 24 hours a day, seven days a week in order to provide senior medical care and support for patients and staff.
- Increase the NHS Family and Friends survey response rate.
- Improve safety for patients by reducing reliance on bank and agency staff and improve critical care consultant cover on evenings and at weekends.
- Address the lack of high dependency unit facilities and the issue of patients being cared for in the coronary care unit, which are potentially comprising patients' safety.
- Provide accessible information for patients for whom English is a second language.
- Implement pain protocols for children and ensure that children are seen by the pain team.
- To mitigate the risk of potential safeguarding issues, the hospital should consider providing a separate waiting area for children waiting to be seen in the Urgent Care Centre.

## Good practice

Our inspection team highlighted the following areas of good practice:

- Play leaders in the children's service provided creative play opportunities for children to prepare them for surgery.
- The volunteer service had created a reminiscence room to provide a non-clinical environment for patients with dementia, which was decorated and equipped with items from the past to stimulate their memories.
- The 'do not attempt resuscitation' (DNAR) forms were comprehensive and enabled medical staff to identify treatment and care options with patients.

# Newham University Hospital

## Detailed Findings

**Services we looked at:** Accident and emergency, Medical care (including older people's care), Surgery, Intensive/critical care, Maternity and family planning, Children's care, End of life care and outpatients

## Our inspection team

**Our inspection team for Barts Health NHS Trust was led by:**

**Chair:** Dr Andy Mitchell, Medical Director (London Region), NHS England Team Leader: Michele Golden, Compliance Manager, Care Quality Commission

**Our inspection team at Newham University Hospital was led by:**

**Team Leader:** Sue Walker, Compliance Inspector, Care Quality Commission

Our inspection team included CQC inspectors and analysts, doctors, nurses, student nurses, allied health professionals, patient 'experts by experience' and senior NHS managers.

## Why we carried out this inspection

We chose to inspect Barts Health NHS Trust (the trust) as one of the CQC's Chief Inspector of Hospitals' new in-depth inspections. We are testing our new approach to inspections at 18 NHS trusts. We are keen to visit a range of different types of hospital, from those considered to be high risk to those where the risk of poor care is likely to be lower. After analysing the information that we held about Barts Health NHS Trust using our 'intelligent monitoring' system, which looks at a wide range of data, including patient and staff surveys, hospital performance information, and the views of the public and local partner organisations, we considered them to be 'high risk'.

## How we carried out this inspection

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

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

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

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

Before visiting, we looked at information we held about the trust and also asked other organisations to share what they knew about it. The information was used to guide the work of the inspection team during the announced inspections on 5 and 6 November 2013. Two further unannounced inspections were carried out on 11 and 15 November 2013.

# Detailed findings

During the announced and unannounced inspections we:

- Held six focus groups with different staff members as well as patient representatives.
- Held two drop-in sessions for staff.
- Held four listening events, one of which was specifically for Newham University Hospital at which people shared their experiences of the hospital.
- Looked at medical records.
- Observed how staff cared for people.
- Spoke with patients, family members and carers.
- Spoke with staff at all levels from ward to board level.
- Reviewed information provided by and requested from the trust.

The team would like to thank everyone who spoke with us and attended the listening events, focus groups and drop-in sessions. We found everyone to be open and balanced when sharing their experiences and perceptions of the quality of care and treatment at the hospital.

# Are services safe?

## Summary of findings

Patients were protected from the risk of infection and the hospital was clean. There was an emerging focus on safety and quality, and on developing a more robust safety culture across the organisation. However, governance systems were not embedded through the clinical academic group (CAG) structures in all clinical areas.

There were concerns that patients' needs may not be met due to the hospital's reliance on bank staff (part-time workers or hospital staff working overtime) and agency staff in some areas.

Improvements are needed as medicines were not being stored safely.

Risks may be increased for patients when staffing levels were not maintained and senior staff not available on site. There is also a potential increased risk to patients following the introduction of yellow wrist bands to identify two different risks: the presence of a swab to prevent bleeding following a surgical procedure, as well as a patient who is at risk of falls.

## Our findings

### Patient safety

Patients told us they felt safe in the hospital and the majority had experienced good care. Comments from across services included: "The A&E doctor examined me thoroughly and told me they needed to carry out some tests, and I'm just waiting for the results." In medicine they told us: "I can't complain"; "they treat me well". In surgery, patients told us: "I have always felt safe here, I can't praise them [hospital staff] enough"; "I have had excellent care and feel safe".

The trust was trying to promote a strong safety culture and this was seen to be developing but was not embedded. Staff were encouraged to report incidents and did so. Staff received feedback on incidents but this was not always consistent. Incidents were analysed locally and used to improve the quality and safety of services.

Serious incidents were reported to the National Reporting and Learning Service. The trust had reported six serious incidents classified as 'Never Events 'at Newham University Hospital in the last 12 months, five of which related to the retention of packing/swabs. Never Events are serious, largely preventable incidents that should not occur. The Never Events had been appropriately investigated to identify the cause of the error and the trust had taken action and implemented a new policy and identification system to alert staff. Unfortunately not all staff outside of maternity (where most of the events had occurred) were aware of the changes. We also found the same identification system (a yellow wrist band) was being used elsewhere in the trust to identify peple at risk of falling.

The hospital did, at times, experience bed pressures and surgical patients were moved between the Gateway Surgical Centre and main hospital wards to create spare beds. This potentially increased the risks to patients as they did not always receive appropriate specialist care. The trust held daily bed/site management meetings to review the availability of beds and so that staff in all areas could identify 'outlier' and any operational issues that may have an impact on patients.

Medical staff handovers were scheduled twice a day, providing a detailed overview of patients admitted in the speciality ward. However, we did observe some medical staff arriving on the wards without attending the handover meeting and so they were not fully aware of changes in patients' conditions or plan of care.

Patients who became critically ill were managed effectively by the critical care team. Staff used early warning systems to assess patients at risk and patients received timely intervention.

### Staffing

We looked at staffing levels in all the areas visited. The trust had recently completed a review of nursing staff and had set ward levels based on the Royal College of Nursing guidelines. Staff told us they were, at times, understaffed, usually when an absence had occurred at short notice. There was a system for staff to request replacement or additional staff; however, staff reported frequent occasions when shifts were unfilled across the surgical and medical wards. There were vacancies on most wards that had not been filled and there had been an increase in the number of staff resigning following the nursing review.

# Are services safe?

Junior doctors told us they were very well supported by their more senior colleagues but consultant presence out of hours and at weekends was through an on-call at home rota. Junior doctors reported that the majority of consultants were responsive and provided support but this was not the experience of some juniors in Surgery. The General Medical Council's National Training Survey, completed by junior doctors in training, showed that they rated their workload and whether they felt forced to cope with clinical problems beyond their competence or experience to be 'within expectations'.

### Managing risk

The trust was managing patient safety risks. There were safety measures in place to monitor patient falls, development of pressure ulcers, blood clots in veins and catheter urinary tract infections. There was ward-based quality monitoring to improve patient safety and, where care was assessed to be falling below standards, remedial measures were implemented.

### Medicines management

Medicines were prescribed and administered correctly. Medicines were not always securely stored and clinical rooms with stores of intravenous infusion fluids were left unlocked and doors were propped open. We observed cupboards where medication was stored left unlocked.

### Cleanliness and hospital infections

Patients were protected from the risk of infection. The infection control rates for Clostridium difficile (C.difficile) and methicillin-resistant staphylococcus aureus (MRSA) in Newham were within expectations. The hospital was clean and cleaners used appropriate equipment and followed cleaning schedules. Patients and visitors were provided with information about preventing infection and there was antibacterial hand gel available in all areas for patients, staff and visitors to use. We observed staff using personal protective equipment (such as gloves and aprons) and washing their hands in-between seeing patients. Patients were screened for infection on or before admission and side rooms were available to isolate patients with a spreadable infection.

### Safeguarding patients

Staff were aware of and understood how to protect patients from abuse and restrictive practices. The majority of staff had attended safeguarding training to the appropriate level. Procedures were safe and effective and especially robust in paediatrics.

### Patient records

We reviewed patient records on every ward visited and the majority were adequately and appropriately completed. However, on one ward (Silvertown Ward) we observed point-of-care records, such as fluid balance charts and observation charts, were incomplete and not adequately maintained. We found one patient with dementia who did not have a care plan relevant to their diagnosed need. This put patients at risk of inappropriate or unsafe care.

### Medical equipment

Most equipment in the hospital had been serviced and maintained. In one surgical ward there was an outstanding repair request for a macerator (used for waste management) that had been out of use for three days. Emergency equipment was available in all areas and records showed that daily checks were carried out. This meant emergency equipment was available and ready for use.

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

## Summary of findings

National guidelines and best practice were followed but not always consistently and in full. Patient pathways followed national guidance but on-site consultant support out of hours and at weekends did not follow professional guidance. The trust had taken steps to ensure departments were staffed appropriately and there was no evidence of an impact on patient care as a direct consequence. Junior staff in most specialities felt they were supported sufficiently by consultants.

We had concerns that children having orthopaedic surgery did not have input from the paediatric team and emergency surgical procedures on children under 10 were being carried out only occasionally. There were no pain protocols in use and children were not seen by the pain team.

Senior staff in medical services and surgical services were not available at weekends or at night in the Emergency Department, which could impact on decisions about patient care and treatment.

## Our findings

### Clinical management and guidelines

Patients received care according to national guidance. The trust used National Institute for Health and Care Excellence (NICE) and professional guidelines. The trust participated in national audits and there were staff in place to ensure these were implemented and monitored. There were enhanced recovery models of care in surgery and pathways of care were seen in use in most areas to ensure patients received appropriate care and treatment to optimise their recovery. We observed multidisciplinary team working – for example, in the stroke unit, elderly care and end of life care.

Professional best practice guidance relating to the onsite availability of consultants at all times was not always followed. However, the majority of junior doctors felt adequately supported by their immediately senior colleagues and they had good access to on-call consultant advice.

### Staff skills

Staff did have appropriate skills and training but there were concerns about the number of specialisms being admitted to one ward (Silvertown Ward). The trust supported staff to have the appropriate skills, knowledge and training. Staff attendance at training was monitored and reminders sent when an update was due. We saw records showing that the numbers of staff attending mandatory training had increased from August 2013.

# Are services caring?

## Summary of findings

We saw that staff were polite, kind and caring in their interactions with patients, visitors and colleagues. The majority of patients told us staff were caring and compassionate and they were treated with dignity and respect.

## Our findings

### Patient feedback

The majority of patients we spoke with in all wards and departments at the hospital told us staff were kind, caring and treated them with dignity and respect. Patients on the surgical wards told us, "All the staff are wonderful, I can't thank them enough for the care they have given me" and, "The staff are worth their weight in gold". These comments were echoed by patients on other wards, however, one person visiting the elderly care ward told us "... only XX listens to us, none of the others do. When we try to explain they just say 'yes, yes, yes". Another person at the listening event told us that, in their experience, staff were "rude" and answered their mobile phones while providing care.

Information on the NHS Choices website included a number of positive and negative comments. Feedback was acknowledged by the trust and people were offered further contact with a member of staff to discuss any problems they had experienced.

### Patient treatment

Patients were supported to ensure their care needs were met. We saw patients had food and drink when they needed it. They were supported with their personal care and pain management. We saw examples of care rounds taking place in some wards to ensure patients' needs were being met. Staff were observed to be kind, compassionate and caring. They were also honest about when the quality of care did not meet their standards.

### Staffing levels

Nursing staff told us that sometimes there were not enough staff to deliver timely care to patients. The trust had systems in place to replace staff through bank (overtime) or agency staff. However, shifts were not always filled. A 'bed management' meeting was used to review staffing across the hospital and to move staff to provide cover if possible. We also saw that matrons based themselves on wards that were short of staff to assist.

### End of life care

Patients at the end of life were being managed in accordance with interim guidance and the Liverpool Care Pathway was no longer in use, in line with national guidance.

### Patient privacy and rights

Staff respected patients' privacy and dignity and their right to be involved in decisions and make choices about the care and treatment.

### Food and drink

Patients were given a choice of food and drink to meet their nutritional and religious and cultural needs. There were menus available and staff to help patients make appropriate choices. Patients gave mixed reviews about the quality of food – ranging from "satisfactory" to "not good enough". We saw staff helping patients to eat and water was freely available and, in most cases, within reach of the person.

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

## Summary of findings

Patients told us that services in the hospital had usually responded to their needs. We had concerns about the lack of information for patients about being transferred between surgical wards and about discharge arrangements. Information for the public was provided in English and not available in other formats, but there was good access to translation services.

## Our findings

### Patient feedback

Patients told us that services responded to their needs. They said they had been seen fairly promptly in the Emergency Department (ED) and Outpatients. Comments included: "I didn't have to wait too long". Several patients told us they were waiting for investigations, and one inpatient said, "I was told I'd have a scan at 8am, but it's 10am now and I'm still waiting".

At our listening event we heard that some patients had received good, prompt attention when admitted to the hospital as an emergency. We were also told there was good communication and coordination between the various medical teams involved in the person's care.

Information on NHS Choices website included a number of positive and negative comments. We also had people contact us using our Share Your Experience forms. Comments were mixed. Positive comments highlighted that staff were kind and caring and provided prompt attention. Negative comments related to staff attitude, care delivery issues for patients with dementia and waiting times experienced in the Emergency Department.

The trust used the NHS Friends and Family questionnaires to gather patient feedback and results were displayed in all areas. The information published on the NHS Choices website showed that the vast majority of people using the hospital would recommend it to people they knew.

### Discharge of patients

The majority of patients were discharged appropriately. However, several patients on surgical wards told us they had not been given any information about when they were due to be discharged, and there was no information about discharge arrangements on their medical records.

### Waiting times

Patient's in the Emergency Department told us they were seen reasonably quickly, however, a few patients being treated in surgery said they had waited too long to be admitted for their procedure.

The hospital had met the national target and seen 95% of patients in ED within four hours of arrival. There were times when the department had fallen below the target and the number of people attending and availability of beds in the hospital had caused delays. The department had also met the 15-minute target for accepting handover of patients from ambulances and had experienced one breach of the target in the first six months of the year.

There was an Urgent Care Centre (UCC) next to the Emergency Department (ED) which was run by another trust and patients for the UCC and ED sat together in the same waiting area. Waiting time information was displayed for ED but not for the UCC. Staff reported that patients did not know who was waiting to be seen in which service. Patients being seen earlier than those waiting could lead to tension between patients.

### Outpatient care

Patients told us they were normally seen within 30 minutes of their appointments and staff kept them updated with the waiting time and reason for any delays.

The facilities in the temporary children's outpatient building were not conducive to providing high standards of outpatient care.

### Accessible information

Information was readily available in wards and departments but only in English. Information could be produced in other languages. Patients we spoke with did not see this as an issue as they had relatives to help them. The hospital had a translation and advocacy service and the multi-ethnic workforce were able to speak several languages which patients valued.

# Are services well-led?

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

## Summary of findings

We saw there was good local leadership and staff were committed to providing safe and effective services. The trust had established a clinical management structure and governance arrangements. However, we were concerned about a lack of visible leadership and adequate communication from the trust's board with staff to achieve effective working in clinical academic groups (CAGs) and communication upwards to the board.

The implementation and monitoring of safety and quality systems was not embedded and sufficiently effective through the management structures and needed to improve in some areas.

## Our findings

### Leadership

Staff told us they had access to good, local management and leadership. They said they usually felt supported and valued by their colleagues and direct line managers. There had been a recent staffing review, a process that was on-going. Staff morale was described as low and staff told us they thought the impact of the changes on service provision had not been properly assessed.

The CAG management structures were not operating effectively in all areas. Staff were not engaged with the trust leadership and the majority told us they worked for Newham Hospital not Barts Health NHS Trust. There was an obvious disconnect between staff working in the hospital and the senior management of the trust. There was little recognition of the trust Board members and senior leaders in the CAGs, suggesting that senior managers were not visible.

Managers in most areas had a good understanding of the performance of their wards and departments and most staff demonstrated a willingness to respond to change.

### Managing quality and performance

The trust Board had established the CAGs and devolved the management for performance, quality and governance to the CAG leadership board. There was evidence that quality and performance monitoring data was reported at the CAG leadership meetings and senior managers in the hospital reported they attended.

We observed safety and quality of care was monitored and action taken in response to concerns at ward level. Staff's understanding of the clinical governance framework, how risks were managed, controlled and mitigated against was variable. Communication of performance, quality and governance information was not consistent across all CAGs.

# Accident and emergency

## Information about the service

The accident and emergency department (A&E) (known as the emergency department (ED)) is open 24 hours a day, seven days a week and is a designated major incident centre. The department sees approximately 137,000 patients each year. The department included a separate paediatric emergency department and eight beds as a clinical decision unit (CDU) and 17 beds as a medical assessment unit (MAU). The CDU is used for people at lower risk who may need further assessment or tests for up to a 12-hour period prior to either being admitted into hospital or discharged home.

People with minor injuries and ailments were seen in the Urgent Care Centre (UCC), which was co-located within the department but managed by another provider and therefore did not form part of this inspection process.

We spoke with 23 patients and 20 staff including doctors, consultants, nurses, senior managers and four ambulance personnel. We observed care and treatment and looked at treatment records. We reviewed information from patient surveys and performance information about the trust. At our listening event, one person provided positive feedback about the care they had received at Newham A&E.

## Summary of findings

The majority of people were seen and treated within the national waiting time limits of four hours. Treatment plans were put in place for either discharge or transfer to inpatient services for further care and treatment. Senior nursing staff had specialist qualifications in treating adults and children within an emergency department setting. There were not enough consultants to provide night-time cover and this was managed via an on-call consultant rota. However, there was always senior medical cover provided by experienced doctors throughout the night.

People who walked into the department were initially seen by reception staff who referred them to either the emergency department (ED) or Urgent Care Centre (UCC) using set guidelines. This may present a risk as patients referred to the ED or UCC were not always seen within 15 minutes of arrival for further assessment. The assessment was completed by a registered nurse or doctor.

# Accident and emergency

## Are accident and emergency services safe?

Services were safe but there were issues that children were not segregated while waiting to be seen in the urgent care centre (UCC).

### Patient safety

People who arrived by ambulance told us they felt safe while being treated in the department and that they were seen promptly. However, some people felt they were not always kept informed about the treatment they needed.

People told us they felt staff knew what they were doing and were very good. One person said, "the doctor examined me thoroughly and told me they needed to carry out some tests, and I'm just waiting for the results".

Staff told us they felt supported to deliver safe and appropriate care. All new nurses and junior doctors were supported and supervised by either the practice development nurse or more senior medical and nursing staff. Support was provided until they were deemed competent to work independently and provide safe care. A new member of staff confirmed they had been given support by someone more senior and that there was an excellent training programme in place for all team members.

### Caring for children

Staff had the appropriate qualifications to care for children in an emergency setting. All staff had qualifications in paediatric life support and two senior consultants had experience and specialist interests in caring for children. All children with life-threatening conditions were initially treated within the resuscitation room specially equipped for children.

There was a separate waiting area for children waiting to be seen by the paediatric ED staff. However, children waiting to be seen by UCC nurse practitioners were not segregated from other adult patients waiting to be seen, either in adult ED or as patients in the UCC. Staff we spoke with expressed their concerns about maintaining the safety of children in this area. Staff also reported that suggestions to address this had been made to the UCC provider but had not been acted on.

### Staffing

The consultant team provided on-site medical cover during the week days and at weekends. There was a consultant on call at night and junior doctors were supported by sufficient numbers of middle-grade, experienced doctors during the busy night shift. However, this could potentially place patients at risk during the night as there were insufficient consultants employed to provide continuous cover.

There were sufficient numbers of nursing staff with the appropriate qualifications to provide both senior and junior cover for the day and night shifts. Staffing numbers remained consistent over a 24-hour period. Staff had all received training regarding the safeguarding of children and vulnerable adults. The senior consultant was nominated as the department lead for safeguarding.

Patients assessed as low risk were admitted to the 25-bed CDU/MAU for further observation. The unit was staffed by registered nurses and support workers. Medical cover was provided by the ED consultants for the CDU beds and they aimed to review patients within 12 hours of admission to the unit for either admission or discharge home. Medical cover for the remaining MAU beds was mostly provided by the physicians as well as the ED consultants. Patients told us that care was generally good but they were not always provided with information about their care.

### Managing risks

There were systems in place to report and review incidents.

### The environment

The department was new and the adult emergency department was divided into four main areas: the UCC for minor injuries; assessment/ triage area; major injuries or serious conditions; and the resuscitation room. The major treatment cubicles gave privacy to patients being examined and having further tests carried out, with good visibility for staff to maintain observations of all patients in that area.

# Accident and emergency

### Infection control

The emergency department was clean and tidy. We found there were sufficient sinks, towels and hand gel available for staff to use. Patient toilets were clean and soap and hand towels were available. Cleaning support was available at all times.

## Are accident and emergency services effective?

Patients were seen and treated effectively by appropriate staff.

### Clinical management and guidelines

Patients received diagnostic tests promptly and treatment was not delayed. There were plans in place for discharge or transfer to specialist teams for further care and treatment.

People told us they had not waited long periods for blood test results. One person said, "The doctor met the ambulance and I went into a cubicle and was treated quickly, I didn't wait at all". Some people told us that, although they were assessed quickly, they were not kept regularly informed about their treatment.

The ED had met national targets relating to patients being assessed, treated and admitted within four hours. Patients received care according to specific care pathways which were developed in line with national guidelines and best practice. The care pathways were consistently applied and updated with ongoing improvements and reflected guidance from the National Institute for Health and Care Excellence (NICE) and other professional bodies. For example, the department demonstrated that they had improved the quality and safety of the management of patients with problems during pregnancy and patients with fractured hips. The department participated in national audits used by the College of Emergency Medicine (CEM) audits as well as the Trauma Audit and Research Network (TARN). This ensured that patients with serious traumatic injuries were managed safely and effectively.

The department worked in partnership with other professionals to ensure patients received appropriate care and support. There was support for referring patients with mental health issues by a psychiatric liaison team which was based in the department. The department and CDU also had access to social workers and physiotherapists to enable and support safe discharges for patients. GPs also worked in the department seven days a week to manage patients with conditions that would normally be treated in a primary care setting.

### Staff skills

Senior nursing and medical staff working in the department had specific qualification in the treatment of emergency care. This included Advanced Life Support (ALS), Paediatric Life Support and Advanced Trauma Life Support (ATLS). However, some nursing staff told us they had not been able to secure funding for either the emergency care course or some of these additional specialist courses.

## Are accident and emergency services caring?

Patients received safe care from staff that were kind and caring.

### Patient feedback

The majority of people we spoke with told us they had received good care from kind and caring staff. We observed staff responding quickly, professionally and politely to patients and visitors across all of the areas in ED. This included ambulance crews and other speciality teams visiting the department. Comments included: "Staff are very competent and have treated me with respect," and, "I am happy with the day-to-day care I have received". We saw some 'thank you' letters and cards the department had received which were very complimentary about the care and compassion people and relatives had received.

# Accident and emergency

Some patients in all areas of the emergency department and the CDU commented that staff did not always keep them informed about delays in treatment, or when they were going to be discharged or moved to a ward. Some patients in the waiting area were not sure who they were waiting to see and how long the wait would be. The patient experience was reported to be generally good on the days we visited, although the response rates to the trust 'Friends and Family' questionnaires was comparatively low at 11.6% compared to the national average of 16.9%. Staff told us they were aware of the low response rate to the Friends and Family test and felt that some people were too unwell to complete the questionnaire when they were admitted to the emergency department.

### Pain relief

Patients received pain relief at their initial assessment and then when required. We observed pain killers being dispensed to a patient in a safe manner at the initial assessment/triage. We did not see staff use a pain assessment tool to determine the patient's level of pain. The department held a stock of simple medication, such as pain relief, for patients being discharged when the hospital pharmacy was closed. For patients whose first language was not English, or who had dementia, staff had access to advocates and interpreters. Some senior nurses who had undertaken specialist training were able to prescribe pain relief for patients to ensure there were no delays in the administration of medication. The paediatric ED used a specific tool for assessing and administering pain relief for children and staff told us this was considered a priority.

### Privacy and dignity

The major injuries (majors) area had single cubicles that ensured patients' privacy and dignity were maintained during examinations. We saw staff ensured they closed cubicle doors and knocked and waited prior to entering. Patients told us they felt staff respected them and treated them with kindness at all times. The department had a bereavement room where relatives could spend time with family members following an unexpected death.

### Food and drink

Patients received adequate nutrition and hydration in the department. We saw patients being offered snacks and hot drinks. Staff told us they used the facilities on the CDU and could always make hot drinks and toast for people at any time of day.

## Are accident and emergency services responsive to people's needs?

Services were responsive to patients and had established protocols to respond to emergency situations.

The ED had a major incident plan in place. We were told the plan had been reviewed and the department could respond quickly if needed. However, we were told by staff that the trust had not carried out a major incident practice exercise of the plan within the last three years to ensure the whole system could respond appropriately. The trust told us that an exercise was carried out in March 2012.

Staff responded promptly to emergency situations. We observed several emergency situations following calls from the London Ambulance Service (LAS). Staff were dispatched to meet and treat the patients immediately. We confirmed that resuscitation trolleys and equipment were checked on a daily basis within the ED and CDU/MAU. However, we did note that the majors area did not have dedicated emergency equipment. And, although it was in close proximity to the resuscitation area, the lack of emergency equipment in the majors area may have an impact on the staff's ability to respond quickly.

### Waiting times

In the last nine months the department had met the national target of seeing 95% of patients within four hours of arrival in the department. There had been instances when this did not happen – for example, in August 2013, due to high number of people attending the department. The department had also met the target for accepting handover of patients from ambulances within 15 minutes. and had one ambulance 'black breach' (where patient handovers took longer than one hour) documented within the first two quarters of 2013-2014.

# Accident and emergency

On the two days we visited the department, all patients were seen within the national target times and the department had a total of 700 people attend for treatment. The department was performing better than the other two emergency departments within the trust.

The department was under pressure at times and the staff were responsive to fluctuating numbers of patients attending the department. Senior staff monitored patient flows and ensured that patients were seen promptly. The department was made aware of ambulances that were en route to the hospital and the approximate time they were expected to arrive. Staff told us this enabled them to respond to a sudden influx of ambulances. We observed, during an evening visit to the department, how staff responded to the early closure of the UCC which had resulted in a large increase of patients. We saw that staff took immediate action and additional staff were allocated to the assessment area to ensure that patients were assessed as promptly as possible.

### The CDU/MAU

The CDU/MAU provides 25 beds for patients either needing admission by specialist teams or monitoring by the ED consultants. The senior staff monitor 'decisions to admit' times and move patients as quickly as possible.

Staff told us that they always maintained 100% single-sex bays within the unit. We saw staff responding to the need to create 'male' beds for patients waiting in the ED by liaising with bed managers and moving patients to other wards to ensure that admissions from ED were not delayed.

### Caring for children

Staff were able to respond quickly to the needs of children in an emergency situation. The paediatric ED had a high-dependency cubicle which was equipped to deal with children who became unwell. Staff told us that, if they were alerted to a child coming in by ambulance, staff from the paediatric department, senior consultants and paediatrians responded to the emergency call. There was also an intercom system between the adult and paediatric areas for staff to get immediate assistance if required.

### Accessible information

There was a variety of information available for patients. However, all the literature and signs were only in English, including signs directing people to the ED and other areas in the hospital. Newham had a high ethnic population and staff told us that they were able to access interpreters easily if required.

## Are accident and emergency services well-led?

The emergency department was well-led and there was sharing of practice across the trust's emergency department units. There were some issues about the IT systems in use.

### Leadership

Staff were motivated and worked well as a team. We saw that all grades of staff communicated well internally as well as with other departments across the hospital. The department was jointly managed with the Emergency Departments at the trust's other hospitals. We saw evidence that, following the merger, the departments had begun to work more closely together. Recent consultant appointments had been cross-department and some initiatives, such as the 'How to guides', were being shared. The guides had been developed to inform staff on the appropriate actions and care/treatment pathways to follow and the contact numbers for referring patients to other services. Clinical leads were working clinically and managerially across hospitals. Learning was also beginning to be shared between the departments. However, staff we spoke with acknowledged that it will take time to develop this relationship to its full extent.

# Accident and emergency

### Managing quality and performance

The service monitored safety and the quality of care, and action was taken to address concerns. There was an electronic process for reporting and reviewing incidents or concerns. Although the department had not had a 'Never Event' (serious safety incidents that should not occur) and only one serious incident within the last three months, we saw that the appropriate investigations were carried out, learning identified, and any changes required implemented. For example, we saw an incident relating to the lack of follow-up on a young patient with a hand injury. The learning from this incident was reported in the department's monthly governance report and shared with all the nursing and medical staff. The learning and appropriate care was clearly identified and protocols for the future management of such patients was highlighted.

Regular quarterly joint clinical governance days took place across the three emergency departments in the trust to share learning and discuss improvements. We saw the attendance list from a recent day. This showed that staff from a range of nursing and medical backgrounds and grades had attended. Discussions had included a session on learning from recent serious incidents. Monthly clinical governance meetings were also held.

### Information and technology system

There were some concerns raised by staff about the information-collection system for patient arrival and treatment times. We were told that, when the department is busy, data is not accurately recorded by staff. The system was described as "slow" and there were inaccuracies noted in the records. For example, we saw that one person had been seen within seven minutes of arrival by a doctor, but the assessment time on the computer showed a time some two hours later. Staff did not always record when a patient had left the department when it was very busy. Also, the three emergency departments within the trust did not share the same computer system across the sites.

# Medical care (including older people's care)

## Information about the service

We inspected Medical Care (including services for older people) at Newham University Hospital. We spoke to patients, relatives and staff in every area visited over the course of the two-day inspection. We visited seven medical wards including a stroke rehabilitation ward, elderly care wards and speciality specific wards.

## Summary of findings

Overall care was safe and effective, and staff worked hard to ensure patient safety. The majority of patients were complimentary about their care and told us that most staff were kind and caring. There were concerns that nursing staff were sometimes unable to meet people's needs due to staff absence and bank staff or agency cover could not be provided. Senior medical support to junior doctors at weekends was by a consultant on-call system and did not meet current professional guidance.

Quality and safety monitoring systems were in place and there was evidence that staff escalated incidents appropriately and received some feedback locally. Staff were not aware of shared learning from incidents/ investigations across the trust, which showed the dissemination of learning across the organisation was not effective.

Staff were supported by their line managers and had access to mandatory training and annual appraisals. Staff morale was low following a recent staffing review but we were impressed that staff remained committed to providing good services to patients at Newham Hospital.

## Are medical care services safe?

Services were generally safe but there were issues around safe levels of staffing to meet patient dependency and safe storage of medicines.

### Patient safety

There were electronic reporting systems in place and staff said they were encouraged by managers to use them to report incidents. There was a variable response from staff about the ease of use of the system. Staff told us that managers investigated incidents and they did receive feedback but this was variable. Some staff demonstrated that they were aware of learning from serious incidents or Never Events – incidents which should never happen. For example, they were able to explain changes in the procedure for checking the position of nasogastric tubes post insertion. They were not aware of incidents that had happened outside of their clinical academic group (CAG) or at other sites in the trust, showing that systems to share and spread learning from incidents across the whole trust were not effective.

Patients told us they felt safe and had confidence in the staff. Comments included: "I can't complain," "they treat me well" and "they are always here and they are good". Most patients were complimentary about the care they received, with comments including, "they help me in every way" and "the staff are brilliant".

Patients' medical and nursing needs were initially assessed in the medical admissions ward and they were then moved to the appropriate ward for ongoing care and treatment. We saw examples of records that were fully completed and risks identified, including those relating to malnutrition, skin integrity and pressure damage, moving and handling, falls and (if needed) the use of equipment. Patients all had a care plan to manage their risks.

### Staffing

There were sufficient medical staff to meet the needs of patients; however, there were fewer medical staff on duty at night and weekends. Junior doctors reported that they were well supported by their consultants and registrars. There was an on-call consultant at weekends which junior staff said was "no problem", however, this did not follow professional guidance which required 12-hour onsite consultant presence. Staff told us that consultants did come in to support junior medical staff if they had concerns. We were also told there were structured handovers twice a day for medical staff to discuss patients, but we also saw evidence of doctors coming on to wards

with no formal handover. We saw the patient list provided at handover which detailed the patient's name, medical history, reason for admission, results of most recent tests, their progress and outstanding tasks relating to the patient's care. It also noted those patients who were not for resuscitation or were receiving end of life care. The list also included an expected date of discharge.

There had been a recent review of staffing and we were told that nurse staffing levels met professional guidelines. Staff told us there was a process in place to book overtime (bank) or agency nurses to cover short notice staff absence. Staff reported the system had recently changed and was fairly onerous. They said by the time permissions and bookings had been made, the additional staff were often unavailable to fill the shift. We were told that shifts identified early were more likely to be filled. Weekend absence and short notice bookings were those least likely to be filled.

Staffing levels on the wards did not always meet the number needed to provide safe care to patients, especially when shifts had not been filled. For example, on one ward we observed the matron was based on the ward to provide care to patients and 'plug the gap' as three staff had called in sick at short notice and the shifts couldn't all be filled. Nurse handovers were ward-based and included discussions about all patients in detail. There was a daily matron's bed meeting to review bed management, share staff around the wards if needed, and any other site management concerns.

Ward-based staff worked in partnership with other professionals to ensure patients received appropriate care and support, including physiotherapists, occupational therapists, dietitians, pharmacists and speech and language therapists. We saw there was a ward-based gym and occupational therapy kitchen on the stroke ward to facilitate patient recovery.

There were systems in place to ensure patients received appropriate help and support with their nutritional intake. All of the wards we visited had established protected mealtimes, and red trays were used to identify those patients who needed support to eat and drink. Patients had a choice of food and there were menus to meet the religious and cultural requirements of the patient population. Patients were referred to appropriate specialists when needed – for example, the dietitian or speech and language therapists for dietary advice and swallowing assessments.

### Managing risks

There were systems in place to monitor the risks to patients. Patient's records showed the risks of developing pressure-related skin damage, and blood clots and infections were appropriately managed. We saw the hospital had implemented the Newham Quality Assurance System (NQAS) to monitor and report on a range of safety indicators. Charts were used with green and red crosses to indicate good or poor performance ratings (the Safety Cross system) relating to falls, hospital acquired pressure ulcers and other criteria. These were displayed on noticeboards in every ward we visited, although it was noticeable that, in some wards, only the positive (green cross) results were made public. The results of this monitoring was discussed weekly at a meeting of ward managers and matrons to share best practice and learning. We also saw the results were fed into an integrated performance report so the CAG and ward managers could access all the metrics for their area.

### Hospital infections

Patients were protected from the risk of infection. Medical wards were clean and standards were monitored. Notices at the entrance to wards advised visitors to use hand gel prior to entry and on leaving. There were hand-washing facilities with soap and towels in every area and hand gel was stationed at sinks and at each patient's bed as well as on notes trolleys. We observed that staff washed their hands and used gel in-between attending patients. Personal protective equipment such as gloves and aprons was available. There was signage displayed on side room doors where patients were being isolated and staff were observed to follow the associated instructions.

### Medical equipment

Medical equipment was adequately maintained, although staff reported there were some delays and equipment was taken out of use for extended periods of time. We found staff had access to pressure-relieving mattresses for patients identified as being at risk of developing pressure ulcers. It was noted on one ward that the medical store room door was propped open as agency/bank staff did not have a 'swipe card' to access the room and permanent staff were not always available to open the door.

# Medical care (including older people's care)

### Safeguarding procedures

The trust had processes in place to identify people at risk – for example, the use of flags on the patient electronic record and 'passports of care' for people with learning disabilities. There were also established processes to refer safeguarding concerns to the local authority. The Chief Nurse was responsible for safeguarding in the trust and there were regular meetings held with safeguarding leads to review policies and procedures, safeguarding training and ongoing safeguarding concerns. We saw the trust had developed assurance frameworks for safeguarding processes and the trust had discharged its duties to complete a Section 11 audit and action plan demonstrating its compliance with Section 11 of the Children Act.

### Medicines management

We visited Plashet Ward and looked at medicines storage and supplies, records relating to people's medicines and talked to pharmacy staff and nurses.

Medicines were prescribed and given to people appropriately. Appropriate arrangements were in place for the recording of the administration of medicines. All allergies were documented and we saw no missing doses. There was provision for nursing staff to record if a dose had been missed or delayed and the reason.

Medicines were available when people needed them. Appropriate arrangements were in place for obtaining medicines. We saw that prescribed medicines were available; there was a weekly pharmacy top-up service and a daily weekday visit from a ward pharmacist. The pharmacy was open at weekends between 10am and 2pm and there was a pharmacist on call out of hours. There was evidence of medicines reconciliation on admission. There is no policy to allow patients to self-administer their own medicines if they request to do so, however, we saw patients self-administering their own insulin. Medicines were available on the ward and suitably labelled to allow nursing staff to discharge patients out of hours. Emergency medicines were kept on the ward and they were being checked regularly. There was evidence of routine checking of controlled drugs and a register of patients' own controlled drugs.

There was a risk that unauthorised people could access some medicines. Medicines were not securely stored. There was no control of access to the clean utility room where infusions solutions were kept in boxes below the bench. Oral medications and injections were in locked cupboards. Medicines requiring cold storage were kept in a fridge and the temperature was monitored, however, the fridge was not locked. One patient's medicines were stored on top of the fridge and not in the designated locked cupboard.

## Are medical care services effective?

Services were generally effective, patient treatment and care followed national guidelines.

### Clinical management and guidelines

Patients received care according to national guidelines. The trust participated in national audits and standards of care were 'within expectations' for the majority of specialities in medicine, for example, respiratory conditions care and stroke.

We looked at a number of patient records across the medical wards. Patients had all been assessed and had a plan of care to meet their identified needs and mitigate risks. There were records of all staff interventions in patient notes. The majority of patients we spoke with said they were happy with their care and knew what was happening. Patients were aware of the next steps in their treatment/care. For example, one person told us they were to be transferred to another site for a procedure, another said they were being discharged and staff had discussed their ongoing ability to manage at home.

There was evidence of multidisciplinary working and meetings to coordinate care and treatment across the medical specialities. Staff of all disciplines attended and relatives on the stroke ward told us they were also invited to participate in the discussions about their relative with the multidisciplinary team. Junior medical staff reported they spent a lot of time arranging intersite transfers for patients with deteriorating health. They told us there were delays to patient's treatment at times because the bed managers could not identify a bed in a suitable ward.

# Medical care (including older people's care)

### Patients with dementia

The Older People's Liaison Service (OPLS) was jointly provided with the neighbouring mental health trust and gave advice, support and carried out assessments for patients over the age of 65 with memory problems. Patients were referred directly to OPLS and, in addition, the Consultant Nurse Lead attended the elderly care multidisciplinary team meetings and identified patients who would benefit from their input. The team provided support to patients and their carers to ensure they had access to specialist services and support once discharged into the community. Staff valued the support OPLS provided in the ward setting to enable them to provide care to patients with a diagnosis of dementia.

The trust had published a dementia strategy developed by the Dementia Strategy Group led by the Consultant Nurse for Older People. The group had ambitions to implement a trust recognition symbol which would alert staff to patients with special needs due to dementia. We were told the electronic patient record at Newham would identify when patients had a diagnosis of dementia or any other type of special need.

### Patient mortality

We reviewed our surveillance information about the trust and the data showed there was no evidence of risk identified at Newham University Hospital. We were told that Mortality meetings were due to commence in the CAG to review patient deaths.

## Are medical care services caring?

Services were generally caring and patients recognised the majority of staff were kind and caring. There were some issues about staff attitude toward relatives and the quality and variety of food available.

### Patient feedback

The majority of patients and visitors we spoke with felt they were treated with kindness, dignity and respect. Most were complimentary about staff and mentioned staff who were particularly kind to them. We were told staff were abrupt on occasion and appeared not to listen to people. Relatives of one elderly patient told us, "Only XX listens to us, none of the others do. When we try to explain they just say 'yes,yes,yes'".

At the listening event we held for Newham Hospital, one person told us of staff talking over their relative while delivering care. They also said staff were, on occasion, rude and answered their personal mobile phones while with a patient. People told us they "weren't in a position to complain".

### Patient treatment, privacy and dignity

Staff treated patients with dignity and respect. Staff interactions with patients were observed to be overall kind, patient and professional. Personal care was delivered discreetly behind closed curtains. Care records showed some people had been involved in planning their care, but not all.

Patients told us they were able to talk to staff about their treatment and care. Comments included: "They asked lots of questions and did tests, then told me what was wrong and what the treatment could be if I agreed".

### Food and drink

Patients had adequate nutrition and hydration and, if required, were supported to eat meals. We observed breakfast and lunch in several wards. Patients were supported to choose their meal. We saw drinks were available and most were left within reach of the patient. A red tray was used to identify patients who needed help to eat or needed their intake monitored. Staff were observed providing assistance and food and fluid records were completed when required. Patients told us, "I can choose what I want to eat and it's very good, no complaints". Another patient required a halal meal and said, "there's a good choice" although relatives felt the portions could be more generous. People who had contacted us were less complimentary about the food, particularly halal meals and said, "they are all curry based, not everyone likes curry".

## Are medical care services responsive to people's needs?

Services were responsive to people's needs and they told us staff responded to their requests for assistance.

### Patients' feedback

Patients told us they were cared for and staff responded to their needs and requests for assistance. They told us it sometimes took staff longer at night to answer call bells.

# Medical care (including older people's care)

One patient told us they were frequently admitted to the hospital, and said on this occasion it had taken a "long time" to find the clinical records but overall they were happy with the treatment provided.

### Ward environment

We visited seven wards and they were appropriate for patients. All wards had single-sex bays and side rooms. Bathroom and toilet facilities were also single-sex designated. One patient told us they had asked to move away from a disruptive patient and were given a side room on another ward.

### Patient records and end of life decisions

We looked at patient records in every ward visited and saw they were completed in accordance with professional guidance. There were details of medical, nursing and allied health professional's assessments in the notes and plans for discharge formed part of the record for some patients. 'Do not attempt resuscitation' (DNAR) forms were appropriately completed and were reviewed every seven days; the decisions were discussed with the patient and relatives.

### Accessible information

Services were provided to a varied multi-ethnic population and a very large number of languages were spoken in the vicinity. The Trust website allowed patients to choose their preferred language to view the information about Newham University Hospital.

Information was readily available on medical wards but only in English, although it could be made available in different formats and languages if needed. Interpreting and advocacy services were available to help patients using services.

### Complaints

The Patient Advice and Liaison Service office at the hospital was closed at the time of the inspection. There was a contact number displayed, which we rang, but it wasn't answered. We heard the service was being reorganised and the office was no longer permanently manned. We saw posters and leaflets were being distributed at the time of inspection to inform people of the changes.

## Are medical care services well-led?

Services were well led locally but not at a senior level and there were issues about the involvement, recognition and visibility of leaders in the trust.

### Leadership

Medical services were part of a CAG with a management and governance structure across all sites in the trust. The CAG had devolved responsibilities from the trust Board to manage all activity and performance.

Staff at Newham Hospital told us they felt well supported by their managers at a local level and valued by their senior nursing and consultant colleagues. The majority of staff did not identify themselves as being part of Barts Health NHS trust and could not provide examples of when executive and director level staff had visited their area. Staff morale was low following the recent staffing review and consultation, although staff were committed to providing a good standard of care to their patients despite this.

We were told senior nursing staff undertook 'Clinical Fridays' to provide support and work alongside staff on wards. Some staff described the senior staff attendance as a "short ward round" and said that senior nurses were "not that visible".

### Managing quality and performance

Ward managers, matrons and heads of nursing met regularly to report on quality, safety and performance in the service. Senior staff confirmed they attended CAG managerial and governance meetings to represent the services at Newham Hospital. Performance and quality data was collated into an overall CAG integrated performance report which allowed managers to look at the data in-depth. Ward staff were provided with verbal updates at ward meetings or handovers.

There were risk registers for each CAG which contributed to the overall trust risk register. Risks were being identified and there was some evidence that the document was regularly updated and action was being taken to mitigate the risks. Untoward incidents, complaints and concerns were monitored and discussed at a local unit level, there was some evidence the information was considered by the CAG leadership.

# Surgery

## Information about the service

The surgical care services are provided in two areas of the hospital. In the main hospital building, Silvertown Ward receives emergency and trauma patients and patients undergoing elective major surgery and Jasmine Ward provides day care surgery. In a separate building, the Gateway Surgical Centre, elective surgery is carried out on Maple Ward for patients who require an inpatient stay and Clover Ward for day care patients. Both sites have their own theatres. The hospital provides a range of surgery which includes orthopaedic, trauma, urology, gynaecology and general surgery.

During our inspection we visited Silvertown Ward, Jasmine Ward and Maple Ward, along with theatres in both areas; this included the pre-assessment area for surgical patients.

We talked with a number of patients and staff working in the surgical areas including nurses, doctors, senior managers, therapists and support staff. We observed care and treatment and looked at care records.

## Summary of findings

Patients were treated in accordance with national guidance – for example, for joint replacement surgery. Risk management processes were in place and staff were aware of how to report incidents. Staff were aware of learning in their own area but they were not aware of learning from incidents across the wider trust.

We saw safety checks in theatres followed the World Health Organisation (WHO) checklist. However, we observed that not all surgeons participated in the safety checks at appropriate times in the patient care pathway in theatres. We also noted there was a lack of consultant engagement in theatre planning meetings and in clinical academic group (CAG) management and leadership roles. We found there was no consultant presence on site out of hours and at weekends. Patients were transferred to other wards and junior staff covered 'outliers' (patients on wards not the specialty for their needs) around the hospital which created additional workload and patient care and discharge could be adversely affected.

There were sufficient staff available to provide care to patients, but they did not always have the skills to meet all of the types of surgical needs on the inpatient ward.

# Surgery

## Are surgery services safe?

Services were generally safe but there were issues around safe levels of staffing cover and safe storage of medicines.

### Patient safety

Patients repeatedly told us they "felt safe" in the surgical wards. Their comments included: "I have always felt safe here, I can't praise them enough"; "I have had excellent care and feel safe"; and "The staff are always respectful to me and my family".

There was a computerised system in place for reporting incidents, and we saw the system in operation on Maple Ward where incidents had been recorded. There had been a recent serious patient incident called a 'Never Event' on Maple Ward relating to a retained swab. The ward manager told us she had been involved in investigating the serious incident and putting in place recommendations to change practice to minimise the risk of the incident happening again. We asked for a copy of this report but we did not receive it, as the investigation was still ongoing.

Staff in both theatre sites told us they used the WHO checklist and we saw evidence of this. We observed a theatre team undertaking a surgical procedure but the checklist was not completed at the appropriate times which could have increased the risk to patients. We observed computer-generated theatre lists which did not specify the particular surgery an individual was to receive. For example, the list included one patient who was listed for 'joint replacement'. It was not clear which particular joint this referred to. This lack of detailed information increased the risk for potential mistakes. We raised this with the manager who told us they did not schedule the patient for surgery until the detail was clarified.

### Managing risks

Staff we spoke with were unaware of any learning from mistakes or serious incidents that had occurred in the trust other than those related to their specific ward or area of practice. This meant that staff did not have the opportunity to learn from mistakes and improve standards of safety.

### Hospital infections and hygiene

Patients were protected from the risk of infection. We observed hand hygiene gel in all ward areas and at the end of each patient's bed. All patients waiting for elective surgery were pre-assessed and had swabs taken to screen for methicillin-resistant staphylococcus aureus (MRSA). Patients were not admitted for surgery until clear swab results had returned. Staff were observed to wear colour-coded aprons for different activities and gloves appropriately. Infection control audits had been completed on Silvertown Ward in March and July 2013. The audits reflected that improvements were needed in some aspects of infection control and a further audit is to be carried out within six months. Overall, patients were cared for in a clean environment and the patients we spoke with confirmed this.

### Equipment

Resuscitation trolleys in all areas of surgery were checked on a daily basis and this was recorded. The contents of the trolley were complete and in date. On Silvertown Ward we observed the ward macerator was out of order and staff confirmed the machine had been broken for several days. This meant that cardboard bedpans used by patients were collected in plastic bags prior to removal from the ward. The sluice area was full of plastic bags containing used cardboard bedpans and this could potentially compromise patient safety.

### Staffing

At the time of our visit the staffing levels were safe and met national guidance, however, nursing staff told us that the staffing levels were not usual. The majority of the patients on Silvertown Ward had complex needs and there was no indication of how the patients' changing dependency levels had been taken into account in determining appropriate numbers of staff on duty. Junior doctors reported that they were unsupported by their consultant surgeons, although this was not having an effect on patient care.

# Surgery

### Medicines management

We visited Silvertown Ward and looked at medicines storage and supplies, and at records relating to people's medicines. We talked to pharmacy staff and nurses.

Medicines were available when people needed them. Appropriate arrangements were in place for obtaining medicines. We saw that prescribed medicines were available; there was a weekly pharmacy top-up service and a daily, weekday visit from a ward pharmacist. The pharmacy was open at weekends between 10am and 2pm, and there was a pharmacist on call out of hours. There was evidence of medicines reconciliation on admission.

Medicines were prescribed and given to people appropriately, with proper recording of the administration of medicines. All allergies were documented. There was provision for nursing staff to record if a dose had been missed or delayed and the reason. There were no missing doses.

There is no policy to allow patients to self-administer their own medicines if they request to do so. Medicines were available on the ward and suitably labelled to allow nursing staff to discharge patients out of hours. Emergency medicines were kept on the ward and they were checked regularly. There was evidence of routine checking of controlled drugs, although the date of opening of a liquid morphine medicine had not been recorded.

Medicines were not securely stored. There was no control of access to the clean utility room where infusions solutions were stored in trays and the door was left open. One cupboard containing tablets was open. Other oral medications and injections were in locked cupboards. Medicines requiring cold storage were being kept in the fridge which was locked and the temperatures of fridges were being monitored There was a separate storage cupboard for epidural infusions Therefore unauthorised people could access some medicines.

## Are surgery services effective?

Services were generally safe but there were issues around staff skills and communication between the multidisciplinary team.

### Clinical management

Patients received care in accordance with national guidance. Pathways of care were referenced to National Institute for Health and Care Excellence (NICE) guidance (for example, for joint replacement surgery).

We looked at a number of patient records across the surgical areas. Patients who were receiving elective surgery under a general anaesthetic had a pre-assessment appointment where investigations had been completed prior to admission to hospital. Overall risk assessments were completed and patients in Maple Ward followed an integrated care pathway. There was an enhanced recovery programme in place for patients who received joint replacements and patients receiving care in Maple Ward reported being happy with the care they received and felt well informed.

We observed regular ward rounds taking place. On Silvertown Ward these were not multidisciplinary and medical staff then had to go back to a member of nursing staff after the ward round was completed to inform them of any changes to patient care. Potentially, this could mean that patients did not receive planned care changes.

### Staff skills

Staff had completed mandatory training and we saw records to verify this. Other training for staff was limited and we were told by nurses that they did not always have staff on duty with the appropriate skills to meet the needs of the patients. This was particularly evident on Silvertown Ward which looked after patients with multiple specialities. For example, a patient with dementia was being cared for on the ward but not all staff had received dementia training. We asked to see records of staff training on Silvertown Ward but only mandatory training records were available.

# Surgery

### Patient Mortality

We reviewed our surveillance information about the trust and the data showed there was no evidence of risk identified at Newham University Hospital.

## Are surgery services caring?

Services were generally caring but there were issues about maintaining people's privacy and dignity and the quality of food available.

### Patient feedback

Patients we spoke with were happy with the care they had received and described the staff as "kind and caring".

Their comments included: "The staff are very good, very caring"; "All the staff are wonderful, I can't thank them enough for the care they have given me"; and "The staff are worth their weight in gold". We observed staff talking to patients in a calm and friendly manner. They were respectful and polite, even at times when the wards were very busy.

Staff told us that they used the NHS Family and Friends test to obtain feedback from patients. However, there were very few comments cards in the ward areas for patients or their families to complete. Staff were unable to identify any areas of change as a result of patient feedback. We did see noticeboards displaying large numbers of 'thank you cards' from patients to the staff on the wards.

### Patients privacy and dignity

We observed that patients' privacy and dignity were maintained. Curtains screening beds were closed when required and staff spoke with patients in private. People described staff as "always respectful" and said they were treated well.

Patients were cared for in mixed-sex wards. Overall, the wards were designed to have male and female segregated bays with toilet and bathroom signage indicating male or female. The exception to this was on Silvertown Ward which had segregated male and female bays, however, washing and toilet facilities did not have signage indicating male or female. In addition, the side room on Silvertown Ward, next to the female bay, was occupied by a male patient and staff confirmed that it was not always possible to allocate a female patient to the room. Lack of clear, single-sex designated areas meant that patients' privacy and dignity may be compromised.

### Food and drink

Patients told us they were able to choose their meals according to their religious and cultural preference. Patient's comments included: "The food's OK", however, one person told us, "The food is awful, I don't expect too much, it's not a hotel but it's not good enough".

Meal times were flexible and food trolleys on each ward meant that the food could be served warm. Most patients thought the food was satisfactory. The hospital operated a 'red tray system' which indicated the patient required assistance to eat their meal. We observed one person in Silvertown Ward: the tray was placed on a bed table out of reach of the patient and the food was untouched. We raised this with the manager during the inspection and action was taken to ensure the patient received a meal.

## Are surgery services responsive to people's needs?

Services were generally responsive to people's needs but there were issues about communication with people about transfers and discharge plans.

### Patient records and discharge planning

We reviewed patient records on every ward visited and the majority were adequately completed. However, on Silvertown Ward we observed patient records which were incomplete. There were gaps in the recording of observations of blood pressure monitoring, fluid balance charts were not always accurately maintained, and the P-vital handover tool was not always followed. We found one patient with dementia who did not have a care plan relevant to their diagnosed need. This meant that effective processes were not always in place to meet patients' needs.

There were no records of discharge planning taking place. The patients we spoke with confirmed they did not know when they might be discharged or any arrangements that had been made. This meant there was not an effective process in place to manage patient discharge.

# Surgery

### Patient journey/flow

We spoke with patients in the Gateway Surgical Centre (Maple Ward) who told us they had originally been admitted to Silvertown Ward, in the main hospital, and had been transferred. We spoke with staff on both Maple and Silvertown Ward who confirmed that patients were often transferred to create beds on Silvertown Ward for emergency admissions. Staff also told us patients were transferred from Maple Ward if their medical condition deteriorated. There were patient transfer arrangements in place. Managers confirmed that the hospital patient transport service was used to transfer patients during the day and out-of-hours transfers were transported by the London Ambulance Service. There was no data available to confirm the number of patient transfers between the wards as the information was not collected by the trust.

We were told there were a number of surgical patients who had been transferred to other, non-surgical wards in the hospital due to bed shortages on Silvertown Ward. Medical staff confirmed this and said they continued to manage the care of surgical patients wherever they were in the hospital. Patients we spoke with had not been informed that they may have to transfer to a different ward during their stay and the number of patients who were outliers meant there was a potential risk that patient care was not reviewed in a timely manner.

### Accessible information

Patients told us they had received information about their planned admission to hospital. Patients' comments included: "I was sent the letters but didn't read it all, I was too frightened", and another said, "The information sent out was fine and easy to understand. Others reported they had been fully involved in discussions about their care and had received sufficient information.

Newham University Hospital had a high percentage of patients where English was not their first language. Staff explained that translating and interpreting services were available. Patients confirmed this and did not have any concerns about the services available. The trust website allowed patients to choose their preferred language to view information about the hospital.

## Are surgery services well-led?

Services were generally well led locally but not well led at senior management level and there were issues about the involvement, recognition and visibility of leaders in the trust.

### Leadership

There was a management structure in place. Overall, at a local level, nursing staff on Maple Ward, Jasmine Ward and theatres said they felt well supported by their direct line manager. Managers had a good understanding of the performance of their wards and there was a willingness to respond to change. Silvertown Ward was a very busy surgical ward and there was a lack of cohesiveness in the team. The Senior Manager was aware of this and measures had been put in place to address shortfalls.

The surgical staff we spoke with in all areas told us they had not been visited by a senior member of the trust management team. They did not recall any visits taking place and did not feel well supported by senior management above their direct line manager. The CAG management structure was not embedded and staff we spoke with confirmed this.

Staff told us that the consultant surgeons worked very much in isolation and did not participate in operational meetings. For example, we attended a theatre meeting and there was no consultant surgeon representative. The focus group we held for consultants during the inspection was not represented by a member of the consultant surgeon body. Other departments in the hospital also raised concerns about the difficulty in obtaining a surgical opinion for their patients when requested. This meant that the consultant leadership within the surgical team was not visible.

### Managing quality and performance

Safety and quality of care was monitored and action taken in response to concerns at ward level. Staff did input information regarding incidents when they were able to access a computer but staff reported that this was sometimes difficult because of the IT systems which were slow.

# Surgery

There as evidence that quality and performance monitoring data was reported on at the CAG leadership meetings.

Staff told us they did not receive information about governance meetings that took place. Staff we spoke with were unaware of the governance framework, how risks were managed, controlled or mitigated against. This meant that the governance framework was not embedded and this could potentially have an impact on the safety of patients.

# Intensive/critical care

## Information about the service

The critical care service at Newham University Hospital comprised an eight bed intensive therapy unit (ITU) delivering care to patients with serious life-threatening illness. Six beds are within one area and there are two cubicles. There are no high dependency unit (HDU) beds at the hospital.

We spoke with one patient and their relatives, nursing and medical staff and looked at care records.

## Summary of findings

Patients received appropriate care and treatment in accordance with national guidelines. The critical care service performed as well as similar units across the country.

There were sufficient numbers of staff on duty to provide 24-hour care, however, this was only achieved with overtime (bank) or agency staff. There were five unfilled nursing vacancies on the unit. Out of hours and at weekends there was no specialist critical care consultant cover and a consultant anaesthetist provided support to the unit.

There were delays in discharges from the unit due to the availability of beds elsewhere in the hospital. The unit was small and lacked facilities and storage. Patient privacy could be compromised due to the close proximity of the beds.

## Are intensive/critical services safe?

Services were generally safe but there were issues about the reliance on bank/agency staff to provide safe staffing level and the lack of critical care consultant cover at evenings and weekends.

### Patient safety

Patients' care needs were assessed and plans were in place to meet those needs. The consultant carried out a daily round and we observed staff caring for patients on the unit in a timely manner. The unit collected relevant patient safety and quality metrics data and acted on the findings and the records we looked at confirmed this. This meant that patients' needs were being met. There was a warning system on all wards to enable early identification of deteriorating patients and alert intervention by medical staff.

The unit had systems and processes in place for recording adverse incidents. We observed monitoring taking place at local level. We saw staff handovers taking place and that they were used to share learning.

### Equipment

The resuscitation trolley was checked daily and the contents were in date and records completed. There was a security system in place on the entrance to the unit which meant people were protected from the risk of unauthorised people accessing the unit. Equipment was adequately maintained.

### Staffing

There were sufficient numbers of qualified nursing staff on duty to meet the needs of the patient on the day of our inspection. However, nursing staff reported that vacancies were not being filled and the unit was reliant on bank and agency staff to maintain adequate levels. We were told by staff that there was no critical care consultant available after 5pm and at weekends and the service consultant cover was by a consultant anaesthetist. The trust told us that there was an intensive care consultant on duty between the hours of 9am and 5pm at weekends.

The reliance on bank and agency staff may potentially compromise the safety of patients.

The patient we spoke with said they were happy with the care they received and said that staff were 'attentive'.

# Intensive/critical care

### Environment

The environment in ITU did not ensure the safety of patients. The unit was small and the beds were close together. There was a lack of facilities and storage space. We observed this and staff we spoke with confirmed this. The Operations Director at Newham Hospital was aware of the environmental concerns in ITU and told us that they were a priority for action.

There was no provision of HDU facilities and patients who no longer required ITU level care were transferred to either the coronary care unit (CCU) or to Silvertown Ward. This could potentially comprise patient safety.

## Are intensive/critical services effective?

Services were generally effective although discharges from the unit were sometimes delayed.

### Clinical management and guidelines

Mechanisms were in place to manage the quality and effectiveness of service provision. Patients received care and treatment according to national guidelines and this was monitored. The trust submitted data to the Intensive Care National Audit & Research Centre (ICNARC) which aims to improve the practice of critical care in the UK. We also saw reports monitoring information related to venous thromboembolism (VTE) or blood clots, infection rates and falls.

### Patient mortality

A national independent survey by ICNARC highlighted that the number of unplanned readmissions to ITU was relatively low. The comparative figures showed that Newham Hospital had a higher number of delayed discharges to other wards than similar units. The patient mortality rate in ITU was the average expected, given the area, age and health of the population the hospital serves. Meetings with medical and nursing staff took place to monitor and understand why people might die on the ward so improvements could be made.

### Outreach team

We received positive feedback from staff about the support provided by the hospital's outreach team. The response to requests for support were prompt and staff felt supported by the team.

### Staff skills

Staff had the appropriate training to provide effective care. We saw records to verify this. Patients received one-to-one care from nursing staff.

### Transfer

We observed delays in the transfer of patients out of the ITU environment once the patient's condition had improved. This was due to difficulties in finding a bed on Silvertown Ward and led to transfer delays in excess of four hours on some occasions. The medical and nursing staff we spoke with confirmed this.

## Are intensive/critical services caring?

Services were caring and patients were treated with dignity and respect but there were issues with the environment.

### Patient and relative feedback

The patient we spoke with and their relative confirmed the care they had received was "excellent". They reported the staff as being "kind and caring".

There was a system in place to capture patient feedback. A collection box for comment cards was available for patients and their families. The completed cards were analysed by the Patient Advice and Liaison Service. Staff confirmed they received the analysis of the patient's experience and the information was used to inform practice and make changes.

### Privacy and dignity

The patient we spoke with said the staff had maintained their privacy and dignity. We observed staff treating other patients as such and speaking with patients in a polite and respectful way. However, the environment in the unit compromised the ability to maintain privacy and dignity due to the close proximity of beds and the lack of space in the unit.

# Intensive/critical care

## Are intensive/critical services responsive to people's needs?

Services were responsive to patients needs and used patient feedback to make changes.

### Management of complaints.

Patient experiences and complaints were used to inform and improve practice. Patients and relatives had identified there was a lack of general information available about the unit. As a result a notice board was set up for the use of professionals, patients and their relatives which provided general information about the unit, 'do's and don'ts' and the safety thermometer information.

The unit holds a multidisciplinary meeting each month to discuss any complaints. We saw the meeting advertised on the unit's noticeboard and staff confirmed they regularly took place. There is an average of one complaint received each month.

### Patient care

Patients were monitored closely in the unit and staff responded quickly to any changes in patient care and treatment. The records we looked at supported the monitoring we observed. The unit operated seven days a week, 24 hours a day and was supported by medical staff of differing grades.

## Are intensive/critical services well-led?

### Leadership

The ITU was well-led. Senior managers and clinicians were well-informed about the performance within their department. However, senior management in the trust were not visible and staff reported that, as far as they were aware, they had not been visited by senior management.

### Managing quality and performance

The ITU carried out a range of audits. Information was provided to the ICNARC which helped to ensure services are delivered in line with good practice. Regular meetings ensured that staff openly discussed concerns about the service and critical care.

# Maternity and family planning

## Information about the service

Newham University Hospital maternity services delivers more than 6,850 births a year and this number is increasing. The maternity unit includes: booking and antenatal clinics; a labour ward; an induction of labour suite; maternity assessment unit; high dependency unit; a postnatal ward; and a birthing centre. There are two dedicated operating theatres and a level two neonatal intensive care unit.

We spoke to 16 women and over 40 staff including midwives, doctors, consultants, senior managers and support staff. We observed care and reviewed performance information about the service.

## Summary of findings

The unit was refurbished two years ago and was bright, spacious and clean. The use of colour-coded signs helped people find their way around.

There had been a number of 'never events in the last year; these are events that are so serious they should never happen. The trust had undertaken much work on incident reporting, investigation, learning lessons and changing practice to prevent a recurrence.

There was a significant number of vacancies for midwives within the maternity service. Steps had been taken to address this, but staff expressed feeling "burnt out".

There were appropriate arrangements for obtaining medicines but management, storage, prescription and administration of these did not protect women against unsafe use.

Although most staff were caring and respectful towards the women in their care, there were examples of women who had not consistently been treated with consideration and respect.

The service responded to patients' needs and was well-led.

## Are maternity and family planning services safe?

Improvements are required in the maternity services to ensure women are safely looked after.

### Patient safety

In the 12 months from October 2012 to September 2013, seven Never Events occurred at the trust, four of which were at Newham University Hospital. These four events related to swabs or packs being left in patients following obstetric or gynaecology procedures. Much work had been undertaken to analyse these events and learn lessons to prevent them happening again. A few days prior to the inspection, a new process for the recording of retained packs was introduced which included a yellow card within the patient's records and a yellow wrist band to alert staff to the need to remove a pack or swab. There was clear communication of this at handover meetings, information on noticeboards and good staff awareness. It was too early to audit the effectiveness of this new process.

Staff reported that there has been an increased focused on safety. Staff reported incidents, received feedback and learned lessons for improvement. Each month "hot topics" or key information was communicated to staff, and we observed discussion of these at handover as well as information on noticeboards.

### Medicines management

Medicines were available when people needed them, and there were appropriate arrangements in place for obtaining medicines with a pharmacist on call out-of-ours.

Medicines were not secured or managed safely and there was a risk that unauthorised people could access some medicines. There was no control of access to the clean utility room. Two medicine trolleys were in the clean utility room, one of which was not locked and neither trolley was secured. Other oral medications and injections were in locked cupboards. There was no evidence that pharmacists had seen medicine charts or of medicines reconciliation on admission. Expired medicines were found in the fridge which was not locked.

# Maternity and family planning

Medicines were not prescribed and given to people appropriately. Allergies were not always appropriately documented. In two cases, no allergy status had been filled in on patients' records. Appropriate arrangements were in place for the recording of the administration of medicines, however, we saw that there were two cases of delayed administration of intravenous antibiotics without explanation and staff did not always check patients' wrist bands.

### Infection control

Both the maternity unit and neonatal unit were visibility clean. In the antenatal clinic, hand gel was not available in every area, however, in all other areas it was readily available. There was access to personal protective equipment (such as gloves and aprons) as required.

### Equipment

Staff within maternity felt that the availability of some basic equipment such as blood pressure monitoring equipment was not adequate and said they wasted time looking for equipment that may have been borrowed by other areas. They stated that they had received no response to their raised concerns.

On the delivery suite, there were three resuscitation trolleys, one for adults and two for newborn infants. Tthere were records that these were checked daily, however, the contents were not consistent with the checklists, it was difficult to see the expiry date on some packs, and the blood culture bottles had expired. Some plastic containers on the trolleys for newborn infants were labelled but the contents did not match the label. The box with drugs and equipment for caring for women with pre-eclampsia contained the relevant items but also unnecessary equipment which could delay treatment in an emergency. The trolley for managing postpartum haemorrhages was kept locked in the drug cupboard and there were some labelling errors – for example, the list showed that one drug was kept in the controlled drug cupboard whereas it was (correctly) kept in the fridge. Many of these issues were addressed during the inspection, however, the trolleys were not clearly labelled as to their purpose and there was confusion from staff over which trolley to use in each emergency.

### Security

Access was restricted in all clinical areas. The neonatal unit adhered to these restrictions, however, on the maternity unit, visitors were seen gaining unauthorised access to the unit. In the postnatal ward, it was common to see the curtains drawn around the beds all the time; while this maintained privacy and dignity, it also meant that staff did not have patients and babies easily in their sight. Babies had name bands on but there was no electronic tagging.

### Staffing levels

During our inspection there were sufficient numbers of midwives to meet the needs of the women, with one-to-one care for women in established labour. The ratio of midwives to births was one midwife for every 32 births which is less than the national recommended level of one midwife to every 28 births.

There were a significant number of vacancies for midwives and staff told us that they had concerns about the staffing levels. We were frequently told that staff felt "burnt out". There was access to overtime (bank) and agency staff, although it could be difficult to secure them at short notice. Senior managers were aware of these challenges and a number of midwives had recently been interviewed and further posts were being advertised.

There was good medical cover, with consultants available on site 74 hours per week, which is above the 60 hours per week as recommended by the Royal College of Obstetricians and Gynaecologists. Junior doctors felt well supported. There were dedicated lists for elective caesarean sections and a second theatre for emergencies with dedicated staff.

## Are maternity and family planning services effective?

Treatment in maternity services was effective.

### National guidelines

Currently guidelines were in use. Following the merger of the trust and the three maternity units, much work had taken place on reviewing the clinical guidelines to promote consistency and best practice. While a significant number

had been approved, none had been published at the time of inspection, although this was expected soon. Many staff were unable to find copies of the existing guidelines on the intranet and advised that they asked a colleague or looked on the Royal College website. This meant that care may not be appropriate to meet local needs.

### Collaborative working

Multidisciplinary meetings were held each week to review cases and incidents for learning purposes, and staff said they found them very useful.

### Improvements

In the last two years, the number of emergency caesarean sections being undertaken for this service was above the national average. There had been much work to promote normalising birth and a newly opened induction suite was having a positive impact on reducing the number of emergency caesareans.

### Staff skills

Midwives had access to a Supervisor of Midwives and met the statutory requirement to have an annual meeting with their Supervisor. Midwives told us that they were well supported to attend mandatory training and records confirmed this. This training included "skills and drills" sessions that included simulation and learning events and management of incidents. There was mixed feedback on additional professional development.

Staff had recently started to be rotated from day to night duty and throughout clinical areas. This aims to ensure that patients benefit from their skills which are not limited to one area.

Staff who were on the preceptorship programme of practical experience and training stated they felt well supported and valued the time they spent getting to know the unit and understand its policies and procedures. As a result, they felt better prepared to care for the women in the unit.

Concerns were expressed by both midwives and doctors regarding a lack of specialist midwives. For example, there was very limited focus on breastfeeding and no specialist midwife to lead this. On the maternity services dashboard dated September 2013 the percentage of women starting breastfeeding within 48 hours of delivery ranged from 80% to 89%. During the observation of a handover on the postnatal ward, the majority of women were noted to be "mixed feeding". There was a lack of promotion of breastfeeding with only information leaflets found in the room where bottled milk was prepared.

## Are maternity and family planning services caring?

Maternity services in Newham University Hospital were caring although some improvements are required.

### Involvement

Midwives spoke with compassion about wanting to provide the best care, but frustration that staffing levels meant they could only just provide the basic care. Staff were not consistently developing trusting relationships or communicating effectively, therefore women and their partners did not always understand what was happening and why it was happening. Feedback from women and their partners was mixed: some were very happy with the support and explanations they received; but others felt explanations were lacking and therefore they were unable to make informed choices. Many women could not tell us who their named midwife was and some did not know what one was.

### Privacy and dignity

The maternity unit was refurbished about two years ago and was bright and spacious. All the rooms in the delivery suite had ensuite facilities and each room had a fixed birthing pool. We observed that staff knocked on the doors prior to entering and also checked with the women before allowing any visitors in. In the postnatal ward, the curtains were drawn around to maintain privacy and dignity but frequently left drawn all the time, meaning that women and their babies could not be easily observed by maternity staff.

### Respect

All the interactions we observed were polite and respectful, however, some women felt that their care was minimal and the attitude of some staff was abrupt

and rude. These issues had been recognised by the trust and actions were in progress to address this, including a project called 'Great Expectations' which aimed to make every contact between staff and patients worthwhile. There were examples of investigations into individual instances, however, staff were concerned that the culture was so embedded that it went unnoticed at times.

There was a dedicated room for bereaved parents which was located in an appropriate position in the unit, with an additional room for parents to be by themselves. There was a multicultural bereavement service offered through the chaplaincy.

## Are maternity and family planning services responsive to people's needs?

Maternity services at Newham University Hospital were responsive to the needs of women.

### Planning of services

The service had seen a significant growth in the number of deliveries in the last few years with 6,850 deliveries in the last year. This was expected to rise to 7,200 next year. The maternity unit was designed with the need for growth taken into account so there was the physical space available to meet growing demand. In addition, new ways of working and the increasing use of the birthing centres would help with capacity issues.

All signage was in English but each area within the maternity unit was colour-coded to help people find their way around more easily – the result of community consultation when the unit was planned. The system was clearly displayed outside the unit.

Following a review of a higher-than-expected number of admissions to the intensive care unit, a high dependency unit had been opened within maternity. As a result, admissions to intensive care had reduced.

Women who attended triage but were not in established labour were usually sent home, however, it had been recognised that some women did not feel confident to go home and so access to a pre-labour room was being offered. While anecdotally this was meeting women's needs, it had not been monitored for effectiveness.

### Access to information

The local population was very diverse. There was access to an interpreter advocacy service on site for the most commonly spoken languages and telephone support for others. In practice many women relied on their partners for translation and, while this worked well, staff were aware of the issues of privacy and possible safeguarding implications.

Information was not readily available throughout the unit, with few leaflets available. For example, the only information seen on breastfeeding was in the room where bottled milk was prepared.

## Are maternity and family planning services well-led?

### Leadership and governance

Leadership within the maternity was visible and staff knew how to escalate issues and report concerns.

Overall leadership for maternity services was provided by the women's and children's clinical academic group (CAG) who oversaw monitoring of the quality and safety of care. Leadership within the maternity unit was visible and staff knew how to escalate issues and report concerns.

It was a time of change in the trust and a number of senior midwifery roles had been reviewed. The change had resulted in the introduction of a Head of Midwifery post for the hospital with the post due to be filled in December 2013. Further changes were expected and this was resulting in a period of instability and uncertainty and many staff commented on the poor effect this was having on their morale.

There was a maternity performance dashboard produced monthly – a computerised indicator of issues such as delivery rates, caesarean section rates , number of antenatal bookings, number and percentage of women who smoked at booking and number and percentage of women who started breastfeeding in the first 48 hours.

There were meetings across the CAG which focused on quality, safety and assurance. We saw evidence of the review of training, risks, incidents, complaints, themes and trends. While the meeting attendance aimed to be multidisciplinary, a review of the minutes showed that attendance by medical staff was minimal.

# Maternity and family planning

### Accuracy of information

Some staff advised us that the IT systems were complicated, with different systems not being able to communicate with each other. As a result, data entry sometimes had to be duplicated and searching for information was difficult.

We reviewed 10 sets of patient records, and we found them difficult to follow as information was provided in different sections, not all entries were legible and, although dated, were not always timed. Not all papers were secure within the folder and could be lost.

At handover we observed that staff took notes which were discarded at the end of the shift. Some staff were very clear that these notes contained personal information and disposed of them in the confidential waste; others had not recognised this and disposed of them in the normal waste bins.

# Children's care

## Information about the service

Newham University Hospital paediatric service has a dedicated day ward, one inpatient ward for children, a neonatal unit and an outpatient service.

We talked to four parents (or relatives) and their children and 11 staff including nurses, doctors, consultants, senior managers and support staff. We observed care and treatment and looked at five care records. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

## Summary of findings

We had some concerns about the safety of children's care. The orthopaedic surgeons were operating on children without input from the paediatric team. Emergency surgical procedures on children aged under 10 were being carried out only occasionally. Medicines were not being stored safely.

Children's care was not always effective. We had some concerns that there were no pain protocols in place and the pain service did not see children.

Staff were caring and responded to children's needs but there were no specific facilities for teenagers and the temporary accommodation used for children's outpatients did not met the needs of the service.

We found the service was well-led. We were concerned that the trust only had one children's governance manager and there was no liaison with other governance managers across the trust.

## Are children's care services safe?

Services were generally safe but there were issues about the involvement of paediatric medical staff in the care of children having surgery and the storage of medicines.

### Patient safety

Paediatric services monitored and minimised risks effectively. For example, there was a screening protocol for methicillin-resistant staphylococcus aureus (MRSA) for children admitted to the unit and all children admitted with diarrhoea and vomiting were automatically tested for Clostridium difficile (C. difficile). Children who were admitted to the inpatient ward were risk assessed on admission and care was planned accordingly.

There were effective systems for identifying and learning from incidents. This was important for promoting safety. The department followed the hospital's incident reporting processes. The Matron told us that staff within the service were "very good" at reporting incidents. We saw that 20 incidents had been reported since August 2013 and learning was fed back to staff via regular ward meetings. Any serious incidents were reviewed at the weekly multidisciplinary team meeting.

### Staffing

There were adequate numbers of appropriately skilled staff on duty on the children's ward and neonatal unit. The matron told us the unit was over 95% established, with their own staff from the hospital doing any bank (overtime) shifts available, so that no agency staff were required. Staffing levels met the recommended Royal College of Nursing requirements of one nurse for every four children aged over two years and one nurse for every two children younger than two years old.

Normally each child was seen by a specialist registrar within the quality standard timeframe of four hours of admission and by a consultant within 12 to 24 hours. There was a daily ward round by the paediatric team to review each child's care. However, we were told the paediatric team did not review children who had

orthopaedic surgery. This was confirmed when we spoke with the parent of a child who had recently had this type of surgery. The parent told us she had been waiting over three hours to see the orthopaedic team and was unsure when they would be coming to see her child. The Matron told us it was always difficult to get the orthopaedic team to review children on the ward in a timely manner.

Data provided by the trust showed that nine children under the age of 10 had emergency general surgical procedures between 1 April and 31 October 2013. This is considered to be occasional practice as surgeons do not operate frequently enough on children to maintain their expertise.

### Safeguarding children

The children's unit had a named safeguarding lead. All qualified staff had completed level three training and support staff level one. We spoke with three nurses who were very clear about the process they had to follow if they had any concerns. The trust's IT system flagged up if a known 'at risk' child was admitted to the hospital. This meant children at risk were cared for appropriately.

### Infection Control

All areas in the children's unit were visibly clean. The neonatal unit was spacious, bright and well equipped. Hand hygiene gel was available and used by staff, parents and visitors on the ward. The children's unit environment was well maintained. There were toys and activities available for children. They were clean and in good condition.

We saw examples of regular audits completed, including a hand hygiene audit, a weekly cleanliness audit and a weekly bedside audit. We saw an action plan developed from the infection control audit with dates when the actions had been completed.

There had been a serious incident in the neonatal unit and there was a particular focus on infection control. We observed staff who did not adhere to infection control polices being challenged and asked to rectify this immediately.

### Medicines management

We visited Rainbow Ward and looked at medicines storage and supplies, records relating to children's medicines and talked to pharmacy staff and nurses.

Medicines were available through appropriate procedures when children needed them. We saw that prescribed medicines were available; there was a twice-weekly pharmacy top-up service and a daily visit from a ward pharmacist. The pharmacy was open at weekends between 10am and 2pm and there was a pharmacist on call out of hours. There was evidence of medicines reconciliation on admission. There is no policy to allow parents to administer medication to their children if they request to do so. Medicines were available on the ward and suitably labelled to allow nursing staff to discharge children out of hours. Emergency medicines were kept on the ward and they were being checked regularly.

Unauthorised people could access some medicines as they were not securely stored. There was no control of access to the clean utility room where infusions solutions were kept in an open rack system. Oral medications and injections were in locked cupboards. The two fridges were locked.

Medicines were not being kept safely. The temperature of the room was 27ºC on the day of the inspection. Staff told us they had repeatedly reported that the room was too hot. Medicines requiring cold storage were being kept in the fridge and the temperatures of fridges were being monitored. The record showed that, on three occasions, the maximum temperature of the fridge had reached 12ºC and there was no record of action being taken. There was evidence of routine checking of controlled drugs. We noted the cytotoxic spillage kit had expired.

Children received their medicines as prescribed, with appropriate records of medication administration. Allergy status had not been documented in one case. We did not see any missing doses.

## Are children's care services effective?

Services were not always effective and there were issues about management of children's pain.

### Clinical management and guidelines

The parents and children we talked to said they received prompt care and attention. We saw each child had a pain chart in their care record, and there was a limited range of medicines used to control pain. However, there was no pain protocol or regular pain audits in place for children

# Children's care

and the pain service did not see children. Staff told us they were working to standardise guidelines after the trust merger using a multidisciplinary approach.

### Staff skills

Children were normally cared for by staff specially trained to care for and treat children. However, children who had orthopaedic surgery were not cared for by a team of doctors which included a paediatrician. This not does not comply with national guidelines.

## Are children's care services caring?

Parents and children said the service was caring and their needs were met.

### Patient and parent/carer feedback

Parents and children said staff were very caring and kind, and responded well to their needs. Parents told us their children's treatment and care was explained to them in a way they could understand and they felt comfortable discussing concerns with staff. They said they felt well supported and could get help from staff when they needed it. Parents of children who had surgery were given information about any risks involved with the procedure, how to prepare for their child's operation, and what to expect after discharge. The children we talked to said they enjoyed the food.

### Support for children and their families

There were arrangements to ensure children felt secure and comfortable, and less anxious about being in hospital. Parents were able to stay with their children overnight on the ward. Toys, books, and other forms of entertainment were available for children of all ages. The ward had a play specialist who showed us photographs and toys they used to help prepare children for different procedures. Parents were given information about any risks, how to prepare for their child's operation, and what to expect after discharge.

Staff and services met patients' physical, social, psychological and emotional needs. Nursing care records showed that staff had assessed children and families according to their individual needs.

## Are children's care services responsive to people's needs?

Services were responsive to people's needs but there were issues about facilities for teenagers and the outpatient department.

### Hospital premises

Parents were able to stay with their children overnight on the inpatient ward. There were also single rooms that could be used for parents with babies or children with special or complex needs. Older children were separated from younger children where possible by using different bays, however, there were no specific facilities for teenagers.

The Children's Outpatient Department was situated in temporary accommodation accessible via a large metal gate at one side of the main building. The facilities were very cramped and crowded when we visited. There was no soundproofing and noise could disturb consultations.

### Discharge arrangements

We looked at the discharge planning process. For complex patients, there were discharge planning meetings. Most children were discharged within a couple of days of admission. All the parents we talked to said that the doctors had discussed when their children might be discharged, and they felt well informed about this.

## Are children's care services well-led?

Services were well-led and safety and quality measures were in place.

### Leadership

Children's services were part of the women's and children's clinical academic group (CAG). The Group Director reported directly to the Chief Executive. There were weekly delivery group meetings and monthly performance review meetings. The Matron on the children's ward confirmed there was a monthly meeting with all the matrons from the other hospital sites, the Group Director and the Head of Nursing of the CAG.

# Children's care

Staff on the children's ward showed a high level of enthusiasm for their work and the service was clearly developed around the needs of children. Staff worked together as a team and told us the matron was very supportive but they were worried the matron may move with the planned reorganisation.

### Managing quality and performance

Safety and quality of care was monitored and action taken to respond to concerns. This included reporting on performance indicators via patient safety metrics, including incidents, falls, pressure ulcers and infection control, which were reviewed at monthly performance meetings.

Complaints came in through a central team and were reviewed by the Children's Governance Manager who determined the response required. However, the trust only had one Children's Governance manager who told us most of their activity was involved in crisis management with serious incidents and complaints requiring travel between sites. We were told there was liaison with the governance managers in maternity and neonatal care. This would suggest there was no overall trust liaison between governance managers outside of the CAG.

# End of life care

## Information about the service

We observed end of life care provided in the elderly care and general medical wards supported by a specialist palliative care team comprising appropriately qualified and experienced medical and nursing staff. The chaplaincy service was also very involved in providing a multi-faith coordinated service to patients. The team worked across the trust and had permanent staff based at Newham Hospital to provide a local point of contact.

## Summary of findings

Staff were supported to provide safe and effective palliative and end of life care by the specialist palliative care team. Patients and relatives were supported during this phase of care and their wishes were taken into account and respected. There was good use of the 'do not attempt resuscitation' (DNAR) documentation and decisions were reviewed regularly. Interim guidance was available to replace the Liverpool Care Pathway (for delivery of end of life care) following its removal from use in 2013 according to national guidance.

## Are end of life care services safe?

### Patient safety

Patients received safe end of life care. The records of several patients on the elderly care wards who were receiving palliative or end of life care, demonstrated they were being appropriately treated for their condition, and in accordance with their wishes. Pain relief, nutrition and hydration were provided according to their identified needs. Patients' wishes for their end of life care were clearly documented.

Patients' care was coordinated by a multidisciplinary team. The palliative care specialist team supported staff to ensure ongoing care, including pain management advice, discharge or transfer were appropriate. We saw that patients were discussed within the multidisciplinary team meetings and care decisions were agreed and actioned to ensure patients were cared for and their relatives were supported appropriately.

### Patient records and end of life decisions

Information about end of life care was fully documented. Decisions about resuscitation were also well documented and the DNAR form in use ensured other treatment decisions were recorded – for example, the use of antibiotic therapy and administration of nutrition and hydration. Records showed the forms were reviewed every seven days and decisions were discussed with the patient and relatives. The trust had not conducted a formal audit of DNAR forms at the Newham Hospital site to assess the standard of record-keeping across the hospital.

## Are end of life care services effective?

Patients' end of life care was managed effectively.

### Clinical management and guidelines

Patients received effective support from the palliative care team. There was a lead consultant and palliative care nurses who worked five days a week and provided 'on call' telephone cover at weekends. A multi-faith chaplaincy team provided spiritual support and attended the weekly palliative care multidisciplinary team meeting. A bereavement coordinator ensured the families of patients received personal belongings and essential documents following a patient's death and provided information about bereavement services. There were reported delays in families receiving death certificates which impacted particularly on the religious and cultural requirements of a proportion of the patient population. There were however, examples given of medical staff coming into the hospital out of hours on their own initiative to sign certificates to ensure families were able to make arrangements to meet their religious requirements.

The end of life care followed government guidelines. The hospital had undertaken a review of all patients on end of life care plans in response to a request from the Department of Health following the publication of a national independent review, More Care, Less Pathway: A review of the Liverpool Care Pathway in July 2013. An interim process had been introduced to replace the Liverpool Care Pathway, (previously been used to deliver end of life care) in line with national guidance. The palliative care team were consulting on a new policy.

# End of life care

## Are end of life care services caring?

The palliative care services were supportive, caring and enabled staff to provide patients with dignified, caring and kind end of life care.

Staff were very appreciative of the palliative care team and valued their advice and support. We did not see any specific patient feedback that directly related to the end of life service. We saw the wards had comment cards for the NHS Friends and Family test and the results were displayed and in the main positive.

### Support for patients

Patients' spiritual and emotional needs were met by a team of chaplains, volunteers and staff. We spoke with the bereavement lead for the hospital who was a member of the chaplaincy team. The chaplaincy service covered all faiths and there was an onsite multi-faith prayer room with religious services four times a week. Staff could refer to the chaplains at any time and there was an on-call rota which staff were aware of. The chaplains regularly attended the multidisciplinary team meetings and were aware of people who required end of life care. There were posters displayed around the hospital advertising the service and how to contact a member of the team. The hospital also had a team of volunteers led, by a coordinator, available to support patients.

Staff told us bereaved families were able to stay with their relative for up to several hours on the ward. We did view the mortuary and family viewing facilities available at the hospital. At the time of inspection these were not fit for purpose and were used to store equipment and specimens due for disposal. Managers accompanying us took immediate action to clear the viewing room and ensure the area was cleaned and made ready for use. There was also a garden area available for people to reflect on their loss. Staff we spoke with were not aware that the mortuary and viewing facilities were available.

There was a Macmillan cancer support drop-in area at the main entrance where relatives and patients could access advice and additional support if required.

## Are end of life care services responsive to people's needs?

Services were responsive to people's needs and involved them in decisions about their care.

Patients at end of life were seen promptly after referral. Ward staff told us the team was very responsive to referrals and saw patients as soon as possible. They talked to patients and families and explained end of life care, the options available and pain control.

### Patients' rights and wishes

Patients received care and support and were able to make choices about their end of life care. Their needs and wishes were discussed at the palliative care multidisciplinary team meeting.

### Patient records and end of life decisions

Information about end of life care was fully documented. Decisions about resuscitation were also well documented and the DNAR form in use ensured other treatment decisions were recorded – for example, the use of antibiotic therapy and administration of nutrition and hydration. Records showed the forms were reviewed every seven days and decisions were discussed with the patient and relatives.

### Support on the wards

Patients received good support and information on wards providing end of life care. The palliative care service was available Monday to Friday, 9am to 5pm, and there were designated team members on site at Newham Hospital to provide the service. Consultant on-call advice and support was provided at weekends. The team also supported staff training in end of life care and symptom control.

# End of life care

## Are end of life care services well-led?

The palliative care service was well-led and worked well across services to benefit patients.

### Leadership

The palliative care team was led by an experienced lead consultant and were managerially responsible to a clinical academic group (CAG). The trust had conducted a review of staffing and there was a rebanding exercise in progress which could affect staff working in the service.

### Managing quality and performance

The palliative care team monitored the quality and safety of the end of life service. The team published an annual report and there was an established trust-wide end of life care steering group to develop common policies and promote consistent practice across the trust.

# Outpatients

## Information about the service

A wide range of outpatient services were available at Newham Hospital.

We visited the main outpatients department that hosted a wide range of clinics and the fracture clinic.

We talked to 12 patients and eight members of staff.

## Summary of findings

The outpatients department provided safe and effective care. However the consultation, assessment and treatment process in clinics were not regularly monitored by the trust.

Staff were caring and responded to patient's needs. We had some concerns about the leadership of the department. There was no evidence the performance was being checked on a daily basis and staff sometimes felt unsupported by their line manager.

## Are outpatients services safe?

Patients received safe and appropriate care.

### Patient safety

Patients had consultations, diagnostic tests and assessments with appropriately qualified staff and advice was sought from other healthcare professionals where necessary. Staff knew what to do in the event of an emergency and the department had appropriate equipment.

### Safeguarding patients

Staff understood safeguarding processes and what to do if they needed to raise an alert. Staff we talked to said they had received training on safeguarding children and vulnerable adults and knew how to access policies and procedures. We saw training records which showed all staff had completed their mandatory training.

### Hygiene and the environment

The outpatient service was provided in a clean, safe and accessible environment. We observed hand hygiene gels were available and used throughout the department by staff and some patients. All clinics were on the ground floor, making access safe and easier for patients with mobility difficulties.

### Staffing

There were adequate numbers of appropriately skilled staff on duty in outpatients. We saw there was a daily staff meeting in the morning where the staffing levels for each clinic was checked and any changes made if required. However, we were told that a qualified nurse on long-term sickness was not being covered by agency or bank (overtime) staff which meant sometimes patients had to wait longer for tests and procedures.

## Are outpatients services effective?

Services were generally effective but there were issues about monitoring key performance information to demonstrate the efficiency of the service.

### Clinical management and monitoring

Patients were allocated sufficient time with staff when they attended clinics. The reception staff explained to us how clinics were organised. Patients were normally booked in when they arrived and new patients had any routine tests done before they saw the doctor.

Patients told us that the outpatient service was effective. For example, one patient said, "The booking system was efficient and so far we have been seen quickly. My son has received wonderful care". Another patient told us, "The nurse checked the appointment times for all the patients waiting. All the staff are friendly and professional".

Outpatient services – consultation, assessment and treatment process in outpatient clinics – were not regularly monitored by the trust.

### Staff skills

Staff received training, support and supervision to enable them to provide a caring environment in the outpatient department. We saw all staff had completed an annual appraisal. Staff also attended clinic meetings and supervision sessions to review their learning and competencies in dealing with patients.

# Outpatients

## Are outpatients services caring?

### Patient feedback

Patients considered the outpatient service to be caring and supportive and told us about positive experiences. Comments included: "I am very happy with the service". Another patient told us, "Staff are always friendly, professional and reassuring".

### Patients' privacy

Staff respected patients' privacy and dignity and patients' religious and cultural beliefs were considered. We observed patients had consultations in private rooms and clinic doors were closed during clinical examinations. Staff did not discuss patients in public places and reception areas were separate from waiting areas so that private conversations were possible. Where any intimate personal care and support was being given by a member of the opposite sex, the patient was offered the option of a chaperone – a healthcare professional, where possible, the same sex as the patient.

The reception staff provided clear information and advice. Patients were advised about follow-up appointments, and transport that could be arranged if required.

## Are outpatients services responsive to people's needs?

Services were responsive to people's needs and ensured patients were kept informed of waiting times and reasons for delays.

### Patients' feedback

Patients told us that the outpatient department communicated well with patients. There were waiting time announcements and a good booking system and treatment choices.

The trust had just introduced a new booklet, Tell us what you think about services – a guide to making comments, compliments or complaints, which explained to patients how they could give feedback.

### Waiting times

The patients we spoke with told us that normally they were seen within 30 minutes of their booked appointment. We saw that staff informed patients if there were going to be any delays. The receptionists and outpatients manager told us that some consultants overbooked their clinics but this was the individual consultant's decision. Staff told us that, although clinics were due to finish by 5pm, on average, three out of five days per week they overrun by between 30 and 60 minutes. We could see no evidence of how this was being recorded or managed.

### Meeting patients' needs

Outpatient services were responsive to patients' needs. One patient told us that specific appointment times could be changed if needed. Another patient, with visual problems, said staff were helpful in guiding her where to go. One staff member explained how they contacted some patients the day before the clinic to remind them to drink one litre of water prior to their appointments so tests could be successfully completed. Patients found this very helpful.

### Accessible information

For patients whose first language was not English there was an advocacy service which provided interpreters. We spoke with the health advocacy service who explained there was a high-quality interpreter service available mainly within office hours but accessible via a telephone service 24 hours a day. We were told that, across the whole trust last year, there had been 100,000 face-to-face contacts and 15,000 telephone episodes. Staff told us they could easily access this service. This was confirmed when we spoke with a patient whose first language was Portuguese. They told us they sometimes brought a friend to interpret but there was an interpreter available if they requested.

On the day we visited, the outpatients department was very busy, with adults seated in an area reserved for families waiting for children's clinics. There were no toys or books in the children's waiting area.

# Outpatients

## Are outpatients services well-led?

Services were not always well-led as staff felt unsupported and there were issues with monitoring the performance of the service.

### Leadership

Staff confirmed they were up to date with mandatory training and they had completed their annual appraisal. Staff told us there were limited opportunities for continuing professional development because of financial constraints.

We observed the staff worked well as a team but it was apparent when talking to them that they sometimes felt unsupported by their line manager. Access to training and cover for absent staff was a concern for them.

### Managing quality and performance

Staff were aware of how to report any incidents on the trust information system and told us any complaints were discussed at staff meetings. However, there was no evidence that the performance of the department was being routinely monitored. The Outpatient Manager told us there had been a previous method of data collection, but it had stopped in 2012.

# Good practice and areas for improvement

## Areas of good practice

Our inspection team highlighted the following areas of good practice:

- Play leaders in the children's service provided creative play opportunities for children to prepare them for surgery.
- The volunteer service had created a reminiscence room to provide a non-clinical environment for patients with dementia, which was decorated and equipped with items from the past to stimulate their memories.
- The 'do not attempt resuscitation' (DNAR) forms were comprehensive and enabled medical staff to identify treatment and care options with patients.

## Areas for improvement

**Action the hospital MUST take to improve**

- Ensure medicines and fluids for infusion are stored securely.
- Ensure that members of staff follow national guidance for the management of children undergoing surgery and that they do this sufficiently to maintain their expertise.
- To promote a safety culture, the hospital must improve the visibility of management and embed clinical academic group structures and processes.

**Other areas where the trust could improve**

- Consultant cover on site 24 hours a day, seven days a week in order to provide senior medical care and support for patients and staff.
- Increase the NHS Family and Friends survey response rate.
- Improve safety for patients by reducing reliance on bank and agency staff and improve critical care consultant cover on evenings and at weekends.
- Address the lack of high dependency unit facilities and the issue of patients being cared for in the coronary care unit, which are potentially comprising patients' safety.
- Provide accessible information for patients for whom English is a second language.
- Implement pain protocols for children and ensure that children are seen by the pain team.
- To mitigate the risk of potential safeguarding issues, the hospital should consider providing a separate waiting area for children waiting to be seen in the Urgent Care Centre.

This section is primarily information for the provider.

# Compliance actions

## Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury. | Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Management of Medicines.<br><br>Patients and others were not protected against the risks of unsafe use and management of medicines, by means of the making of appropriate arrangements for the safe keeping of medicines used for the purpose of the regulated activity because medication was not kept in secured locations and could be accessed by unauthorised persons. Regulation 13. |

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury. | Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, Assessing and monitoring the quality of service provision.<br><br>Patients and others were not protected against the risks of inappropriate or unsafe care and treatment by means of the effective operation of systems to assess and monitor the quality of care provided and identify, assess and manage risks relating to the health and welfare of patients and others. Regulation 10 (1)(a)(b)(2)(c)(i) |

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury. | Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services.<br><br>Patients were not protected from the risks of receiving care or treatment that is inappropriate or unsafe in such a way as to reflect published good practice guidance from professional and expert bodies. Regulation 9(b)(iii) |

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Barts Health NHS Trust

# St Bartholomew's Hospital

## Quality report

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Date of inspection visit: 8 November 2013
Date of publication: January 2014

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

## Overall summary

St Bartholomew's Hospital is in the City of London and provides a full range of local and specialist services, which include centres for the treatment of cancer, heart conditions, fertility problems, endocrinology and sexual health conditions. It is part of Barts Health NHS Trust, the largest NHS trust in England.

CQC has inspected St Bartholomew's Hospital once since it became part of Barts Health on 1 April 2012. Our most recent inspection was in February 2013 when we looked at cancer care patients undergoing surgical procedures. We found that the trust was meeting all of the 16 national standards of quality and safety. As part of this inspection, we were assessing whether the trust had addressed the shortfalls in other locations, as well as taking a broader look at the quality of care and treatment in a number of departments to see if the hospital was safe, effective, caring, responsive to people's needs and well-led.

Our inspection team included CQC inspectors and analysts, doctors, nurses, allied health professionals, patient 'experts by experience' and senior NHS managers. We spent one day visiting St Bartholomew's Hospital. We spoke with patients and their relatives, carers and friends and staff. We observed care and inspected the hospital environment and equipment. Prior to the inspection, we also spoke with local bodies, such as clinical commissioning groups, local councils and Healthwatch.

We found the wards and departments we visited were clean and infection rates were low. Patients were treated with dignity and respect and were involved in decisions about their treatment and care. The majority of people were satisfied with the service they had received and were complimentary about the care and compassion shown by staff.

Staff were committed to providing good standards of care in all circumstances. Staff morale was low in some areas, mainly due to the implementation of a staffing review. Best practice professional guidelines were used. Most staff had received training to undertake their role and the trust had focused on ensuring staff completed mandatory training.

Services were well-led and staff used quality and performance information to improve. There was evidence that the clinical academic group CAG management structures and leadership were effective.

However, we found there were a number of areas for improvement in some of the services we inspected.

There were not enough staff on some medical wards to meet minimum staffing levels to ensure patients received care and attention in a timely manner. In surgery there were concerns the dependency of patients was not taken into account when staffing levels were set. Across all

# Summary of findings

## Overall summary (continued)

services, patients and staff raised concerns about the quality and quantity of the food served to patients.

There were systems in place to report incidents, but some staff reported that they did not have access to the IT system to do so. There were also problems with the speed and functionality of the IT system.

## The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

**Are services safe?**
Patients were protected from the risk of infection and the hospital was clean. There was a focus on safety and quality and this was embedded through the clinical academic group (CAG) structures in the clinical areas visited. However, we found staffing in some medical wards did not meet the minimum staffing levels at the time of the inspection and patient needs may not be met in a timely manner. There were also concerns that patient needs may not be met due to the reliance on bank (overtime) and agency staff in some areas.

**Are services effective?**
National guidelines and best practice was followed. Care was effective and patients' needs were met.

**Are services caring?**
Patients told us staff were caring and compassionate and they were treated with dignity and respect. We observed staff were polite, kind and caring in their interactions with patients, visitors and colleagues. However, we had concerns about the standard of the meals provided by the hospital which patients described as "inedible".

**Are services responsive to people's needs?**
Patients told us that the hospital services had responded to their needs. We found discharge arrangements were coordinated through multidisciplinary teams and patients were aware of their expected date of discharge. Patients' wishes were taken into account in the planning and delivery of care.

**Are services well-led?**
There was effective leadership and governance at all levels of the clinical academic groups. Staff were clear about their responsibilities and were supportive of each other.

# Summary of findings

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

### Accident and emergency

There were no emergency services provided at the hospital. There is a minor injuries unit (MIU) providing a service to people working in local offices and businesses. Patients were seen and treated within acceptable time limits. Nurse practitioners provided the service and patient treatment was provided in accordance with agreed protocols.

### Medical care (including older people's care)

Staff had appropriate skills and training. Some of the areas we visited were short of staff. However, the staff were caring, compassionate and the majority of people we spoke with told us that they were happy with the care. The areas were well-led at the point of service delivery, although some staff told us that there was a disconnect between the executive team and the wards. Patients were admitted either directly to the wards via the outpatient department, day units or from other hospitals within the trust as well as from other external providers.

### Surgery

Patients were treated in accordance with national guidance, for example, cardiac and thoracic surgery. Risk management processes were in place and staff were aware of how to report incidents. Staff were not, however, aware of learning from incidents to improve patient safety.

Staffing levels were in line with professional guidance. However, there were some concerns that the staffing levels did not take into account the dependency of patients on surgical wards at night and weekends, and the impact of using high levels of agency staff. Patients were not discharged over the weekend on one ward which could lead to an extended length of stay for the patients.

### Intensive/critical care

Patients received appropriate care and treatment in accordance with national guidelines. There were sufficient numbers of staff on duty to provide 24-hour care. Systems were in place to monitor the quality and safety of patient care provided. Staff were aware of the incident reporting system and received feedback. They told us they were encouraged by senior staff to report incidents and raise awareness of patient safety issues.

# Summary of findings

## What people who use the hospital say

The NHS Family and Friends test scores showed the trust average score was above the national figure. Cancer patient's rated the trust in the bottom 20% of all trusts nationally. The NHS Choices website showed St Bartholomew's Hospital had a star rating of 4.5 out of 5.

## Areas for improvement

### Action the hospital MUST take to improve

- Ensure there are sufficient staff with an appropriate skills mix on all wards to enable them to deliver care and treatment safely in a timely manner.
- Ensure patients receive nutritious food in sufficient quantities to meet their needs.

### Other areas where the hospital could improve

- Improve the visibility of senior leaders in the trust.
- Address concerns about the implementation of the review of nursing posts and the effects of this on the skills mix of nursing staff.
- Improve the dissemination of 'lessons learned' from serious incident investigations across all CAGs.
- Improve staff access to suitable IT to ensure timely incident reporting by all staff.

## Good practice

Our inspection team highlighted the following areas of good practice:

- The majority of patients were complimentary about the care and compassion of staff.

# St Bartholomew's Hospital

**Detailed findings**

**Services we looked at:** Accident and Emergency; Medical care; Surgery, Intensive/Critical care

## Our inspection team

**Our inspection team for Barts Health NHS Trust was led by:**

**Chair:** Dr Andy Mitchell, Medical Director (London Region), NHS England

**Team Leader:** Michele Golden, Care Quality Commission

**Our inspection team at St Bartholomew's Hospital was led by:**

**Team Leader:** Sue Walker, Care Quality Commission

Our inspection team included CQC inspectors and analysts, doctors, nurses, student nurses, allied health professionals, patient 'experts by experience' and senior NHS managers.

## Why we carried out this inspection

We inspected this trust as part of our new in-depth hospital inspection programme. The inspection took place on 8 November 2013 we are testing the new approach in 18 NHS trusts. We chose these trusts because they represented the variation in hospital care in England, according to our new 'intelligent monitoring' system – which looks at a wide range of data, including patient and staff surveys, hospital performance information, and the views of the public and local partner organisations. Using this model, Barts Health NHS Trust was considered to be a high-risk service.

# Detailed findings

## How we carried out this inspection

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

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

The inspection team inspected the following services at this inspection:

- Accident and emergency (A&E)
- Medical care
- Surgery
- Intensive/critical care

Before visiting, we looked information we held about the trust and also asked other organisations to share what they knew. The information was used to guide the work of the inspection team during the announced inspection on 8 November 2013.

During the announced inspection we:

- Held four focus groups with different staff members as well as representatives of people who used the hospital.
- Held one drop-in session for staff.
- Looked at medical records.
- Observed how staff cared for people.
- Spoke with patients, family members and carers.
- Spoke with staff at all levels from ward to board level.
- Reviewed information provided by and requested from the trust.

The team would like to thank everyone who spoke with us and attended the focus groups and drop-in sessions. We found everyone to be open and balanced when sharing their experiences and perceptions of the quality of care and treatment at the hospital.

# Are services safe?

## Summary of findings

Patients were protected from the risk of infection and the hospital was clean. There was a focus on safety and quality and this was embedded through the clinical academic group (CAG) structures in the clinical areas visited. However, we found staffing in some medical wards did not meet the minimum staffing levels at the time of the inspection and patient needs may not be met in a timely manner. There were also concerns that patient needs may not be met due to the reliance on bank (overtime) and agency staff in some areas.

## Our findings

### Patient safety

Patients told us they felt safe in the hospital and the majority had experienced good care. Comments included, "Staff are always visible and never rush even though I know they are short-staffed and busy". Another person said, "We always have our call bells to hand and staff usually responded promptly".

There was a focus on safety. Staff reported incidents and were encouraged to do so by their managers. Staff also confirmed that they received feedback and incidents were analysed and used to improve the quality and safety of services. Staff were not aware of learning from incidents that had occurred in other parts of the trust which suggests systems to share learning were not effective.

Serious safety issues and avoidable harm were reported to the National Reporting and Learning Service. The number of reported serious incidents for St Bartholomew's Hospital was 12 and a third of those related to grade 3 and 4 pressure ulcers.

### Staffing

Staff reported they were often "stretched" and under pressure at busy times, particularly in the nursing workforce. We were told there were adequate numbers of doctors. Junior medical staff and student nurses told us they were usually well supported by senior staff. There were systems in place to order additional nursing staff to cover vacant posts and short-term absence. However, we saw on several wards that the minimum staffing levels and skills mix necessary to meet patients' needs were not achieved.

### Cleanliness and hospital infections

Patients were protected from the risks of infection. The trust infection rates for Clostridium difficile (*C.difficile*) and methicillin-resistant staphylococcus aureus (MRSA) were within an acceptable range taking account of the trust size and national infection levels. The wards visited displayed information regarding their individual infection rates for staff and patients to see.

All the wards we visited were clean, with schedules followed by cleaning staff. Patients and visitors were provided with information on how to prevent infections. There was hand hygiene gel at the entrance of every ward and by every patient bed for staff, patients and visitors to use. Staff were seen wearing personal protective equipment (gloves and aprons) and washing their hands in between attending to patients. Patients were screened prior to admission. Patients with a spreadable infection were treated in isolation in side rooms. We also saw that patients vulnerable to infections were nursed in isolation for their protection.

### Managing risks

The hospital was managing patient safety risks. There were safety measures in place to monitor patient falls, development of pressure ulcers, blood clots and catheter urinary tract infections. There was ongoing monitoring to improve safety and ward-based quality monitoring and performance results were displayed on ward notice boards for staff and patients to see.

### Patient records

Patient records contained information regarding patients' wishes with regard to end of life care and, where appropriate, 'do not attempt resuscitation' decisions were documented and discussed with patients.

### Medical equipment

Equipment seen in the hospital was clean and had been serviced and maintained. Emergency equipment was available in all areas and records showed daily checks were carried out.

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

## Summary of findings

National guidelines and best practice was followed. Care was effective and patients' needs were met.

## Our findings

**Clinical management and guidelines**

Patients received care according to national guidance. The trust used National Institute for Health and Care Excellence (NICE) and professional guidelines. The trust participated in national audits and there were staff in place to ensure these were implemented and monitored. We observed good multidisciplinary team working in the services visited.

**Staff skills**

Staff did have appropriate skills and training. The trust supported staff to have the appropriate skills, knowledge and training. Staff attendance at mandatory training was monitored and reminders sent when an update was due. Records seen showed mandatory training rates had increased from August 2013.

# Are services caring?

## Summary of findings

Patients told us staff were caring and compassionate and they were treated with dignity and respect. We observed staff were polite, kind and caring in their interactions with patients, visitors and colleagues. However, we had concerns about the standard of the meals provided by the hospital which patients described as "inedible".

## Our findings

### Patients' feedback

Patients we spoke with told us, without exception, that staff were kind, caring and treated them with dignity and respect. They told us the care they received was "excellent" and the staff were "fantastic". Comments included: "Staff always give me the time I need, they never rush me even though they are busy and short-staffed most of the time"; and "I'm lucky to have had such wonderful care".

Information on the NHS Choices website included a number of positive and negative comments. Most of the comments were positive and highlighted excellent care and that staff were kind and caring. The negative comments highlighted the poor conduct and attitudes of some staff and poor environmental standards.

### Patient treatment

Patients were supported to ensure their care needs were met. We saw patients had food and drink when they needed it. They were supported with their personal care and to manage their pain. Staff were observed to be kind, compassionate and caring. They were also honest about when the quality of care did not meet their standards due to a lack of staff.

### Staffing levels

Nursing staff told us there were frequent occasions when patients were not attended to in a timely manner due to a shortage of staff or because patient dependency was higher than anticipated particularly during evenings and weekends. We saw staff worked very hard to meet the needs of patients and were caring and compassionate towards patients.

The trust had undertaken a review of nursing establishments and posts. Staff across all disciplines expressed concerns that the numbers of experienced staff were reducing and the quality of care provided would be affected.

### Patient privacy and rights

Staff respected patients' privacy and dignity and their right to be involved in decisions and make choices about the care and treatment. We observed communication between staff and patients that was polite, professional and respectful.

### Food and drink

Patients were provided with a choice of food and drink. We were concerned, however, that the majority of patients we spoke with told us the food served was "unacceptable" and "tasteless". Comments included, "The food is terrible, the portions are small and the food isn't always hot". Other patients told us the food was "horrible, burnt" and "shrivelled", and often "inedible".

Staff attending some of our focus groups and drop-in session confirmed patients' comments. We raised the concerns directly with the responsible deputy director to take action to address our concerns that patients were not receiving adequate amounts of nutritious food.

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

## Summary of findings

Patients told us that the hospital services had responded to their needs. We found discharge arrangements were coordinated through multidisciplinary teams and patients were aware of their expected date of discharge. Patients' wishes were taken into account in the planning and delivery of care.

## Our findings

### Patients' feedback

Patients told us they were happy with the responsiveness, care and attention they had received from the services in the hospital.

Information on NHS Choices website included a number of positive and negative comments. Positive comments highlighted prompt attention in minor injuries unit (MIU) and excellent care and attention for inpatient wards. The negative comments related to lengthy processes to book and waiting times in the outpatients department.

The trust used the NHS Family and Friends test to gather patient feedback and results were displayed in most areas. The information published on the NHS Choices website showed the vast majority of people using the hospital would "be extremely likely" to recommend the hospital to people they knew.

### Discharge of patients

Most patients were discharged appropriately and were coordinated by the multidisciplinary teams. Patients told us they were aware of the plans for their discharge. Records showed discharge planning commenced at the pre-admission stage of the patient pathway. However, we were told staff could not discharge patients over a weekend on Vicary Ward and patients waited until the Monday to be discharged reducing the effectiveness of the service and extending the patient's length of stay.

### Accessible information

Information was available in various formats and was made available by staff. The hospital had a translation and advocacy service for people whose first language was not English.

# Are services well-led?

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

## Summary of findings

There was effective leadership and governance at all levels of the clinical academic groups. Staff were clear about their responsibilities and were supportive of each other.

## Our findings

### Leadership

Staff told us they had access to good management and leadership. They said they felt supported and valued by their colleagues and direct line managers. There had been a recent staffing review and a re-grading process was ongoing which had affected staff morale.

There was a clear management structure in place and there was evidence of effective systems and communication at all levels of the CAG. Ward managers and senior clinicians had a good understanding of the performance of their wards and departments. Staff told us the chief nurse and senior nurses in the trust undertook 'clinical Fridays' and spent time on the wards. This allowed senior staff to see the quality of care and gather first-hand feedback from patients and staff. Staff were less aware of other senior managers in the trust and reported that they did not recall seeing them in the clinical areas.

### Managing quality and performance

The trust Board had established the CAGs and devolved the management for performance, quality and governance to the CAG leadership board. There was evidence that quality and performance monitoring data was reported on at the CAG leadership meetings and senior managers in the hospital reported they attended.

We observed safety and quality of care was monitored and action taken in response to concerns at ward level. Staff demonstrated a good understanding of the clinical governance framework, how risks were managed, controlled and mitigated against. Communication of performance, quality and governance information was apparent from 'ward to board'.

# Accident and emergency

## Information about the service

There were no emergency services provided at the hospital. There is a minor injuries unit (MIU) which is staffed from the London Hospital emergency department (ED) and is open from 8am to 4pm Monday to Friday, providing a service to people working in local offices and businesses.

We spoke with staff but were unable to speak with patients as none were in the department at the time of our visit.

## Summary of findings

Patients were seen and treated within acceptable time limits. Nurse practitioners provide the service and work to agreed protocols.

### Are accident and emergency services safe?

Services in the minor injuries unit were safe.

#### Patient safety

The MIU was staffed with two senior staff members that were trained in dealing with minor injuries and minor ailments. Staff told us that there was always two staff present in the unit to ensure patient and staff safety was maintained.

Staff told us that all incidents were reported electronically via the computer system and they demonstrated a good understanding of the type of incidents to report. There was, however, no information regarding incidents available in the unit and staff were unsure of how many incidents had been reported.

#### Managing risks

The risks to patients were managed and monitored on a daily basis. We observed that individual patients were discussed at handover and information recorded on a board which identified issues such as pressure ulcers or falls. Staff told us they were able to access suitable equipment such as pressure relieving mattresses when needed and that equipment was cleaned and maintained.

However, on the outpatient area staff told us that one of the blood centrifuge machines was only checked annually and it was felt that this may be insufficient.

All the areas we visited had resuscitation equipment in place which had been checked regularly, although, due to time constraints, we did not check the emergency checks had been completed in the MIU.

#### Cleanliness and hospital infections

Staff had a good understanding of how to protect patients from the risk of infections. The MIU was clean and there were adequate sinks, paper towels and hand hygiene gel available. Information about the prevention of infections was available for patients and visitors. Hand-washing audits were completed and the majority of the results showed 100% compliance.

### Are accident and emergency services effective?

Services in the minor injuries unit are effective.

#### Clinical management and guidance

Patients were seen, assessed and treated by experienced nurse practitioners who worked to agreed clinical protocols. The department used the same protocols and procedures as other units across the trust, which the staff stated were informative and provided clear guidance.

Staff told us that the x-ray department is not co-located to the MIU and does cause some delay for patients to walk between departments. All x-rays are viewed on the computer system and the staff can ask for opinions from specialist teams if they need to.

#### Staff skills

The MIU staff were employed to work in the emergency department at the Royal London Hospital and had the appropriate qualifications such as advanced life support (ALS) to deal with unforeseen emergencies.

Staff told us they worked in the MIU from 8am to 4pm and then, as all staff work long days, they return to the Royal London ED to finish the shift. We were told the journey on public transport can take up to one hour and staff felt this was not an effective use of their time.

# Accident and emergency

## Are accident and emergency services caring?

Services at the minor injuries unit are caring.

### Patient feedback

There was no information regarding the NHS Family and Friends test available in the waiting room. Staff were unsure how patient feedback was collected and reported on for this part of the service. We could not determine whether the information was collated as part of the Royal London Hospital ED surveys or specific to the MIU. We were unable to ask people about their experiences as the unit was very quiet on the day of our inspection.

We saw that patient feedback on the NHS Choices website was positive and noted that staff were professional, caring and compassionate.

## Are accident and emergency services responsive to people's needs?

Services at the minor injuries unit are responsive to the needs of patients.

### Environment

The MIU comprised a waiting area that was able to accommodate approximately 20 or more patients, there were three treatment areas and a separate resuscitation bay. We were told that, if a patient needed urgent transfer to an A&E, staff called the emergency services via a 999 call which meant that the response was quick and the patient received immediate care.

### Accessible support and information

Staff told us the trust had reversed a decision to reduce the opening hours of the MIU following requests from local businesses.

There were a variety of information leaflets available in English to advise patients on minor injuries and care.

## Are accident and emergency services well-led?

The minor injuries unit is well-led.

### Leadership

The MIU is managed from the Royal London Hospital ED and comes under the clinical academic group (CAG) of Emergency Care and Acute Medicine (ECAM).

Staff told us they are able to access the necessary mandatory training and specialist qualifications and they received supervision and debriefing regarding any difficult situations encountered as part of their work in the department. The records for this were not held at the MIU.

Staff told us there had been no communication from the trust management team regarding the removal of hospital transport for staff to be taken back to the Royal London Hospital ED. They commented told us that they now have to use public transport to get back to the ED at The Royal London Hospital which does not seem to be an effective use of their time while on duty.

# Medical care (including older people's care)

## Information about the service

### General information

We inspected three wards and an outpatient department. The wards and outpatient specialities included haemo-oncology and endocrinology providing services for patients with cancer.

We talked with 10 patients, two relatives and 13 members of staff which included doctors, nurses, support staff, administrative staff and allied health professionals such as physiotherapists. We observed care and looked at care records.

## Summary of findings

Staff had appropriate skills and training. Some of the areas we visited were short of staff. However, the staff were caring, compassionate and the majority of people we spoke with told us that they were happy with the care. The areas were well-led at the point of service delivery, although some staff told us that there was a disconnect between the executive team and the wards. Patients were admitted either directly to the wards via the outpatient department, day units or from other hospitals within the trust as well as from other external providers.

## Are medical care services safe?

Improvements are needed in the medical units for care to be safe. Some of the wards we visited did not have enough staff on duty.

### Patient safety

There were systems in place to report incidents electronically. Staff told us they reported incidents and most felt they were encouraged and able to do so. However, some students working on the wards told us they did not have access to the system and relied on the ward staff to report issues on their behalf. Most staff said that they received an acknowledgement and feedback if they had reported an incident. The wards had display boards which identified any incidents that had been reported and the results of infection control audits that had been completed.

### Patient feedback

Patients told us they felt safe and comments included, "Staff are always visible and never rush even though I know they are short-staffed and busy". Another person said, "We always have our call bells to hand and staff usually responded promptly". The majority of patients felt the care delivered by the doctors and nurses was excellent. Although some patients told us they had experienced problems with outpatient appointment letters and had been sent to the wrong hospital to have tests carried out which had caused delays, as appointments needed to be rearranged in some cases.

At our listening event, people expressed concern about the central appointments system. They gave examples of being sent to the incorrect department and hospital for tests and outpatient appointments. People told us that staff were always apologetic and the clinic staff were very helpful. One person said, "The appointment system is a shambles you can never get through to check things, but the care in hospital is fantastic".

### Patient treatment

Patients' medical needs were assessed appropriately in all the areas we visited to reduce the risk of unsafe or inappropriate care. Patients who attended the day unit for chemotherapy were assessed to ensure they were well enough to continue being treated or admitted to the appropriate ward if necessary. Records were fully completed and risks identified. This included falls, skin integrity and risk of infection which was recorded within their care plans. Staff told us that people were occasionally moved within the ward from a four-bed bay into a side room to reduce the risk of infection if their condition required.

### Patient records and end of life decisions

Patient records contained information regarding patients' wishes with regard to end of life care and, where appropriate, 'do not attempt resuscitation' decisions were documented and discussed with patients.

### Staffing

The majority of areas we visited were short of nursing staff. The treatment provided was very specialised and we were told there were adequate numbers of doctors. Junior doctors and student nurses told us they usually felt supported by senior staff. Some doctors told us that low levels of permanent nurses and the high use of bank (overtime) and agency staff was impacting on patient

# Medical care (including older people's care)

care. Some of the wards we visited had a 33% vacancy factor and staff told us that there was also a high sickness rate. Staff told us they were able to get approval for bank or agency staff to cover shortages. We were told that the process was lengthy and sometimes delays in getting approval meant that shifts remained unfilled. Staff told us it was difficult to achieve the appropriate staff skills mix required to ensure the safe delivery of the complex treatment patients received. Staff told us that delays in treatment due to staff shortages were reported as incidents.

The majority of staff were able to access mandatory training and senior staff covered the wards to enable training to go ahead. Nurses' competency in giving chemotherapy drugs was reviewed annually to ensure safe practice. We were told that junior nurses all take a medication calculation test at interview and were not able to give chemotherapy until they had completed the appropriate competency framework for their speciality. This ensured that staff maintained safe practice.

## Are medical care services effective?

Services in the medical unit are effective.

### Clinical management and guidelines

Patients received care according to national guidelines and the appropriate drug therapy regimes were followed in line with pharmacy instructions. The trust participated in national audits, for example, the trust's urinary tract infection (UTI) rates are consistently above the national average and venous thromboembolism (VTE) rates had fluctuated either side of the national average. One of the ward areas had identified UTIs and catheter care as topics for the trust's Safety Cross system to highlight to staff the appropriate clinical management and care.

### Staff skills

Staff had the appropriate skills and their competency was regularly monitored. On each of the areas we visited we saw that staff were professional and competent in their interactions with patients. Staff told us that they were able to access mandatory training. We were told that senior nursing staff provided individual training or training days to cover specialist topics. Staff said that study days occasionally had to be cancelled due to staff shortages but senior staff tried to cover to enable the training to go ahead. Staff told us that they received computer training at induction. However, it was reported across all areas that the computers were slow and crash regularly in all areas we visited.

## Are medical care services caring?

The staff on the medical wards are caring but people told us the food was inedible.

### Patient feedback

Most patients told us they were happy with the care they received. People told us the care is excellent and staff were fantastic. One person said, "Staff always give me the time I need, they never rush me even though they are busy and short-staffed most of the time" and "I'm lucky to have had such wonderful care". Patients were asked to complete the NHS Family and Friends test. We saw the scores for Garrod Ward had improved for two out of the previous three months. Patients we spoke with told us the main problem they had related to the quality of food provided.

### Patient treatment, privacy and dignity

Staff told us that patients that attended for chemotherapy on Ward 4B had a choice of being able to receive their treatment in bays with other people or in single rooms. Staff told us that, where possible, they tried to accommodate people's wishes. We saw that staff treated patients with dignity and respect.

Some patients and staff felt there was insufficient privacy in curtained areas for sensitive conversations to be held. However, staff tried to maintain confidentiality but it was difficult due to the lack of space. Staff reported they were able to facilitate 'fast track' discharges for patients wishing to receive end of life care in their own home. Staff told us that charitable agencies such as the Macmillan nursing team and the community nursing services provided enormous support to families and enabled staff to facilitate rapid discharges for end of life care.

# Medical care (including older people's care)

Children under the age of 12 were not allowed onto the main ward. However, staff told us they made arrangements so that patients with young children could meet in single rooms.

The wards had processes in place for reviewing care plans and risk assessments. Staff told us that patient care and treatments were reviewed by the multidisciplinary teams on a weekly basis and more frequently if a patient became unwell.

### Food and drink

Patients were provided with food and hydration. The majority of patients reported that the food was unacceptable and tasteless. One patient said, "The food is terrible, the portions are small and the food isn't always hot". Patients told us that, when they had complained about the food, in some cases the chef had provided an alternative meal. Staff told us the menus catered for medical conditions such as diabetes, gluten intolerance as well vegetarians and religious needs. Some wards had house-keepers who did milkshake and snack rounds and people felt this helped to support an adequate diet and stopped them feeling hungry.

## Are medical care services responsive to people's needs?

Services on the medical wards at St Bartholomew's Hospital are responsive to people's needs.

### Patient feedback

Patients told us that they felt cared for and that staff responded to their needs and requests in a timely manner. For example, if people became very unwell or had reduced immunity, staff would transfer people into side rooms. We were told that staff could admit people fairly quickly if they became unwell during chemotherapy sessions and were not fit enough to go home.

### Ward environment

The ward environment was appropriate for patients. All the wards had single-sex bays and side rooms with en suite facilities. The side rooms were used to accommodate patients needing either end of life care or isolation to protect them from the risk of infection or vice versa. One ward had a dedicated clinical treatment area for patients to have minor procedures carried out to enable staff to complete the task more quickly.

### Patient records and end of life decisions

Patient records contained information regarding patients' wishes with regard to end of life care and where appropriate 'do not attempt resuscitation' decisions were documented and discussed with patients. Information regarding conditions and treatments were available in all the areas in English but could be requested in other languages.

## Are medical care services well-led?

Medical care was well-led.

### Leadership

Senior doctors told us that they were involved in the performance of their individual clinical academic groups (CAGs) and that the teams were starting to work well together. Information regarding the NHS Family and Friends test was regularly distributed to all the ward and outpatient areas.

Some staff told us that senior managers visited the wards on a regular basis and they were aware of the initiative 'clinical Fridays'. This is where the senior nurses in the trust worked in the clinical settings. Other staff told us they were familiar with the matrons and heads of nursing but had never met anyone above that designation. Ward managers told us that regular updates and information was distributed by the CAG management team.

Staff told us the consultation process relating to the review of grading of some of the clinical staff had been communicated through the CAG. Staff confirmed they had received the information but felt there had been little recognition of the impact this had on staff morale and the impact of staff resigning as a result of management's decision. Some staff felt there was a 'disconnection' between the wards and the trust Board and the impact the consultation was having on care.

# Surgery

## Information about the service

We visited surgical care services on Vicary Ward (cardio thoracic), Ward 5b (surgical oncology) and the theatre suite in the George V block.

We spoke with a number of patients, staff working in the surgical areas including doctors, senior managers, nurses and support staff. We observed care and treatment and looked at care records.

## Summary of findings

Patients were treated in accordance with national guidance, for example, for cardiac and thoracic surgery. Risk management processes were in place and staff were aware of how to report incidents. Staff were not aware of learning from incidents to improve patient safety.

Staffing levels were in line with professional guidance. However, there were some concerns that the staffing levels did not take into account the dependency of patients on surgical wards at night and weekends, and the impact of using high levels of bank (overtime) and agency staff. Patients were not discharged over the weekend on one ward which could lead to an extended length of stay for the patients.

## Are surgery services safe?

There are improvements needed to ensure there is sufficient equipment in good condition available and enough staff on duty to provide a safe level of care.

### Patient safety

There was a system in place to record serious incidents that occurred. This was through the use of a computerised logging system. The ward managers of all the areas we visited were familiar with the system and told us they used it. Other staff we spoke with on Ward 5b, including staff nurses and student nurses, were unaware of the system. The last entry to the system from Ward 5b was three weeks prior to the day we inspected and was associated with a fall. However, staff told us they had been short of staff for the previous two shifts (night duty and morning shift) which they said was the type of incident that should be reported as patient safety was compromised. On Vicary Ward, doctors and nurses were aware of the system but said that access to a computer was unlikely to be available because there were problems with both the number of available computers and slow running of the IT systems.

Staff we spoke with were unaware of any learning from incidents that had occurred throughout the trust. This meant that the systems in place were not effective and opportunities for lessons to be learned to improve standards may be missed.

### Medical equipment

Resuscitation trolleys in all areas visited had been checked daily and were complete and in date. Records of the checks were available and showed consecutive entries. Staff told us equipment such as pressure-relieving mattresses was available with minimal delay.

The theatre in the George V block did not have a blood gas machine in the unit and staff were required to obtain one from the intensive therapy unit (ITU) if needed. We also noted there was no overnight 'O negative' emergency blood stored in the theatre and staff told us they had to obtain this from another building if it was needed. The delay in availability of emergency blood may compromise the safety of patients.

### Staffing

At the time of our inspection, staffing levels were safe and met national guidance. However, staff on Vicary Ward told us that staffing levels on an evening and at a weekend reduced to one qualified nurse to nine patients without any indication as to how the changing needs of the patient or dependency levels were taken into account. This may compromise patient safety. The duty rotas we looked at confirmed these staffing levels.

We found the staffing levels on Ward 5b met national guidance, but staff told us this did not take into account the dependency needs of the patients. This ward also used a high percentage of agency nurses to cover short-notice absence.

Staffing levels in the theatres in George V block were adequate during the day. However, there was no on-call rota for theatre staff and a second on-call emergency team from the Royal London Hospital would attend if required.

The staff in all areas we visited had a cohesive team and a positive attitude towards the provision of care. Staff had completed mandatory training but reported that access to developmental training was limited.

# Surgery

### Cleanliness and hospital infection

Patients were protected from the risk of infection. Areas we visited were clean and the patients we spoke with confirmed this. Hand hygiene gel was available in the ward areas and at the foot of each patient's bed. Staffs wore personal protective equipment such as gloves and were observed to wash their hands between caring for each patient. It was observed that one of the hand gel dispensers at the entrance to Ward 5b was empty.

### Transfer of patients

If a patient's condition deteriorated on Ward 5b, transfer to the high dependency unit (HDU) in the Queen Elizabeth unit a separate building would require a qualified nurse to accompany the patient. Staff we spoke with and the duty rotas confirmed that this may impact on the safety of patients on the ward if a nurse was required to leave the ward to transfer a patient.

## Are surgery services effective?

Services in the surgical ward are effective.

### Clinical management

Patients felt their care and treatment had been effective at each stage from consultation to successful surgery and discharge. Staff were enthusiastic to ensure that patients had successful outcomes. The care records we looked at were complete and included risk assessments and effective discharge planning which commenced pre-admission.

### National guidelines

Patients received care in line with national guidelines. Integrated pathways of care were used for patients undergoing cardiac or thoracic surgery. Multidisciplinary wards rounds were carried out on a daily basis during the week. Although the consultant surgeon was not present, staff told us this did not compromise the care the patient received. However, staff told us that, on Vicary Ward, they were unable to discharge patients at weekends and patients waited until Monday to be discharged, reducing the effectiveness of the service and lengthening the patient's hospital stay.

### Staff skills

Staff had completed mandatory training and records seen confirmed this. Staff spoken with confirmed they received annual appraisal.

## Are surgery services caring?

Although staff are caring on the surgical ward patient's complained that the food offered is boring and inedible.

### Patients' feedback

We saw, and patients told us, that staff treated patients with kindness and respect. Patients were pleased with the care they received and, on Vicary Ward, the ward manager was particularly complemented for her care and compassion.

The wards and theatres we visited were very busy and the care needs of the patients were complex.

We were told by staff that they used the NHS Family and Friends test to obtain feedback from patients about their experience. On Ward 5b, a monthly report was received from the Patient Advice and Liaison Service (PALS) who analysed the feedback. The ward manager told us there had not been any adverse reporting.

### Privacy and dignity

Patients' privacy and dignity were maintained. Some wards were mixed-sex with segregated male and female bays. There was adequate signage for male and female toilet and bathroom areas. We observed screen curtains were used by staff to maintain dignity and patient communication was carried out in private.

### Food and drink

We were told by patients and staff that the quality of the food served was poor. Patients described the food as "horrible, burnt" and "shrivelled", and often "'inedible". Meal times were flexible and the food trolleys on each ward meant that the food could be served warm. We raised the concerns with the deputy director responsible for catering.

# Surgery

## Are surgery services responsive to people's needs?

Services are responsive on the surgical wards.

### Patient treatment

We observed, and the care records we looked at confirmed, that staff responded appropriately to the changing needs of patients. Patients were regularly monitored and their observations recorded. The elective admission system was planned and coordinated from the consultation through to a successful discharge.

### Discharge planning

The care records we looked at included a discharge plan which had commenced at the pre-admission stage and was updated during the patient's stay. There was information in the plan to indicate the tentative discharge date and the support that was required on discharge. Patients we spoke with confirmed that they were informed of the planned arrangements for discharge.

### Accessible information

St Bartholomew's Hospital had a high percentage of patients for whom English was not their first language. Staff we spoke with explained the arrangements in place for obtaining translation services through the use of Language Line phone service and interpreters. Information booklets were available in a range of languages for patients. However, they were not on display. Staff we spoke with knew where to access the information booklets.

## Are surgery services well-led?

Services in surgery were well-led.

### Leadership

Senior managers had a good understanding of the performance of their department. There was cohesiveness in surgical teams, although patients reported not seeing their consultant cardio-thoracic surgeon from the initial consultation prior to admission until following discharge. There was a management structure in place and there was evidence of effective systems and communication at all levels of the CAG.

### Managing quality and performance

Overall, patients said they were very pleased with the care they had received and felt the service was well run. They were complimentary about how hard the staff worked in the wards. Safety and quality of care was monitored and action taken in response to concerns. Risk registers were maintained for the CAG and fed into the overall trust risk register. Risks were militated against.

# Intensive/critical care

## Information about the service

The intensive therapy unit (ITU) and high dependency unit (HDU) cared primarily for patients who had cardiac or thoracic surgery post-operatively. At the time of the inspection, there was only one patient in ITU. Further patients were expected later that day, following surgery.

## Summary of findings

Patients received appropriate care and treatment in accordance with national guidelines. There were sufficient numbers of staff on duty to provide 24-hour care. Systems were in place to monitor the quality and safety of patient care provided. Staff were aware of the incident reporting system and received feedback. They told us they were encouraged by senior staff to report incidents and raise awareness of patient safety issues.

## Are intensive/critical care services safe?

Intensive care services were safe.

### Patient safety

The unit had in place a range of systems and processes to ensure the safety of patients. Relevant patient safety data was collected and submitted to the Intensive Care National Audit & Research Centre (ICNARC).

### Staffing

Nursing staff worked on a one-to-one ratio for patients in ITU at level 3 and one-to-two ratio for patients in HDU.

### Hospital Infections

The building was old but was clean, and all the equipment we observed was clean. Hand hygiene gel was available and staff were observed to use it. Hand wash basins with soap and disposable towels were available. Infection control information was available for patients and visitors. The unit had not reported any incidents of hospital-acquired infections in the past 12 months.

### Transfers

Transfer of patients in and out of the unit was mostly planned.

## Are intensive/critical care services effective?

Services in the intensive care unit are effective.

### Clinical management

Patients received care and treatment in line with national guidelines. Staff working in the unit had received appropriate training.

### Patient mortality

A national independent survey by ICNARC highlighted that there were no unplanned readmissions to the unit. The comparative figures showed that 25% of patients being discharged from the St Bartholomew's unit experienced a delayed discharge, 1% of these occurred after 10pm. The unit is about average for hospital mortality however, the total number of admissions is very low.

## Are intensive/critical care services caring?

Services are caring in the ITU.

### Patient privacy and dignity

Staff were observed to be respectful and maintained the privacy and dignity of the sole patient in ITU. Staff were seen to be polite and spoke in a respectful way. Staff told us there was a system in place for obtaining patient feedback.

## Are intensive/critical care services responsive to people's needs?

Services in ITU are responsive to people's needs.

### Patient care

The unit provided a service 24 hours a day, seven days a week. The trust had in place networks and arrangements with other NHS trust regional centres should a patient require transfer to another unit outside of the trust.

We saw the patient was monitored closely in the unit and staff were observed to respond quickly to any changing needs. The records we looked at supported the monitoring we observed.

# Intensive/critical care

### Translation services

St Bartholomew's Hospital had a high percentage of patients whose first language was not English. Staff we spoke with explained they had access to Language Line and interpreters when required.

## Are intensive/critical care services well-led?

Services in ITU are well-led.

### Leadership

There was a management structure in place and staff said they felt well supported by their line managers in the unit.

### Monitoring quality and performance

The ITU carried out a range of audits. Information was provided to ICNARC which helped to ensure services are delivered in line with good practice. Regular meetings ensured that staff openly discussed concerns about the service and critical care.

# Good practice and areas for improvement

## Areas of good practice

Our inspection team highlighted the following areas of good practice:

- The majority of patients were complimentary about the care and compassion of staff.

## Areas for improvement

**Action the trust MUST take to improve**

- Ensure there are sufficient staff with an appropriate skills mix on all wards to enable them to deliver care and treatment safely in a timely manner.
- Ensure patients receive nutritious food in sufficient quantities to meet their needs

**Other areas where the trust could improve**

- Improve the visibility of senior leaders in the trust.
- Address concerns about the implementation of the review of nursing posts and the effects of this on the skills mix of nursing staff.
- Improve the dissemination of 'lessons learned' from serious incident investigations across all CAGs.
- Improve staff access to suitable IT to ensure timely incident reporting by all staff.

This section is primarily information for the provider.

# Compliance actions

## Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder and injury | Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing.<br>The registered person must take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity.<br>Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing |

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder and injury | Regulation 14(1)(a) HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs.<br>The registered person must ensure that patients are protected from the risks of inadequate nutrition and dehydration, by means of the provision of a choice of suitable and nutritious food and hydration in sufficient quantities to meet patients' needs.<br>Regulation 14(1)(a) HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs. |

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Barts Health NHS Trust

# Mile End Hospital

## Quality report

Bancroft Road
London E1 4DG
Telephone: 020 8880 6493
www.bartshealth.nhs.uk

Date of inspection visit: 7 November 2013
Date of publication: January 2014

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

## Overall summary

Mile End Hospital is located within the London Borough of Tower Hamlets and provides a range of inpatient and outpatient services. These include mental health treatment, family planning, termination of pregnancy and rehabilitation services (illness and injury). Mile End Hospital is part of Barts Health NHS Trust.

CQC has inspected Mile End Hospital once since it became part of Barts Health on 1 April 2012. Our most recent inspection was in February 2013 when we visited the care of the elderly and rehabilitation service. We found that the trust was not meeting three of the 16 essential standards – under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the CQC (Registration) Regulations 2009. We issued three compliance actions and asked the trust to provide us with an action plan as to how they would become compliant. As part of this inspection, we were assessing whether the trust had addressed the shortfalls, as well as taking a broader look at the quality of care and treatment in a number of departments to see if the hospital was safe, effective, caring, responsive to people's needs and well-led.

Our inspection team included CQC inspectors and analysts, doctors, nurses and patient 'experts by experience'. We spent one day visiting the Mile End Hospital. We spoke with patients and their relatives, carers and friends and staff. We observed care and inspected the hospital environment and equipment. Prior to the inspection we also spoke with local bodies, such as clinical commissioning groups, local councils and Healthwatch.

We found Mile End Hospital was providing services to older people that were safe and effective. Patients told us they felt safe and were treated with dignity and respect. There were sufficient staff with the appropriate skills to meet people's needs. We saw people's care needs were assessed and they received support to eat and drink. The wards were well-led and patient safety and quality monitoring and management were used to improve services to patients using the service.

# Summary of findings

## The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

**Are services safe?**
We found that staff promoted a culture of safety. Patients were protected from the risk of infection and the hospital was clean. There were sufficient staff available to meet patients' needs in a timely manner. There was a focus on patient safety and we saw staff assess, identify and take action to mitigate risks.

**Are services effective?**
Professional guidance had been followed in setting staffing levels on the wards and staff had the necessary skills and training to provide care to older patients. Safety and quality audits were carried out to demonstrate that the service was operating effectively.

**Are services caring?**
Patients and relatives all commented on the kindness of staff. We observed staff to be polite, caring and professional in their interactions with patients. They treated patients with respect and dignity.

**Are services responsive to people's needs?**
Patients told us staff responded to their needs in a timely manner. There were support services in place to prepare patients for discharge and we saw there was a multidisciplinary team approach to ensure patients were discharged safely and effectively.

**Are services well-led?**
The care of the elderly and rehabilitation services were well-led. There was a focus on making sure patients received good quality, safe services.

# Summary of findings

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

**Medical care (including older people's care)**
We inspected medical care (including older people's care) at Mile End Hospital. Patient care was safe and effective. Staff were caring and responded to patients' needs. There were systems in place to monitor the safety and quality of the service. We found the service was well-led.

## What people who use the hospital say

Patients told us they were happy with their care and treatment. They said staff were kind and responsive to their needs. Comments included: "The staff are kind to me" and "I have been here four weeks – there are enough staff to look after me".

# Hospital name

**Detailed findings**

**Services we looked at:** Medical care (including older people's care)

## Our inspection team

**Our inspection team for Barts Health NHS Trust was led by:**

**Chair:** Dr Andy Mitchell, Medical Director (London Region) NHS England

**Team Leader:** Michele Golden, Compliance Manager, Care Quality Commission

**Our inspection team at Mile End Hospital was led by:**

**Team Leader:** Sue Walker, Compliance Inspector, Care Quality Commission

Our inspection team included CQC inspectors, doctors, nurses, student nurses and patient 'experts by experience'.

## Why we carried out this inspection

We chose to inspect Barts Health NHS Trust as one of the CQC's Chief Inspector of Hospitals' new in-depth inspections. We are testing our new approach to inspections at 18 NHS trusts. We are keen to visit a range of different types of hospital, from those considered to be high risk to those where the risk of poor care is likely to be lower. After analysing the information we held about Barts Health NHS Trust, using our 'intelligent monitoring' system – which looks at a wide range of data, including patient and staff surveys, hospital performance information, and the views of the public and local partner organisations – we considered them to be 'high risk'.

# Detailed findings

## How we carried out this inspection

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

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

The inspection team inspected the following core services at this hospital:

- Medical care (including older people's care)

Before visiting, we looked information we held about the trust and also asked other organisations to share what they knew about it. The information was used to guide the work of the inspection team during the announced inspection on 7 November 2013.

During the announced inspection we:

- Held a drop-in session for staff.
- Looked at medical records.
- Observed how staff cared for people.
- Spoke with patients, family members and carers.
- Spoke with staff.
- Reviewed information provided by and requested from the trust.

The team would like to thank everyone who spoke with us and attended the drop-in session. We found everyone to be open and balanced when sharing their experiences and perceptions of the quality of care and treatment at the hospital.

# Are services safe?

## Summary of findings

We found that staff promoted a culture of safety. Patients were protected from the risk of infection and the hospital was clean. There were sufficient staff available to meet patients' needs in a timely manner. There was a focus on patient safety and we saw staff assess, identify and take action to mitigate risks.

## Our findings

**Patient safety**
Patients told us they felt safe and staff responded to their needs with minimal delays.

**Staffing**
Staff told us they could provide safer, more personal care to patients since their numbers had been increased.

**Managing risks**
The service managed patient safety risks. Staff took appropriate action to mitigate and manage identified risks.

**Cleanliness and hospital infections**
Patients were protected from the risks of infection. The medical wards were clean. Patients and visitors were provided with information on how to prevent infections and there was hand hygiene gel in all ward areas for patients, staff and visitors to use.

**Safeguarding patients**
Staff had knowledge and understanding of how to protect patients from abuse and restrictive practices.

**Medical equipment**
Equipment was serviced and maintained to ensure it was safe for use. Patients were provided with specialist equipment when required.

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

## Summary of findings

Professional guidance had been followed in setting staffing levels on the wards and staff had the necessary skills and training to provide care to older patients. Safety and quality audits were carried out to demonstrate the service was operating effectively.

## Our findings

**Clinical management and guidelines**
Staffing and skill mix followed professional guidance and best practice. There was a programme of audits carried out regularly to monitor the quality and safety of patient care.

**Staff levels and skills**
There were sufficient numbers of staff with the appropriate knowledge and skills available to care for patients. Staff had completed their mandatory training and the trust had invested in providing staff with a development programme specific to caring for older people.

# Are services caring?

## Summary of findings

Patients and relatives all commented on the kindness of staff. We observed staff to be polite, caring and professional in their interactions with patients. They treated patients with respect and dignity.

## Our findings

**Patient feedback**

Patients and relatives we spoke with all commented on the kindness of staff. One patient told us, "The staff are kind to me". Another said, "I have been here four weeks – there are enough staff to look after me".

**Patient treatment**

Staff were observed to treat patients with dignity and respect. Personal care and support was provided in private and in a discrete and dignified manner. Care records showed patients were involved in planning their care and were able to discuss their preferences on admission.

**Food and drink**

Patients were given a choice of suitable food and drink to meet their nutritional, religious and cultural needs. We observed staff assisted patients to eat and drink and staff placed food and drink within patients' reach.

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

## Summary of findings

Patients told us staff responded to their needs in a timely manner. There were support services in place to prepare patients for discharge and we saw there was a multidisciplinary team approach to ensure patients were discharged safely and effectively.

## Our findings

### Patient feedback

Patients told us they felt well cared for and that staff responded to their needs and requests in a timely manner.

Information on the NHS Choices website had a number of positive and negative comments about the services provided. However, only one related to the care of the elderly and rehabilitation service and noted the good feedback provided about the physiotherapy service for joint replacement operations.

### Accessible information

Information for patients was readily available. Patients and staff reported there was good access to translation and advocacy services or those patients whose first language was not English.

### Discharge of patients

Patients were discharged appropriately. We saw discharges were planned by the multidisciplinary team with family involvement. There was a discharge coordinator post to ensure complex patient discharges were appropriately managed.

# Are services well-led?

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

## Summary of findings

The care of the elderly and rehabilitation services were well-led. There was a focus on making sure patients received good quality, safe services.

## Our findings

**Leadership**

The wards at Mile End were well-led. There had been a review of staffing and key appointments to the ward manager positions had been made. Staff told us they worked as a team and were supported by senior managers and colleagues.

**Managing quality and performance**

Safety and quality of care was monitored and action was taken to respond to concerns. Staff were aware of their responsibilities to report incidents and they received feedback on issues and learning in regular ward meetings. We saw staff were engaged in the assessment of risks and monitoring processes and participated in regular safety audits.

# Medical care (including older people's care)

## Information about the service

We inspected medical care (including older people's care) for this trust at Mile End Hospital. We visited two wards where we spoke with eight patients and 12 members of staff. We checked that actions had been taken to ensure the hospital was now compliant after concerns had been identified around staffing, meeting patients' nutritional needs and records, at a previous inspection in February 2013.

## Summary of findings

Patient care was safe and effective. Staff were caring and responded to patients' needs. There were systems in place to monitor the safety and quality of the service. We found the service was well-led.

### Are medical care services safe?

#### Staffing

There were adequate numbers of appropriately skilled staff on duty to meet the needs of patients. One ward at Mile End Hospital had recently closed and staff had been transferred to the remaining two wards. This meant there was the correct ratio of qualified staff and healthcare support staff on duty on each of the wards. Staff told us that, since the staffing levels had been increased, they had much more time to spend with patients and could respond more quickly to their needs. This was confirmed by the patients we spoke with.

#### Managing risks

We saw that risks to patients had been identified. The care records showed that assessments had been completed to identify a range of risks. We saw that, where risks had been identified, measures had been put in place to reduce them. For example, where people had been assessed as at high risk of falling and from developing pressure ulcers, care plans had been put in place.

We saw in patients' care records if they had been assessed as at risk of malnutrition. We observed staff completed food and fluid charts so they could make sure patients were getting enough to eat and drink. We saw that people's weights were regularly monitored if they were at risk of malnutrition, and staff could seek advice or refer concerns to the doctor or dietitian.

#### Safeguarding procedures

Staff had a good understanding of how to protect patients from abuse and restrictive practices. Staff understood the types of abuse and knew how to report any safeguarding concerns. Staff said they were confident that concerns would be appropriately dealt with to ensure patients were protected.

#### Medical equipment

We saw medical equipment was well maintained and had been regularly checked and serviced to ensure that it continued to be safe to use. Patients had been provided with the specialised equipment they needed. An example included the provision of air flow mattresses to reduce the risk of skin damage.

#### Hospital infections

Patients were protected from the risk of infection. Medical wards were clean and safe. Patients and visitors were provided with information on how to prevent infections and there was hand hygiene gel in all ward areas for patients, staff and visitors to use.

### Are medical care services effective?

#### Clinical management and guidelines

Nursing staff on each of the wards had recently been reorganised into two teams, and every patient had a named nurse and healthcare assistant responsible for their care. This meant there was more effective communication when relatives and other healthcare professionals needed information about a patient.

We saw there was a range of audits completed on a regular basis to check the quality of care being given. For example, we saw the results of records, cleanliness and infection control, safeguarding and hand hygiene audits. This meant there were systems in place to monitor the quality of care being given.

#### Staff skills

Staff had appropriate skills and training to provide care to patients and their competency was regularly monitored. On each of the wards we visited, staff were professional

# Medical care (including older people's care)

and competent in their interactions with patients. We saw that all staff had completed their mandatory training. We were told all staff from the wards had attended a week-long 'older people's service development training' and we saw an action plan had been developed from the training programme for each ward.

## Are medical care services caring?

### Patient feedback

All the patients and visitors we talked to commented on the kindness of all staff involved in their care. Comments included: "The staff are kind to me" and "I have been here four weeks – there are enough staff to look after me".

### Patient treatment

Staff treated patients with dignity and respect. We saw in their interactions with patients, staff were kind, professional and patient. Staff assisted patients in a discreet and dignified manner. Patients told us they were treated with respect and were never made to feel uncomfortable or embarrassed when assisted with personal care.

Care records contained evidence that patients had been involved in planning their care. Patients told us they had been able to discuss their care and preferences when they were admitted to the ward.

### Food and drink

Patients had adequate nutrition and hydration. Patients were supported to eat meals. We observed lunch times on two wards where care was provided to older patients and patients with dementia. Patients could choose their meals from a menu and special requests could be catered for – for example, halal food was available if required. We saw there were regular drinks rounds, and patients confirmed they had enough to drink. We saw staff put refreshments within patients' reach.

## Are medical care services responsive to people's needs?

### Patient feedback

Patients told us they felt well cared for and that staff responded to their needs and requests in a timely manner. For example, patients told us that when they rang their call bells they did not have to wait long before someone came to help them.

### Access to appropriate services

Patients were able to access appropriate services which had met their needs. For example, each ward had a full-time physiotherapist and occupational therapist who spent time with patients preparing them for discharge. The physiotherapist ran a falls group in the gym, which was used to encourage socialisation while increasing patients' strength and balance.

For patients whose first language was not English, there was an advocacy service which provided interpreters. Staff told us they could easily access this service but often members of staff were used, as frequently they were fluent in another language.

### Discharge arrangements

We looked at the discharge planning process. We were told the average length of stay on the wards was between six to eight weeks and discharges were planned at the weekly multidisciplinary team meeting. We were told that relatives were invited to the meetings so they could be fully involved and informed about the arrangements. Each patient had a predicted date of discharge and the wards had a discharge coordinator to manage the process.

# Medical care (including older people's care)

## Are medical care services well-led?

### Leadership

A number of staff said they thought the leadership of their ward was improving since there had been permanent appointments made to the senior and junior sister's role on the ward they worked on.

Staff on the wards showed a high level of enthusiasm for their work and the service was clearly developed around the needs of the elderly. Staff worked together as a team and told us the ward sisters were very supportive. Staff confirmed they were up to date with mandatory training and they had completed their annual appraisals.

### Managing quality and performance

Safety and quality of care was monitored and action taken to respond to concerns. This included reporting on performance indicators via patient safety metrics which included incidents, falls, pressure ulcers and infection control. The information was displayed in the wards by a simple safety cross system which indicated if there had been any falls or if the ward was fully staffed.

Staff were aware of how to report any incidents on the trust information system and told us any complaints were discussed at monthly staff meetings.

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Barts Health NHS Trust

# Whipps Cross University Hospital

## Quality report

Whipps Cross Road, Leytonstone
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Date of inspection visit:
5-7 and 15 November 2013
Date of publication: Janaury 2014

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

## Overall summary

Whipps Cross University Hospital is in Leytonstone, east London, and serves 350,000 people in Waltham Forest, Redbridge, Epping Forest and other areas. It provides a full range of inpatient, outpatient and day case services as well as maternity and accident and emergency departments. The hospital serves an area with a wide variation in levels of deprivation and health needs, ranging from the most deprived 5% to among the most affluent 30% of electoral wards in England.

Whipps Cross University Hospital is part of Barts Health NHS Trust, the largest NHS trust in England. It has a turnover of £1.25 billion, serves 2.5 million people and employs over 14,000 staff. The trust comprises 11 registered locations, including six primary hospital sites in east and north east London (Mile End Hospital, Newham University Hospital, St Bartholomew's Hospital, The London Chest Hospital, The Royal London Hospital and Whipps Cross University Hospital) as well as five other smaller locations.

CQC has inspected Whipps Cross Hospital four times since it became part of Barts Health on 1 April 2012. Our most recent inspections were in May and June 2013, when we visited the A&E and maternity departments, outpatients, surgery services and care of the elderly wards. We issued three warning notices to the trust relating to infection control, safety and availability of equipment and supporting its workers. We also issued compliance actions.

We had significant concerns about the quality and safety of care in certain areas of the hospital. As part of this inspection, we checked whether the trust had addressed some of these shortfalls, and we took a broader look at the quality of care and treatment in a number of departments.

Our inspection team included CQC inspectors and analysts, doctors, nurses, midwives, allied health professionals, patient 'Experts by Experience' and senior NHS managers. We spent three days visiting the hospital. We spoke with patients and their relatives, carers and friends, and hospital staff. We observed care and inspected the hospital environment and equipment. We held two listening events in Leyton and Walthamstow and heard directly from people about their experiences of care. Before the inspection we also spoke with local bodies, such as clinical commissioning groups, local councils and Healthwatch.

We found some good areas of practice and many positive findings. Patients held staff in high regard and felt them to be committed, compassionate and caring. Our observations confirmed this. The intensive care unit (ICU) was safe, met patients' needs and demonstrated

# Summary of findings

## Overall summary

how improvements could be made through learning from incidents. Improvements have been made in both accident and emergency and maternity services since our last inspection, and we saw some good practice in these departments. Palliative care was compassionate and held in high regard by staff, patients and their friends and family. We saw some good practice in children's services. The hospital was clean and staff adhered to good infection control practice. Staff worked well together in multidisciplinary teams.

However, a number of improvements need to be made. Prompt action is required in some areas of the hospital to ensure that care and treatment is safe and responds to people's needs. Work is also needed to make sure the hospital functions effectively and to improve leadership and morale.

Staffing levels on the medical and surgical wards need to be increased to ensure patients' medical and other needs are met. The hospital also needs to ensure that staff have access to the appropriate equipment.

The trust needs to make radical improvements to patient flow and discharge arrangements. Too many patients had to wait to be discharged or were delayed in other parts of the hospital. This impacted on the effective functioning of the hospital.

Equipment in parts of the hospital was either unavailable, in short supply, inappropriate or not subject to the appropriate checks. Some of this equipment was essential.

The hospital environment was satisfactory, although improvements need to be made to the some wards, the Margaret Centre and outpatients so that patients' needs can be met and their privacy and dignity can be maintained.

Patients need to be made aware of how to make a complaint and the hospital needs to improve how it learns from complaints. In addition, the hospital's risk register needs to be more actively managed.

While some areas of the trust were well-led, some wards needed stronger leadership and better support from the hospital. The governance of the hospital needs to be improved so that staff are empowered to make decisions and know how to make changes or get problems solved. We recognise that the trust has started to make changes, although these need time to become effective.

Staff culture was not sufficiently open and some staff felt inhibited in raising concerns. Morale was low across all staffing levels and some staff felt bullied.

# Summary of findings

## The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

### Are services safe?

Many aspects of care and treatment were safe. However, some aspects were unsafe. Staffing levels on some medical and surgical wards were not always safe. Equipment in parts of the hospital was either unavailable, in short supply, inappropriate or not subject to the appropriate checks. Some of this equipment was essential. The hospital was clean and staff adhered to infection control practice. The hospital environment was safe, although there were some shortfalls that meant that people's needs were not always met.

### Are services effective?

Patient care and treatment was effective and guidelines for best practice were monitored. We saw good collaborative working a number of areas in the hospital. Audits were carried out and used to improve patient care.

### Are services caring?

The majority of the patients spoke highly of Whipps Cross staff. Many patients were full of praise and said that staff were kind, caring and attentive to their needs. Patients' privacy and dignity were maintained. Patients received appropriate support to eat and drink. During the inspection we saw staff being attentive and caring towards patients. We did, however, hear at our listening events and via people calling and writing to us, about a number of concerning instances of very poor care. The hospital needs to ensure that the positive experiences we saw and heard about during the inspection are maintained and that instances of poor care are minimised as far as possible.

### Are services responsive to people's needs?

In some areas of the hospital, patients' needs were not being met. While some improvements had been made in some areas, essential checks on patients did not always happen. There were problems with patient flow through the hospital, bed occupancy and discharge planning. This was having a negative impact on patients' experiences. Patient feedback was being obtained, although further work was required to embed learning across the hospital. Patients' complaints were not always appropriately handled. Some patients did not know how to make a complaint, although the trust was beginning to make improvements in this area.

### Are services well-led?

There is variability in leadership across the hospital. Some areas were well-led, but others were not and this had an impact on patients' care and treatment. The clinical leadership structure was relatively new and it needs time to become embedded and effective. The trust had recognised this and action had been taken to address some shortcomings in the governance structure, such as the introduction of site-level organisational and clinical leadership. The culture was not sufficiently open and some staff felt inhibited in raising concerns. Morale was low across all staffing levels and some staff felt bullied.

# Summary of findings

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

### Accident and emergency

Progress has been made since we last inspected A&E. However, further improvements are required to improve the safety, effectiveness and responsiveness of the service. Managing patient flows through A&E is challenging. When the service is very busy, staff are less able to provide support to patients to help them cope with their treatment and hospital visit. Effective leadership is establishing the ways and means of changing working practices and the culture of the organisation to take the service forward.

### Medical care (including older people's care)

Urgent action is required to ensure that patient care is safe and meets patients' needs. We found staffing levels to be unsafe on some wards and identified some errors which could have led to harm to patients. On some wards there were not enough nurses to meet the needs of patients. The out-of-hours medical cover was inadequate and patients' needs were not always met. The trust is reconfiguring its staffing arrangements on the medical wards, but prompt action is required in the interim. There remained a lack of equipment on some wards. Patients were often washed in bed and not always offered the option of a shower. There were delays in discharging patients which had a significant impact on patients and other areas in the hospital, such as the surgical department and A&E. Some of these delays were not necessarily attributable to the hospital. However, we did see examples of good practice. Staff were kind and caring towards patients. Patients were positive about the way they had been cared for by staff. Action had been taken to improve patient outcomes. Staff were receiving intensive training on caring for older people.

### Surgery

Overall, surgical services were safe, effective and caring. However, some improvements needed to be made, particularly to the pre-admission ward arrangements. We saw evidence of safe surgical practice and good use of the World Health Organisation (WHO) surgery checklist, which is designed to prevent avoidable mistakes. Measures had been implemented to improve safety on the wards and there had been a reduction of incidents, such as patients' falling. There were good arrangements in place to manage hospital infections and maintain hygiene. Patients were very complimentary about staff and said that they were well cared for. Staff worked well together to assess patients' needs.

However, the way the pre-admission wards were organised needed to be reviewed. Staffing levels and staff skills levels on these wards did not always meet people's needs. Patients sometimes had to wait a long time on these wards.

Problems with the availability of beds in the hospital impacted on surgical services. As a result, patients sometimes had to wait in the recovery area after surgery. There were some medical patients on the surgical wards. Patients were not always discharged in a timely way and were not always involved in planning their discharge from hospital. Patients did not know how to make a complaint.

There was a lack of appropriate equipment (oxygen and suction) on some wards. Appropriate checks on emergency equipment were not always carried out.

Staff morale was low. Some staff said that when they raised concerns about patient safety, they felt bullied and fearful of raising further issues. There was some good leadership at a local level. However, staff were concerned about the effectiveness of the trust's governance system as a whole.

# Summary of findings

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

### Intensive/critical care

Overall, this was a safe, caring, effective and well-led service. Infection control was managed appropriately. There were enough appropriately qualified staff on duty. There was good education support and the unit learned from incidents and applied best practice guidelines. There were systems in place to monitor quality and safety. However, there were some delays to patients being transferred into and out of ICU and occasional single-sex ward breaches, although this was due to the shortage of available beds in the hospital.

### Maternity and family planning

We saw that improvements had been made in the maternity department, but further progress was needed. The service was clean, which was not the case at our last visit in June 2013. Reporting of faulty equipment and checking of resuscitation equipment had also improved since our last visit. However, other equipment was found to be faulty and there was still need to improve the availability of safe equipment. Enhancements had been made to the way the service learned from incidents and this should continue so that the changes are embedded. Women said that they felt staff cared for them well, although on occasions security staff were discourteous. Staffing levels were appropriate and there was sufficient consultant cover, although some staff said that there were times when they were stretched and could not provide one-to-one care to women in established labour. We found that the maternity service did not always respond to people's complaints in a timely manner. Although systems were in place for reporting and reviewing incidents, we did not always see evidence that appropriate action was taken. The risk register and meeting minutes we reviewed did not always demonstrate the sequence of actions taken to minimise the risk. Staff told us that current changes to the staffing structure were affecting morale and left some staff feeling undervalued.

### Children's care

Overall, children's care at Whipps Cross was a caring, effective and well-led service, with some issues around equipment checks, record keeping and communication with families. Parents and children were generally happy with the care they had received and felt they had been supported by caring and considerate staff. There were systems in place to ensure patients' safety and to minimise risks in relation to medication management, although the effectiveness of the measures in place had yet to be determined. Equipment checks of resuscitation trolleys and records of medication expiry dates were not consistently completed. Children's care and treatment was monitored through participation in local and national clinical effectiveness audits. Facilities were appropriate to provide holistic care to children and young people, including developmental play and educational support. Communication and information provided to families was not always responsive to their needs.

### End of life care

We found that the service was generally safe, effective and caring. Staff worked together well to deliver end of life care in a compassionate and effective way. The hospital was following national guidelines in relation to end of life care and had stopped using the Liverpool Care Pathway. Patients said that they felt well cared for by staff. However, the unit where end of life care was delivered was in need of refurbishment as it compromised patients' privacy and safety. In particular, bathing facilities were not available. There was no out-of-hours palliative medical cover or speciality-specific advice, although the hospital plans to put this in place in 2014.

# Summary of findings

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

### Outpatients

Overall, improvements are needed. Outpatient services at Whipps Cross Hospital were caring and well-led with some issues around waiting times, information governance and over-crowded clinics. Transformation projects were in place to improve waiting times and patients' experiences. The department was generally clean and hygienic but waiting rooms were noted to be overcrowded. There were long waiting times for many clinics. However, the trust was aware of these issues and had strategies in place to address them. Patients were pleased with the treatment they received and felt well informed and involved in decisions about their care. Patients' dignity and respect were maintained by staff in the outpatients department. There was evidence the department had made efforts to ensure their services were accessible and responsive to people's needs. Some people did report difficulty in re-arranging appointments that had been made for them.

# Summary of findings

## What people who use the hospital say

Patients' comments were polarised. Many people were very happy with the care they had received. However, we heard a significant minority of patients tell us about the poor care they had received.

During the inspection, the majority of the patients spoke highly of Whipps Cross staff. Many patients were full of praise and said that staff were kind, caring and attentive to their needs. One patient said that the nurses had been "lovely". Another had been "really impressed" and thought the nurses were "friendly… I can't fault them at all".

Comments from the listening events and comment cards included: "I could not complain", "I am generally quite pleased with service that my relative received. Everyone was very professional and polite", "The staff at Whipps Cross provide excellent healthcare. They are friendly, respectful and treat my situation with the highest confidence", "Excellent, well-oiled machine", "From start to finish, all staff at Whipps Cross Hospital are very caring and respectful. They listen and treat patients in a professional manner", and "The service is very bad."

We heard about a number of concerning instances of very poor care through our listening events and from people calling and writing to us.

## Areas for improvement

**Action the hospital MUST take to improve**

- Ensure staffing levels meet people's needs on all medical and surgical wards.
- Address delays to providing care. Patients' discharge from hospital is sometimes delayed. This impacts on other areas of the hospital and its effective functioning.
- Ensure that equipment on the medical and surgical wards, maternity services and in ICU is always available, appropriately maintained and checked in accordance with the trust's policies and safety guidelines.
- Improve staff morale across all grades.
- Make changes to the culture of the organisation. There is a lack of an open culture. Staff feel bullied and unable to raise safety issues without fear.
- Make changes to the hospital environment. Some parts of the hospital do not meet patients' care needs. The hospital environment in the Margaret Centre and outpatients compromises patients' privacy, dignity and safety.
- Ensure that patients know how to make a complaint. Changes are needed to ensure that the hospital learns effectively from complaints.
- Strengthen governance arrangements. Currently, these are not always effective. Staff do not feel empowered to make changes and the governance structures hinder them at times.
- Ensure that the hospital's risk register is managed more effectively.

# Summary of findings

## Good practice

Our inspection team highlighted the following areas of good practice:

- Staff were compassionate, caring and committed in all areas of the hospital.
- The ICU was safe, met patients' needs and demonstrated how improvements could be made through learning from incidents.
- Improvements have been made in both accident and emergency and maternity services since our last inspection and we saw some good practice in these departments.
- Palliative care was compassionate and held in high regard by staff, patients and friends and family.
- We saw some good practice in children's services, particularly in relation to education and activities for children while in hospital.
- The hospital was clean and staff adhered to good infection control practice. Staff worked well together in multidisciplinary teams.

# Whipps Cross University Hospital

## Detailed Findings

**Services we looked at:** Accident and emergency, Medical care (including older people's care), Surgery, Intensive/critical care, Maternity and family planning, Children's care, End of life care; Outpatients.

## Our inspection team

**Our inspection team for Barts Health NHS Trust was led by:**

**Chair:** Dr Andy Mitchell, Medical Director (London region), NHS England

**Team Leader:** Michele Golden, Care Quality Commission

**Our inspection team at Whipps Cross University Hospital was led by:**

**Team Leader:** Seaton Giles, Care Quality Commission

Our inspection team included CQC inspectors and analysts, doctors, nurses, allied health professionals, patient 'experts by experience' and senior NHS managers.

## Why we carried out this inspection

We chose to inspect Barts Health NHS Trust (the trust) as one of the CQC's Chief Inspector of Hospitals' new in-depth inspections. We are testing our new approach to inspections at 18 NHS trusts. We are keen to visit a range of different types of hospital, from those considered to be high risk to those where the risk of poor care is likely to be lower. After analysing the information that we held about Barts Health NHS Trust using our 'intelligent monitoring' system, which looks at a wide range of data, including patient and staff surveys, hospital performance information, and the views of the public and local partner organisations, we considered them to be 'high risk'.

## How we carried out this inspection

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

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

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

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

Before visiting, we looked at information we held about the trust and also asked other organisations to share what they knew about it. The information was used to guide the work of the inspection team during the announced inspection on 5, 6 and 7 November 2013. An unannounced inspection was carried out on 15 November 2013.

# Detailed findings

During the announced and unannounced inspections we:

- Held six focus groups with different staff members as well representatives of people who used the hospital.
- Held three drop-in sessions for staff.
- Held two listening events specifically for Whipps Cross University Hospital at which people shared their experiences of the hospital.
- Looked at medical records.
- Observed how staff cared for people.
- Spoke with patients, family members and carers.
- Spoke with staff at all levels from ward to board level.
- Reviewed information provided by, and requested from, the trust.

The team would like to thank everyone who spoke with us and attended the listening events, focus groups and drop-in sessions. We found everyone to be open and balanced when sharing their experiences and perceptions of the quality of care and treatment at the hospital.

# Are services safe?

## Summary of findings

Many aspects of care and treatment were safe. However, some aspects were unsafe. Staffing levels on some medical and surgical wards were not always safe. Equipment in some parts of the hospital was either unavailable, in short supply, inappropriate or not subject to the appropriate checks. Some of this equipment was essential. The hospital was clean and staff adhered to infection control practice. The hospital environment was safe, although there were some shortfalls, which meant that people's needs were not always met.

## Our findings

### Safety

Patients said that they had received good care at the hospital and that they felt safe. Action had been taken on the medical wards to identify the main risks to patient safety and monitor them on an on-going basis. On most wards, this system was working well. Patients were protected from avoidable harm during surgery. The World Health Organisation (WHO) surgical checklist had become embedded into practice. The intensive care unit (ICU) focused on safety, learning from incidents and minimising risk. Staff were aware of, and were using, the trust's system for reporting patient safety incidents. We saw departments acting on safety alerts and learning from incidents. Staff in ICU were actively learning from incidents that had occurred or from patient safety information. However, the method of disseminating learning from incidents was not established in A&E.

### Medicines

There were inconsistencies in the monitoring of medications in children's services. We saw that reconstitution dates of medical suspensions were recorded on bottles stored in the fridge on the children's ward. This meant that expiry dates could be monitored to ensure medication efficacy. In contrast, monitoring records did not appear to be consistently maintained in children's A&E. Medication expiry checklists that should have been completed monthly had not been recorded in five of the months between February 2013 and October 2013.

### Managing risks

There was a mixed picture on managing risks. On the medical and surgery wards, up-to-date patient safety information was displayed which related to key risks, such as pressure ulcers, falls, hospital acquired infections, staffing levels and use of bank staff. However, some risks on the trust's risk register, such as emergency and critical care, were not actively managed or addressed in a timely way.

### Hospital infections and hygiene

The hospital environment was visibly clean. Staff were seen to adhere to good hand hygiene and infection control practice. There were adequate handwashing facilities for staff and patients throughout the hospital. Patients felt that the hospital was clean. Action had been taken to minimise the risk of infection.

### Staffing

Staffing levels were mixed. In some departments, there was a full complement of staff. In other departments, there were either staffing shortages or skill deficits and this impacted on patient safety. Some medical and surgical wards had sufficient staff on duty to ensure safe practice. However, the lack of staff on some medical and surgical wards made them potentially unsafe. On some medical wards we found that relatively junior staff were in charge and there had been a number of incidents as a result. We identified an error relating to staffing issues during the inspection on a ward. A number of wards did not have enough permanent staff and relied on agency staff which could impact on the continuity of patient care. Sometimes shifts were unfilled on a number of wards, meaning that the wards were short-staffed. Out-of-hours cover on the medical wards was insufficient and, on occasions, this had a detrimental impact on patients. The pre-admission surgical wards were open for longer than had been intended due to demand and were reliant on agency staff. Patients reported long waits on these wards.

Staffing in theatres was satisfactory, although staff were concerned about proposed changes to nursing support. Midwife staffing levels were mostly maintained.

Staffing levels in A&E were satisfactory. A&E consultant cover had increased and the department had seen benefits from these appointments, such as a reduction in the number of serious incidents of patient harm. The

# Are services safe?

department was compliant with College of Emergency Medicine (CEM) guidelines on A&E senior clinician presence throughout the day and night and at weekends. The A&E department was currently seeking to improve out-of-hours consultant cover.

### Safeguarding

Staff knew about safeguarding adults and/or children and what to do in the event of a safeguarding concern. The majority of staff had received safeguarding training. Safeguarding guidance was available to staff.

### The environment

The hospital environment met most people's needs, although there were some significant shortfalls. A&E and the medical assessment unit were newly built. These were good environments in which to treat patients. However, the Margaret Centre was designed in such a way that patients' privacy and dignity were compromised. There were no suitable washing facilities for patients in the Margaret Centre. There was no covered route between the two buildings and we observed one patient in a critical condition being transferred in the rain. The centre was in need of refurbishment. Patient transfers between theatres and wards were often a long journey along public corridors. The outpatients department was suitably designed, although some waiting areas were overcrowded and we also noted adult patients waiting in children's waiting areas.

### Medical equipment

Much of the equipment in the hospital was in good working order. For the most part, staff had access to the equipment that they needed. However, some equipment in parts of the hospital was either unavailable, in short supply, inappropriate or not subject to the appropriate checks. Some of this equipment was essential. In ICU, there was only one operational ventilator trolley. The other trolley was not working. The hospital had not provided a replacement in over five months and the interim arrangements for obtaining another trolley were inadequate. Within older people's care, staff said that they had difficulties in finding bladder scanner machines, used to detect urinary retention and infection, which were shared between all the wards. This meant that staff spent time locating and retrieving it before they could use it to treat people effectively. We found this was also the situation at our inspection in June 2013.

In a number of different areas in the hospital, resuscitation equipment was not always checked when required and in accordance with the trust's policy.

In the maternity unit, systems to ensure that essential equipment was available had improved since our last inspection, although further improvement is required.

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

## Summary of findings

Patient care and treatment was effective and guidelines for best practice were monitored. We saw good collaborative working across a number of areas in the hospital. Audits were carried out and used to improve patient care.

## Our findings

### Clinical guidelines

We saw evidence of adherence to national and guidelines. For example, the ICU took part in the Intensive Care National Audit & Research Centre (ICNARC) national audit programme. The hospital had replaced the Liverpool Care Pathway for end of life care with other protocols. This was in line with national guidance.

### Collaborative working

Staff worked well in multidisciplinary teams. Staff from a range of disciplines worked well together when discussing discharging patients. The palliative care team worked well with others when delivering end of life care.

### Audits

We saw evidence of a range of audits being carried out, with the results used to improve the quality of care. This included high-impact intervention audits relating to catheters, venflons (intravenous plastic tubes), central lines, handwashing and methicillin-resistant staphylococcus aureus (MRSA) screening on the medical wards. The results of the audits were fed back to staff so that they could improve the quality of the care being provided.

The paediatric clinical audit programme for 2013/14 was regularly updated in line with National Institute for Health and Care Excellence (NICE) professional guidelines. The children's A&E had participated in a number of CEM clinical effectiveness audits, which measured the department against national standards.

# Are services caring?

## Summary of findings

The majority of the patients spoke highly of Whipps Cross staff. Many patients were full of praise and said that staff were kind, caring and attentive to their needs. Patients' privacy and dignity were maintained. Patients received appropriate support to eat and drink. During the inspection we saw staff being attentive and caring towards patients. However, from our listening events and people calling and writing to us, we have heard about a number of concerning instances of very poor care. The hospital needs to ensure that the positive experiences we saw and heard about during the inspection are maintained and that instances of poor care are minimised as far as possible.

## Our findings

### Patient feedback

The majority of patients said they were impressed by the caring attitude of nursing staff and felt that they were being well cared for. One patient said that the nurses had been "lovely." Another had been "really impressed" and thought the nurses were "friendly…I can't fault them at all". This applied to all of the departments we visited. However, from our listening events and people calling or writing to us, we heard about a number of instances of poor care.

### Communication

Patients said that staff communicated well with them, but there were one or two minor exceptions when more information would have been useful to the patient.

### Privacy and dignity

Patients said that staff respected their privacy and dignity. We confirmed this when we observed care being provided to patients. We saw respectful interactions between staff and patients. Curtains were drawn around bays when personal care and treatment was being provided. However, the trust should note that, on some occasions, patients were treated on trolleys in A&E and this potentially compromised their privacy and dignity. The design of the Margaret Centre, where palliative care is provided, did not enable staff to maintain patients' privacy and dignity.

### Food and drink

Patients were given a choice of suitable food and drink to meet their nutritional needs and had a good choice of food. We saw patients being supported to eat. Some children had to wait a long time without food when waiting for an operation.

### End of life care

Patients at the end of life were cared for with compassion and in line with national guidance.

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

## Summary of findings

In some areas of the hospital, patients' needs were not being met. While some improvements had been made in some areas, essential checks on patients did not always happen. There were problems with patient flow through the hospital, bed occupancy and discharge planning. This was having a negative impact on patients' experiences. Patients' feedback was being obtained, although further work was required to embed learning from their comments across the hospital. Patients' complaints were not always appropriately handled. Some patients did not know how to make a complaint, although the trust was beginning to make improvements in this area.

## Our findings

### Responding to patients' needs

Most areas of the hospital were providing satisfactory care, although some required improvements. In some areas of the hospital, such as some of the medical and surgical wards, people's needs were not being met, the quality of care being provided was inadequate and prompt action is required to address this.

On a respiratory ward, we found that one nurse was doing a medication round while another was in a multidisciplinary meeting and that patients were not being turned every hour, as identified on assessments. Monitoring paperwork had not been completed.

On other wards, we found that, although people's medical and social needs were being met, patients said that staff were busy and did not spend quality time with them. Patients told us that staff answered their call bell when they needed help and were responsive to their needs. However, some patients also told us that staff "generally missed the little things", such as having a shower, shaving or being able to look after their hair. It was generally felt that staff did not have sufficient time to communicate with patients and families. Staff confirmed this.

There were 15 patients with medical needs on surgical wards ('outlier' patients). While their needs were being met, these wards were not the most suitable environment for these patients.

Patients reported long waits on the surgical pre-admission wards.

Improvements have been made in the A&E department in relation to responding to people's needs. Hourly checks on patients had been introduced following our last inspection. However, we found that these checks were not always carried out or the documentation was not always completed. When we approached staff about these omissions, most said that they had not had time to complete the observations or that they had forgotten to complete the hourly checks chart. Some protocols to help staff determine where patients should be to receive the treatment they needed worked well, while others did not.

There were issues with the interface between A&E and the Urgent Care Centre (UCC) which is run by another organisation, the Partnership of East London Co-operatives (PELC). These issues were also present at our last inspection.

Patients in ICU had their needs met.

In Outpatients, some patients waited too long to be seen and the waiting rooms were overcrowded.

### Bed occupancy, patient flows and discharge planning

There are significant problems with patient flow in the hospital. Delays to discharge and/or a lack of beds impact on other areas in the hospital: patients have to stay in recovery, ICU or A&E for extended periods until beds become available. There are medical patients on the surgical wards ('outlier' patients) due to a lack of beds on the medical wards. Patients were not always discharged in a timely manner, in part due to a delay in obtaining an appropriate care package from the local authority, but also a lack of consultant and social worker seven-day working. There was an effective system in place to review bed occupancy, although these problems are systemic and action at trust level is required. We found this situation at our last visit in June 2013. The trust, in conjunction with the local authority, needs to take prompt action to improve patient flow in the hospital to ensure that patients receive appropriate care and treatment.

Some progress had been made in improving patient flows and waiting times in A&E and ambulance handover. We saw a number of initiatives in place to improve the flow of patients through A&E. This included a new acute assessment unit and multidisciplinary admissions avoidance

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

team. However, on the evening of the first day of our visit, A&E was very busy and there was a queue of ambulances waiting to hand over their patients to A&E. Staff told us this was a regular occurrence. There was delayed access to diagnostics and investigations. Many staff we spoke with told us patients were discharged from the wards in the hospital late in the day and this impeded the flow of patients through A&E.

By contrast, we found that where people had a prognosis of end of life within three months, a 'fast track' process enabled funding and a care package to be arranged in a matter of days from the point of application.

### Patients' feedback and complaints

Patients were not always supported to make complaints. Some departments learned from complaints, whereas other departments did not do so effectively. There was little information available and the majority of patients did not know how to make a complaint. However, the trust had recently published some new complaint leaflets and was in the process of disseminating these in the hospital. Some patients who had made a complaint felt that their complaint had not been handled effectively.

The hospital's Patient Advice and Liaison Service office, which provides patients with information and helps them with complaints, had closed. There was a number for patients to call, but when we tried, we were unable to get through.

In maternity, patients' experiences and complaints were used to improve the service and the effectiveness of treatment, although improvements were needed. In A&E, little information about complaints was provided to staff. There was no analysis of trends or dissemination of learning that would help the service improve and prevent similar problems arising again.

The hospital had arrangements to obtain patient's feedback through the NHS Friends and Family Test. Patients were completing the test more often than previously after a drive by the trust to increase returns.

### Patients with mental health needs

Systems in A&E did not always support patients with mental health needs. The discharge of these patients from A&E was sometimes delayed because of difficulties securing a registered mental health nurse to escort them to mental health services. There were sometimes long delays in obtaining psychiatric assessment out of hours, although there was a plan for the psychiatric liaison team to be on site 24 hours a day in future.

### Ward environment

Some of the medical wards and the Margaret Centre did not meet patients' needs. We did not identify any instances of patients being supported to shower where wards were equipped with walk-in shower rooms. Patients were washed in bed.

# Are services well-led?

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

## Summary of findings

There is variability in leadership across the hospital. Some areas were well-led, but others were not and this had an impact on patients' care and treatment. The clinical leadership structure was relatively new and needs time to become embedded and effective. The trust recognised this and action had been taken to address some shortcomings in the governance structure, such as the introduction of site level organisational and clinical leadership. The culture was not sufficiently open and some staff felt inhibited in raising concerns. Morale was low across all staffing levels and some staff felt bullied.

## Our findings

### Leadership and clinical governance structures

Whipps Cross University Hospital merged with several other hospitals to become Barts Health NHS Trust in April 2012. As such, it is still a relatively new organisation. Following the merger, the trust introduced a clinical leadership structure covering specific specialties, such as emergency medicine or surgery clinical academic groups, across all Barts Health sites. There are distinct advantages to this structure: it creates the opportunity to share best practice, make improvements, streamline services and innovate. However, there are also risks, particularly in the way the trust implemented the new structure. Some staff reported difficulties in working across the three main hospitals. They said it was sometimes difficult to know who was in charge in specific areas. At times, they found that the governance structure prevented issues being addressed. The trust recognised this and strengthened site level leadership at operational and clinical levels. This had been implemented just prior to our inspection so its impact could not be assessed. It is, in our view, a positive move.

From our inspection of Whipps Cross, we found that one clinical academic group (CAG) for emergency care and acute medicine – had developed the most and was working relatively well. This CAG was aware of the issues it had to tackle and had, or was putting, plans in place to address them. There was effective leadership at all levels in this CAG. However, this was not necessarily the case with other specialties.

We found that some areas of the hospital were well-led. We found well-run wards in the surgical and medical departments. The ICU was well-led. Equally, we found other wards that lacked effective ward leadership and/or support from the hospital, which resulted in poorer care and treatment for patients.

### Organisational culture

The hospital does not have an open culture that allows staff to raise issues without fear. Some staff felt inhibited in raising safety issues for fear that it would affect their jobs. Staff felt that changes to staffing structures were being imposed from the leadership without consultation. Some staff felt that they were being bullied by the organisation.

Morale was low among many staff. This was, in part, caused by the changes to nursing staff structures, but also staffing levels and the ability of staff to meet patients' needs in these circumstances.

# Accident and emergency

## Information about the service

The accident and emergency department (A&E) is open 24 hours a day, seven days a week. It is housed in new, purpose-built premises. There are six resuscitation bays (one of which is for children), 22 major injury bays ('majors') and a minor injuries area. An acute assessment unit opened in September 2013 providing 40 additional beds and bringing together services that used to be provided in three separate units. A majors triage area with three beds opened on the day of our inspection. A clinical decision unit accommodates patients for up to 12 hours while waiting for tests and observations to be completed before a decision on further treatment. An acute ambulatory care service is open Monday to Friday.

A&E works alongside an Urgent Care Centre (UCC) operated by the Partnership of East London Co-operatives (PELC). PELC is a not-for-profit social enterprise delivering out-of-hours GP services as well as two UCCs in outer north east London and west Essex. The purpose of the UCC is to ensure that patients presenting to A&E are seen by the most appropriate clinician, which may redirect them to community-based services or their own GP. In 2012, the A&E and the UCC together saw over 150,000 patients.

We spoke to patients, relatives and staff, including nurses, doctors, managers, therapists, support staff, porters, receptionists and ambulance crew. We observed care and looked at treatment records. We received comments from patients and the public at our listening events, and we reviewed performance information about the trust.

## Summary of findings

Progress has been made since we last inspected A&E. However, further improvements are required to improve the safety, effectiveness and responsiveness of the service. Managing patient flows through A&E is challenging. When the service is very busy, staff are less able to provide support to patients to help them cope with their treatment and hospital visit. The department's effective leadership is establishing ways to change working practices and the culture of the organisation to take the service forward.

## Are accident and emergency services safe?

Although the trust had taken steps to reduce harm to patients, further improvements are required to ensure people are protected from avoidable harm at all times.

### Learning from incidents

Staff were aware of, and using, the trust's system for reporting patient safety incidents. Teams in A&E were given information about the levels of delays in care, patient falls and skin trauma. However, there was no established method of disseminating learning from incidents. Information for staff about progress towards achieving harm-free care was not readily available in A&E. The trust was planning to produce a regular bulletin for staff to address this.

### Hospital infections and hygiene

The environment was visibly clean and domestic cleaning staff were present in each of the areas we visited. Adequate hand washing facilities were available and we saw staff taking care to protect patients from cross infection, for example by using disposable gloves and aprons, being bare below the elbows, and dealing appropriately with clinical waste.

### Safeguarding

Guidance was available for staff on identifying and reporting possible abuse. Safeguarding was included in annual refresher training for staff and senior staff told us that 96 to 98% of staff were up to date with this training. Training records confirmed this. Staff told us they knew how to report safeguarding issues and were aware of the trust's whistleblowing policy, and would feel confident to report to management any concerns they had about patient safety.

### Staffing

The trust had recruited additional A&E consultants to increase the availability of senior clinical leadership and expertise for doctors in training in A&E. It was compliant with College of Emergency Medicine (CEM) guidelines on A&E senior clinician presence throughout the day and night and at weekends. The number of serious incidents of patient harm had reduced following the appointment of additional A&E consultants. Work in other areas was on-going, for example out-of-hours consultant cover.

# Accident and emergency

During our visit we saw good involvement of consultant physicians and surgeons in the acute assessment unit. Work was progressing on consultants' plans to increase the presence of senior clinicians to meet Royal College of Physicians' recommendations.

The trust was consulting staff at Whipps Cross about proposed changes to the deployment of nurses in the hospital, which would align it with other comparable hospitals. The proposals took in account Royal College of Nursing guidance on safe staff nursing levels and the recommendations of the Safe Staffing Alliance about minimum staffing levels to ensure quality care. However, many staff told us they were unclear about how the proposals would affect them personally and were concerned the changes would have an adverse impact, for example, on skills mix and support for student nurses.

A&E relied regularly on agency staff to maintain staffing levels. We spoke to a few agency staff who told us they preferred working at Whipps Cross to other hospitals because they were treated as part of the team and found their manager supportive and approachable.

### The environment and medical equipment

A&E was housed in new, purpose-built premises with new facilities. Staff had no concerns about availability of equipment. However, we saw that a number of routine checks to ensure that equipment was available and in working order were not being made consistently in all areas. Records showed resuscitation equipment was not being checked every day in resuscitation, majors, minors, the acute assessment unit or acute ambulatory care. This was not in accordance with the trust's policy. On one occasion, we saw keys left in the drugs cupboard in the acute assessment unit and medicines were accessible to unauthorised people. There were no temperature monitoring records available for a drugs refrigerator in resuscitation. Staff using these medicines could not be assured that they had been stored at the correct temperature and fit for use.

## Are accident and emergency services effective?

Improvements are required to ensure people's needs are met and that care and effective treatment results in the best quality of life.

### Clinical guidelines

There were a number of protocols available in the resuscitation area of A&E to provide guidance to staff about the best way to treat conditions. Staff were developing protocols in collaboration with other hospitals to ensure they shared best practice, such as managing patients with acute myocardial infarction (heart attack). However, the development of a number of care bundles (a collection of evidence-based interventions) to improve the consistency of treatment and care in A&E and across the hospital were in an early stage of development. The trust had set up the emergency clinical improvement group to take this work forward.

## Are accident and emergency services caring?

Staff were caring, but improvements are required to ensure patients receive care tailored to their needs at all times.

### Communication

Patients and relatives were complimentary about the treatment and care they received. They said staff communicated with them well about their treatment. This included a patient who used the trust's interpreter service. We observed staff speaking with patients and relatives in a caring manner. However, when the service was very busy, patients and relatives were concerned about the lack of information about why they were waiting and what was going to happen to them. For example, a pregnant woman told us she was very worried as she had had a fall and had been waiting for more than four hours for a scan. A few staff told us that pressure to meet waiting time targets meant that they couldn't take time out to reassure patients and make sure their needs, other than clinical ones, were being met.

# Accident and emergency

The trust launched a 'Because We Care' campaign in August 2013, described as "a call to action for compassionate care across the trust." Staff were unclear about how the campaign worked. A group of healthcare support workers thought that their "hourly chats" with patients in A&E were part of the campaign, but had no way of recording this activity. Staff in acute ambulatory care and the acute assessment unit were unable to show how the campaign had any impact on the way they cared for patients. There was no feedback to staff from the trust about how well the campaign was working.

### Privacy

People's privacy and dignity were respected, although improvements could be made. When we inspected A&E on 22 and 23 May 2013, we saw patients' privacy being compromised when receiving treatment in corridors when cubicles were available. We did not see this practice at this inspection, although when the service was very busy, patients were being cared for on trolleys in corridors.

## Are accident and emergency services responsive to people's needs?

Improvements are required to ensure people get the treatment and care they need at the right time, and that the hospital listens and responds to their concerns.

### Responding to patients' needs

At our last inspection of A&E on 22 and 23 May 2013, we found prioritisation of patients' treatment did not always change in response to a change in their condition. A&E was not always meeting national emergency department indicators for waiting times and handover times for patients arriving at A&E by ambulance. 'Time to treatment' and 'time to consultant sign-off' were inconsistent. The trust told us how it would remedy this situation. During this inspection we found the trust's action plan was mostly being implemented, and was beginning to improve the responsiveness of the service.

### Patient flows and waiting times

Progress was being made on indicators for waiting times in A&E and ambulance handover. We saw a number of initiatives in place to improve the flow of patients through A&E. This included a new acute assessment unit and multidisciplinary admissions avoidance team. The admissions avoidance team was effective and working beyond its operational hours of 10am to 6pm on the evening of the first day of our inspection to provide support when the service was very busy. We saw effective multidisciplinary working to discharge patients from A&E in a safe way and as speedily as possible. However, porters told us they needed training on transferring confused patients.

On the evening of the first day of our visit, A&E was very busy. All bays were occupied. Patients were being cared for on trolleys in corridors and there were not enough seats for all the people in the waiting area. There was a queue of ambulances waiting to hand over their patients to A&E. Staff told us this was a regular occurrence. There was delayed access to diagnostics and investigations. One person we spoke with had arrived in A&E that morning by ambulance at 10.30am, was seen in x-ray at 3pm, and at 7.10pm was still waiting for the results of a blood test.

The trust was monitoring breaches of the national indicators for waiting times in A&E and for ambulance handovers, and held regular review meetings. The service's escalation policy was being revised at the time of our inspection. An escalation policy sets out how the whole hospital responds to increasing demand on A&E to increase patient flow through the service while ensuring patients receive the treatment and care they need. Many staff told us patients were discharged from the wards in the hospital late in the day and this impeded the flow of patients through A&E.

### Hourly rounding

At our last inspection of A&E on 22 and 23 May 2013, we found that patients in A&E did not always have access to food and drink. We saw that hourly rounding had been introduced in A&E to provide on-going monitoring of each patient's condition. Observations included nutrition and hydration. We saw refreshments trolleys in A&E and meals provided for people staying in the acute assessment unit. However, we saw one person in the acute assessment unit who needed help to eat their breakfast, but they did not get this.

We saw nursing staff being encouraged to escalate concerns when a patient's condition deteriorated, triggering a reassessment of their needs and priority for treatment.

# Accident and emergency

However the records we looked at showed that observations were not being consistently completed on an hourly basis. They also showed that some patients were not being turned as often as required, and there had been instances of missed medication. When we approached staff about these omissions, most said that they had not had time to complete the observations or that they had forgotten to complete the hourly checks chart. However, two nurses we approached simply completed the chart without making the observations. We escalated our concern about this falsification of records to the trust.

### Patient pathways

There were protocols to help staff determine where patients should receive treatment: some worked well, while others did not. Staff were clear that patients with deep vein thrombosis would be treated in the acute ambulatory care service. However, following the reconfiguration of the service, we saw examples where staff were unclear about the patient pathway through A&E for neutropenic patients and women with obstetric and gynaecological complaints. Some patients described problems in accessing A&E through the UCC. For example, one person had been sent through to A&E and become lost. Another person had been redirected to their GP, who told them to go back to A&E.

### Patients with mental health needs

Systems did not always support patients with mental health needs. There was a dedicated bay for patients with mental health needs, which provided a more comfortable and safe environment than the waiting area. Psychiatry professionals were available on site during the day to assist with assessment and discharge. Staff said discharge of these patients from A&E was sometimes delayed, however, because of difficulties securing a registered mental health nurse to escort them to mental health services. There were sometimes long delays in obtaining psychiatric assessment out of hours, although there was a plan for the psychiatric liaison team to be on site 24 hours a day in future.

### Patients' feedback and complaints

The hospital sought feedback from patients. The number of people who completed the NHS Friends and Family Test for the A&E department had increased.

There were weaknesses in the way the trust responded to complaints and learned from them. Some patients felt that their complaints had not been handled well. They felt that the trust had failed to provide a coordinated response in a timely way. They were also concerned that the centralisation of the Patient Advice and Liaison Service meant that they had lost a valuable means of resolving problems quickly and getting help navigating their treatment and care. Little information about complaints was provided to staff. There was no analysis of trends or dissemination of learning that would help the service improve and prevent similar problems arising again.

## Are accident and emergency services well-led?

There is effective leadership at all levels of the service. The service is establishing governance mechanisms and ways to collect information, which will enhance its capability to further improve performance.

The trust established the emergency care and acute medicine clinical academic group (ECAM CAG) in October 2012 to provide clinician-led leadership of these services across the trust. More recently the trust had strengthened leadership locally with the appointment of a clinical lead for Whipps Cross. Members of the ECAM CAG and other senior staff understood the challenges faced by A&E and the changes that needed to be made to ways of working and to the culture of the service to bring about improvements.

Nursing staff and healthcare support workers felt well supported through team meetings, briefings and one-to-one supervision. They said that their managers were approachable. Some staff expressed concern that opportunities for training and professional development had been reduced and that there was little on offer in addition to the core mandatory training provided by the trust.

# Medical care (including older people's care)

## Information about the service

Whipps Cross University Hospital provides medical care to people on inpatient wards, some of which specialise in providing care and treatment to frail older people.

We spoke with patients and staff, including doctors, nurses, senior managers and support staff. We observed care and treatment and looked at care records. We received comments from our listening event and from people who contacted us to tell us about their experience. We also reviewed performance information about the trust.

## Summary of findings

Urgent action is needed to ensure that care is both safe and meets patients' needs.

We found staffing levels to be unsafe on some wards and identified some errors which could have led to harm to patients. On some wards there were not enough nurses to meet the needs of patients. The out-of-hours medical cover was inadequate and patients' needs were not always met. The trust is reconfiguring its staffing arrangements on the medical wards, but prompt action is required in the interim.

There was a lack of equipment on some wards.

There were delays in discharging patients, which had a significant impact on patients and other areas in the hospital, such as the surgical department and A&E. Some of these delays were not necessarily attributable to the hospital.

However, we did see examples of good practice. Staff were kind and caring towards patients. Patients were positive about the way staff had cared for them. Action had been taken to improve outcomes for patients. Staff were receiving intensive training on caring for older people.

Action had also been taken on the Warning Notice relating to supervision and appraisal of staff on two care of the elderly wards.

## Are medical care services safe?

Medical care services were not always safe.

### Patient safety

We found that wards were working to reduce falls and they displayed up-to-date information about the number of falls that had occurred on each ward. There were falls assessments for patients on admission. Some wards had access to physiotherapy and occupational therapy staff to help with patients' rehabilitation.

We found the hospital worked well to reduce blood clots (venous thromboembolism or VTE). On a cardiology ward we found a protocol at the front of each patient's drug chart, which assessed the risk of VTE on admission and 24 hours after admission. It prompted medical staff to decide on the best course of prevention therapy. The ward audited VTEs every month. The rate of VTEs had been very low recently, which was attributed to the risk assessment process which had been in place for a year.

### Staffing

The lack of staff on some wards made them unsafe. We found band 5 nurses in charge of renal and care of the elderly wards. On a cardiology ward we found there had been a recent high level of cardiac arrests, and the most senior nurse was a band 5. On one ward, falls had occurred on five days in October. On four of these days the ward was understaffed due to sickness. The ward had been understaffed for a total of 10 days in October, as shifts had been difficult to fill using bank staff, which had affected its ability to prevent falls.

Another ward had a vacant ward manager position, although a recruitment process was underway. We found a lack of coordination on this ward had resulted in key elements of care being missed, such as poor documentation, incorrect information on forms and dangerous levels of paracetamol being mistakenly prescribed by doctors.

# Medical care (including older people's care)

Out-of-hours medical cover for all medical services, including care of older people, comprised three doctors (a foundation year one doctor, a senior house officer and a specialist registrar). This meant that the doctors working evenings and weekends had to prioritise their workload on a risk basis, and there was no time to review patients who had been handed over to them on a Friday for review over the weekend. There was no seven-day working for consultants. We found examples where one patient had a full fluid lung and another with a chest infection but no duty review had taken place over the weekend.

### Safeguarding

Safeguarding referrals had recently become an online process with referrals now sent to another site within the Barts Health group. The target time for a response from the time of referral was 24 hours, although meeting this target had not been measured as it was a new process.

### Equipment

Within older people's care, staff said that they had difficulties in finding bladder scanner machines, used to detect urinary retention and infection, which were shared between all the wards. This meant that staff spent time locating and retrieving it before they could use it to treat people effectively. We found this was also the situation at our inspection in June 2013.

There was a lack of ultra-low beds on care of the elderly wards, which would help staff to prevent falls. However, the hospital was able to respond swiftly to the need for pressure-relieving mattresses, as a supplier was located on site and provided these within hours of requests.

## Are medical care services effective?

Services were effective.

### Staff skills

Whipps Cross was a national audit outlier for respiratory disease (British Thoracic Society national audit programme). Recent audits had not yet fed in to current statistics but showed adequate improvements in outcomes for patients. A senior nurse worked on improving outcomes for patients with respiratory conditions. This included carrying out training and supporting staff to implement individual asthma action plans, and implementing a checklist for chronic obstructive pulmonary disease (COPD) on discharge, inhaler technique and implementing a COPD care bundle across the hospital.

All the staff from each older people's care wards had, or were about to, participate in the Older People's Service Development Programme. This week-long training focused on key elements of caring, such as compassion, behaviour, making a difference and improving the patient experience. Staff were assessed before and after the course, to identify any development issues.

### Support for staff

The trust had taken action to address shortcomings in supporting its staff. The issues outlined in a Warning Notice from August 2013 had been met. Appropriate arrangements were now in place to support staff. We found that staff had received their annual appraisals. Team meetings were held regularly and additional support had been provided to ward managers generally.

## Are medical care services caring?

Patients experienced a caring service on medical wards.

We observed staff treating patients in a respectful and kind manner. Staff engaged well with patients on all medical wards, speaking to them appropriately and providing support. We saw instances where staff displayed compassion towards patients. In particular, care for patients with dementia was supportive and compassionate and took account of their condition and needs.

We saw that patients' privacy and dignity was maintained on all of the wards. Patients told us that staff respected them and maintained their privacy and dignity.

Patients consistently told us that they felt well cared for. They spoke highly of ward staff and told us they had great respect for the staff and the way they went about their work. However, patients told us that staff were constantly busy with tasks, which potentially risked the opportunity to spend quality time with patients.

# Medical care (including older people's care)

## Are medical care services responsive to people's needs?

People's needs were not being met and the quality of care being provided was inadequate in some instances.

### Responding to people's needs

On a respiratory ward we found that one nurse was doing a medication round while another was in a multidisciplinary meeting (discharge, progress, support) and that patients were not being turned every hour, as identified on assessments. Monitoring paperwork had also not been completed. Rounds were made to check patients once, twice or three times an hour, depending on the staffing pressure of individual wards, rather than based on the needs of individual patients.

On one ward, staff were constantly being asked to work bank (overtime) shifts and we found that every shift had at least one bank or agency staff. Staff worked hard to meet people's essential care needs, but did not have enough time for some basic duties, such as talking to patients or repositioning them.

On one ward we found that some patients' mouth care had not been attended to, which had caused them discomfort. Relatives felt that they had provided care to patients that the nurses should have provided.

Patients told us that staff answered their call bell when they needed help and were responsive to their needs. However, some patients also told us that staff "generally missed the little things". People spoke about not having had a shower and missed shaving and being able to look after their hair. It was generally felt that there was less time for communication with patients and families to update them or ask them how they were getting on.

Patients told us that the newspapers trolley did not come up to some of the older people's wards and patients felt the pay television was expensive. This meant that people couldn't read a newspaper or watch television and therefore felt unoccupied.

We did not identify any instances of patients being supported to shower, even where wards were equipped with walk-in shower rooms. Patients were washed in bed and not given the option of a shower.

### Ward environment

The ward environment did not meet patients' needs. The number of washing and bathing facilities for patients on the wards was low. Some wards often did not have the facilities for patients to shower or bathe. We did not identify any instances of patients being supported to shower, even where wards were equipped with walk-in shower rooms. Patients were washed in bed.

### Bed occupancy and discharge arrangements

Patients were not always discharged in a timely manner. Medical wards consistently reported to us that patient flow and discharge was negatively affected by the delay in processing and arranging continuing care placements for patients who could not go back home. Applications for continuing care were approved by a local authority funding panel, after which placements were selected. We were given examples where patients had been ready for discharge but the application process had been delayed. In some cases, patients had been waiting on medical wards for seven and 10 weeks. The pressure on bed numbers meant that some medical patients were being cared for as 'outlier patients' on surgical wards.

On a cardiology ward there was a weekend medical team (a house officer and consultant) who worked 9am to 5pm to enable weekend discharges. The team reviewed patients who had been identified for discharge and decided whether they were fit to go home. There was also a cardiology registrar available on call for advice. Apart from this, we found that seven-day working for consultants was not in place.

By contrast, we found that, where people had a prognosis of needing end of life care within three months, a 'fast track' process enabled funding and a care package to be arranged in a matter of days from the point of application.

We found a mixed picture when it came to patients being treated according to their individual identified need, which mostly depended on ward organisation and number of staff for each ward. On a cardiology ward and most care of the elderly wards, we found that essential elements such as nutrition and pressure care were clearly documented and monitored. There were daily multidisciplinary reviews through a 'board round' where all patients' care was reviewed.

# Medical care (including older people's care)

## Are medical care services well-led?

Leadership was lacking on some wards and at a senior level in addressing problems. There was a lack of leadership on some wards due to staffing shortages. This meant that some wards did not function as well as they could, which impacted on patient care. Senior management had not resolved some of the problems on the wards, such as a shortage of suitable staff and equipment, and these issues had been ongoing for some time.

Morale was low among staff at all levels. Staff were concerned about the planned changes to staffing levels and the impact these would have on patients. They were also concerned about access to management and escalation arrangements. Nursing staff felt supported by their direct line manager. They said that they did not feel supported by senior management or the trust management generally.

# Surgery

## Information about the service

Whipps Cross Hospital has 12 theatres for surgery and these are supported by surgical wards. We visited the majority of these wards.

We spoke with patients and staff, including doctors, nurses, senior managers and support staff. We observed care and treatment and looked at care records. We received comments from our listening event and from people who contacted us to tell us about their experience. We also reviewed performance information about the trust.

## Summary of findings

Overall, surgical services were safe, effective and caring. However, some improvements needed to be made, particularly to the pre-admission ward arrangements. We saw evidence of safe surgical practice and good use of the World Health Organisation (WHO) surgery checklist, designed to prevent avoidable mistakes. Measures had been implemented to improve safety on the wards and there had been a reduction of incidents, such as patients falling. There were good arrangements in place to manage hospital infections and maintain hygiene.

Patients were very complimentary about staff and said that they were cared for well. Staff worked well together to assess patients' needs.

However, the organisation of pre-admission wards needed to be reviewed. The levels and skills of staff did not always meet people's needs and patients sometimes had to wait a long time on these wards.

A lack of available beds in the hospital impacted on surgical services. As a result, patients sometimes had to wait in recovery after surgery rather than be transferred to a ward. There were some medical patients on the surgical wards. Patients were not always discharged in a timely way and were not always involved in planning their discharge from hospital. Patients did not know how to make a complaint.

There was a lack of appropriate equipment (oxygen and suction) on some wards. Appropriate checks on emergency equipment were not always carried out.

Staff morale was low. Some staff said that, when they raised concerns about patient safety, they felt bullied and fearful of raising further issues. There was some good leadership at a local level. However, staff were concerned about the effectiveness of the trust's governance system as a whole.

# Surgery

## Are surgery services safe?

Staffing levels on some wards and the lack of some essential equipment put patients at risk, although there was no evidence that patients had come to harm. Safety measures in theatres were effective. A good standard of hygiene was maintained. Overall, improvements are needed.

### Patient safety procedures

Patients were protected from avoidable harm during surgery. At our last inspection in June 2013, we found that the hospital had introduced measures to ensure that the WHO surgical checklist was used at every surgery. At this inspection, we found that the use of the WHO list had become embedded into practice on both the wards and theatres and we saw WHO checklists that had been satisfactorily completed. The WHO list was audited every month and the results fed back to the surgical teams. Staff were able to explain clearly how the WHO surgical checklist was used.

There had not been any 'never events' – serious, preventable patient safety incidents – relating to the use of the WHO checklist in 2013.

### Managing risks

We saw up-to-date patient safety information displayed on each ward visited. This information related to key risks, such as pressure ulcers, falls, hospital acquired infections, staffing levels and use of bank (overtime) staff. This information was provided as part of the trust's 'Because We Care' campaign. Staff were able to explain the campaign, how it affected patient safety and experience, and how it had been embedded into nursing practice since its introduction. On one ward, staff had signed a form to confirm that they had read and supported the campaign. However, not all nursing staff were familiar with the details of the campaign.

Staff told us about acting on safety alerts and learning from incidents. They explained how investigations into pressure ulcers had identified areas for improvement and had changed practice. Staff now discussed patient safety, including pressure ulcers, at daily and monthly meetings. We found that the management of the pressure ulcers we reviewed was appropriate.

Staff knew how to report incidents. However, one ward had a backlog of incident reports, dating back to September 2013, that had not been submitted.

### Hospital infections and hygiene

Patients were protected from the risk of infection. The hospital's rates for Clostridium difficile (C. difficile) and methicillin-resistant staphylococcus aureus (MRSA) were lower than expected. Staff were seen to adhere to good hand hygiene practice. There were sufficient alcohol hand-gel dispensers available throughout the theatres and wards. Wards were clean. We observed the cleaning of some medical equipment and found this to be satisfactory. Domestic staff maintained cleanliness throughout the day. Patients said that the wards appeared to be clean. Staff were able to explain how they kept wards clean and prevented infections.

### Staffing

On theatres, we found that there were enough suitably qualified and experience surgeons, anaesthetists and nurses to meet patients' needs. Surgical staffing was largely stable. Staff were mostly permanent and agency staff numbers were low. However, we noted that the trust is in the process of changing the nursing bandings on theatres. This is being undertaken after a comparative analysis of theatre nursing levels at other similar hospitals, with reference to national staffing guidance and a staff consultation. While we accept that the trust has assured itself that the evidence base for the changes is robust, there are risks associated with these changes, which we wish to bring to the trust's attention – such as the loss of experienced staff and low staff morale, which could have a negative impact on patients.

Some surgical wards were appropriately staffed. Others did not have enough staff on duty or staff lacked the necessary knowledge, skills and experience to ensure safe patient care. Some wards relied heavily on agency nurses, which impacted on the quality and continuity of care. On some wards, we found a relatively high number of unfilled shifts, meaning that the wards were short-staffed. The pre-admission surgical wards were open for longer than had been intended due to demand, and were reliant on agency staff. Patients reported long waits on these wards.

# Surgery

### Equipment

There was not enough equipment and this potentially put patients at risk. There was no bedside oxygen on one ward and staff relied on portable oxygen. On other wards, oxygen flow meters were not always available at the bedside. One ward did not have suction equipment. Some wards caring for patients with tracheostomies shared suction equipment. High vacuum suction pumps were found at suction points designed for cavity suction. On one ward, broken suction equipment was not taken out of use. Staff said that they had difficulties in finding bladder scanner machines. Resuscitation trolleys on the wards were supposed to be checked every day in line with the trust's policy. We found that, although checks were regular, they were not made daily. Some trolleys did not have essential resuscitation equipment for several days. Staff on the pre-admission wards had not been trained to use emergency equipment (a defibrillator), which also put patients at risk.

### Patient records

We found some inconsistencies in the way hourly rounds were recorded in patients' notes on some wards. We found that the confidentiality of patients' records was compromised in two instances on two different wards.

## Are surgery services effective?

Overall, surgical services were effective.

### Collaborative working

We found that staff collaborated well in multidisciplinary teams on the wards. We observed a multidisciplinary meeting where patients' discharge arrangements were discussed. There were effective arrangements to identify the actions that needed to be taken to ensure that patients were discharged from hospital as soon as possible. The findings from meetings are disseminated to the wards for action. We reviewed the discharge arrangements for five patients who were due to be discharged on the day of the inspection. Four were completed quickly, while one was delayed until the next day, although this was due to the need for an increased care package.

### Audits

We saw evidence of high-impact intervention audits relating to catheters, venflons, central lines, hand washing and methicillin-resistant staphylococcus aureus (MRSA) screening. The results of the audits were fed back to staff so they could improve the quality of the care being provided.

## Are surgery services caring?

Staff in the surgical department provided a caring service.

The majority of patients said they were impressed by the caring attitude of nursing staff and felt they were being well cared for. One patient said that the nurses had been "lovely." Another had been "really impressed" and thought the nurses were "friendly…I can't fault them at all". Most patients said that communication with staff was good, although some patients said that there were occasionally language barriers.

### Patients' privacy and rights

Patients' privacy and dignity were maintained. We saw respectful interactions between staff and patients in recovery bays and on the surgical wards. Staff used quiet voices where necessary. Curtains were drawn around beds when necessary. Patients said that staff spoke to them in a respectful way and that their privacy and dignity were respected.

### Food and drink

Patients had adequate nutrition and hydration and, where appropriate, most patients were helped to eat. Patients were given drinks and snacks throughout the day. Protected meal times were in place on the surgical wards to enable patients to eat uninterrupted and be supported to eat if necessary. On one ward in particular, there was a system in place to check that patients needing help were supported to eat. However, on one ward we found that people were not being helped when required. Most patients were satisfied with the food, although few patients were aware that there was an option to order something to eat that was not on the menu.

# Surgery

## Are surgery services responsive to people's needs?

Patients' needs were not always met and improvements are needed.

### Patient feedback and complaints

We saw evidence that feedback from patient questionnaires had altered practice on several wards. Completion rates of the NHS Friends and Family Test was increasing, although the results were yet to be reflected in patient care.

Some patients were unaware of the Patient Advice and Liaison Service, which gives patients information and helps them with complaints, or they found that the hospital's on-site office had closed. There was a number for patients to call, although when we tried, we were unable to get through.

Many patients said that they did not know how to make a complaint and there was little or no information displayed on the wards about the complaints process. The trust had produced a new complaints leaflet (dated October 2013), although this had not been widely distributed.

### Responding to patients' needs

In theatres and on some wards, we found staffing levels to be satisfactory and people's needs were being met. We looked at medical records and made observations on the wards to check this.

People said that call bells were answered promptly. However, on some wards, staffing levels were either just sufficient to perform necessary tasks or, in some cases, insufficient to meet people's needs. One member of staff said that, with the staffing levels, "we've made it hard to care." Some patients felt that their medical needs were being met, but that staff were too busy to spend quality time with them. Patients reported long waits on the pre-admission wards (Hope and Poplar). There were 15 patients with medical needs on surgical wards ('outlier' patients). While their needs were being met, these wards were not the most suitable environment for these patients.

### Bed occupancy

Even though people were safe and cared for well, some patients were waiting too long in the recovery area before being admitted to a bed in a ward. One patient had stayed overnight in the recovery area before being admitted to a ward. Surgery planning meetings were held two weeks in advance of operations to prevent avoidable cancellations. However, operations were sometimes cancelled or delayed because of a lack of beds within the hospital.

There was an established system in place to review bed occupancy in the hospital on an on-going basis. Bed occupancy meetings were held several times a day to review the number of beds available, the patients who needed a bed and the patients who were due to be discharged. However, there were systemic problems that these meetings could not easily resolve. There were insufficient beds for patients. There were 15 medical patients on surgical wards. A temporary overflow ward was now open permanently. Patients were not always discharged promptly. This was partly due to delays in the discharge system and the wait for social care packages.

This constant pressure on bed numbers had a negative effect on patients' experiences and the quality of care. We reported on this situation following our last inspection in June 2013. The situation had not improved.

### Patient involvement in care

While some patients said they had been involved in planning their discharge, a number said that they had not been involved and that the discharge process sometimes seemed disjointed. Some patients reported that they had not had any discussions about being discharged, despite having been in hospital for some time.

## Are surgery services well-led?

While some wards were well-led and there was some good leadership at a local level, there were concerns about the trust's governance system overall and issues with low staff morale.

# Surgery

### Governance and leadership

Staff spoke of a governance structure that had become complex. They said that it was difficult to know who to raise issues with and, when they did know, sometimes no action was taken. Staff felt that local innovation was being stifled and that things were being driven from the centre of the organisation. Shortly before our inspection, the trust had strengthened the role of the site lead to address some of these issues. It is too early to determine whether this will have an impact.

Some senior surgical staff felt that there was a significant disconnect between the views of the leadership and the views of clinicians on what was in patients' best interests. Clinicians were concerned that the decisions of the leadership team would have a detrimental impact on the quality and safety of patient care.

On the theatres and the wards, staff felt that the surgical CAG and hospital nursing leaders were visible and accessible. They also felt that communication was good between these leaders and staff.

Some patients knew who the sister was on these wards. The sister had personally introduced themselves to staff. Patients felt that, on some wards, the nursing teams were well-led by the sisters. Some surgical wards were working effectively and were well-led. Other wards were not working as effectively, partly due to their leadership.

Staff morale was very low. Staff across all specialties were concerned about the staffing review and that experienced staff will leave, having a negative impact on the quality of patient care.

We received many comments about bullying and a lack of an open culture. Staff said they felt bullied by the organisation, particularly where changes to services and/or staffing levels were being implemented. Some people felt afraid to discuss their concerns with the organisation – in some instances about patient safety –for fear of reprisals. Staff felt that they had no voice. They said they used to identify problems and find solutions, but following the merger, they no longer did this.

# Intensive/critical care

## Information about the service

The critical care service at Whipps Cross University Hospital has a nine-bed intensive care unit (ICU). Two beds are for level-two patients and seven beds are for level-three patients. The hospital does not have a high dependency unit (HDU).

We spoke with staff, including doctors, nurses, senior managers and support staff. We observed care and treatment and looked at care records.

## Summary of findings

Overall, this was a safe, caring, effective and well-led service. Infection control was managed appropriately. There were enough appropriately qualified staff on duty. There was good education support and the unit learned from incidents and applied best practice guidelines. There were systems in place to monitor quality and safety. However, there were some delays to patients being transferred into and out of ICU and occasional single-sex ward breaches, although this was due to the shortage of available beds in the hospital.

## Are intensive/critical services safe?

The service was focused on safety.

### Patient safety and managing risks

An ICU consultant was the patient safety lead. Serious incidents in the unit were discussed at a hospital patient safety group where, if the incident was serious enough, a root cause analysis and action plan would be developed. Incidents were also discussed at team and unit meetings. Staff explained how they reviewed incidents to improve practice. One example was the prevention of pressure ulcers on patients' noses caused by ventilation masks. Staff used a chart to record the treatment plans and prevention and care observations. As a result, we were told that there had been none of this type of pressure ulcer for some years.

### Hospital infections and hygiene

Patients were protected from the risk of infection. There were appropriate infection control systems in place. The microbiology team visited the unit every day. Guidelines were followed on controlling or minimising the risk to patients from the bacteria pseudomonas aeruginosa to reduce to reduce the risk of infection. There were appropriate arrangements for patients admitted to the unit with an infection. The unit looked clean. Hand hygiene facilities were available and we observed staff following infection control guidelines, which were checked for compliance by an infection control link nurse. Appropriate facilities were in place for handling clinical waste.

### Staffing and skills

There were enough appropriately qualified staff to meet patients' needs, including sufficient consultant cover. Nursing staffing levels were in line with national and best practice guidance. The unit had a full-time clinical educator to support its training programme, which was mostly in-house to meet its training needs and to support bedside training. Training attendance rates were 95%.

### Equipment

Some essential equipment was out of use. The ICU had two ventilator trolleys: one had not been working for over six months, leaving the unit reliant on one trolley to transfer patients to the general wards. Staff had raised this issue with senior management and it was on the hospital's risk register, categorised as high. However, no prompt action had been taken and the information on the risk register was out of date. The arrangements to manage if the trolley was out of use or broken were inadequate. The lack of this essential equipment could have a potentially serious impact on patients.

# Intensive/critical care

## Are intensive/critical services effective?

The service is effective.

The ICU took part in the Intensive Care National Audit & Research Centre (ICNARC) national audit programme. The ICNARC data highlighted that patient mortality was above average, although the hospital is not an outlier. Unit-acquired MRSA infections were similar to other hospitals, as were non-clinical patient transfers and delayed discharges. Out-of-hours discharges to the ward were much lower than other hospitals. However, unplanned readmissions to the unit within 48 hours were higher than many similar hospitals. The unit had an audit office to support this process.

## Are intensive/critical services caring?

This was a caring service, suitable to the needs of patients requiring critical care.

### Patients' privacy and dignity

Staff were observed to be caring. The atmosphere on the unit was quiet, calm and purposeful. Staff were focused on the patients in the unit. Patients were positioned comfortably. They looked clean and well kept. Their bedclothes were clean and well ordered.

### Patients' rights

The unit had a restraint policy which had been developed in consultation with vulnerable adults and senior nursing, legal and governance teams. The policy considers the ways in which patients can be lawfully and appropriately restrained from removing life-saving equipment – such as the use of mittens, wrist restraints, and medicinal restraints. We observed one patient unconsciously trying to remove their tracheotomy tube. Staff were attending to the patient, but the mittens helped prevent the patient taking out the tube.

## Are intensive/critical services responsive to people's needs?

While services generally responded to patients' needs, the high demand for hospital beds, and the lack of a high dependency unit (HDU) meant that waiting times and bed transfer times were sometimes inadequate.

### Responding to patients' needs

Patients' welfare was regularly monitored to ensure that changes were responded to in a timely manner. Staff used a daily treatment record to complete all essential checks and observations and to record them in one place. This also provided an efficient way for staff coming on duty to see what had occurred during the last shift. The unit had implemented 'The Golden Hour', where, in the first hour of duty, staff were allowed to concentrate on handover and on completing and signing the shift checklist. This included checking the monitor alarms and other equipment, checking the patient's identification band against notes, reviewing wound and other documentation, damp dusting the bed area, shelves, trolleys and pumps, checking the clinical waste and completing a moving and handling assessment. We saw various care bundles in use on the unit, including bowel, central venous pressure (CVP) lines, spinal care, and palliative care.

The hospital does not have a high dependency unit (HDU). This means that there is a big impact on patients who are transferred from ICU to the wards. The trust has reviewed a business case for a HDU, although it has not been implemented. The trust should ensure that it is satisfied with its justification for not having a HDU.

# Intensive/critical care

### Bed occupancy

There were systems in place to monitor the demand for ICU beds and ensure that patients were discharged appropriately. However, the pressure on beds in the hospital impacted on the unit's ability to accept and discharge patients in a timely manner. A site coordinator moves patients to the wards following a decision to transfer out of ICU. The coordinator tries not to move patients from ICU after 8pm. The site coordinator monitored the capacity of external neighbouring hospitals' ICUs so that they can be aware of any potential surges into the emergency department and ICU.

ICU bed occupancy and throughput was high. Where possible, elective patients were allocated a bed in ICU before their operation. However, because of the demand for beds at the hospital, patients sometimes had to remain in the recovery area after their surgery for prolonged periods until ICU beds became available. We also found a female patient who had been waiting for more than 36 hours on ICU for a surgical bed. This had been classified as an unjustified mixed-sex breach and was nationally reportable. The hospital incurred penalty charges as a result.

### Quality care and treatment

The unit took action to improve the quality of treatment. We saw various examples of innovative practice and improvements to patient care. We were given an example of a patient who had airway abnormalities, which had made it difficult to intubate. Staff from all over the hospital had been brought in to help achieve the intubation. A debriefing was held afterwards, examining how to respond to a similar situation in the future.

## Are intensive/critical services well-led?

The unit was well-led, although we identified issues with the trust's clinical governance systems.

### Leadership

We saw evidence of leadership and innovation on the unit. There were clear lines of responsibility and definition of roles. However, some staff reported that, when they needed leadership from the trust, they did not always know who to go to and felt it was difficult to get things done.

### Managing quality and performance

There were systems in place to monitor the safety and quality of care and action was taken to address concerns. There was a comprehensive audit programme and evidence of action taken on the results of audits. There were monthly ICU clinical governance and critical care meetings across three hospitals (Whipps Cross, Royal London and Newham). The critical care group shared ways of doing things, for example, dealing with out-of-hours patient discharge and practice in accordance with National Institute for Health and Care Excellence (NICE) and Intensive Care Society guidelines. However, it was felt that this group could be more effective.

# Maternity and family planning

## Information about the service

Whipps Cross maternity service delivers more than 5,000 babies annually. The maternity services include an antenatal clinic with nine consulting rooms, a 40-bed antenatal and postnatal ward, including four transitional care cots, a labour ward and a triage area. The site includes a special care baby unit (SCBU) with capacity for 18 cots. The SCBU is a level 2 unit, which means that it has the capabilities to care for 27 week-old newborn infants who are at least 1kg at birth.

We spoke to 16 women, four partners and 40 staff, including midwifery assistants, nursery nurses, midwives, nurses, doctors, consultants and senior managers. We observed care and looked at the records of 12 women and babies. We reviewed comments from our listening event, from comment cards left at the hospital reception and from people who contacted us to tell us about their experiences. We reviewed performance information about the trust from internal and external sources and compared it against national guidelines.

## Summary of findings

We saw that improvements had been made in the maternity department, but further progress was needed. The service was clean, which was not the case at our last visit in June 2013. Reporting of faulty equipment and checking of resuscitation equipment had also improved since our last visit. However, other equipment was found to be faulty and there was still a need to improve the availability of safe equipment. The service had enhanced the way it learned from incidents and this should continue so that the changes are embedded. Women said that they felt staff cared for them well, although on occasions security staff were discourteous. Staffing levels were appropriate and there was sufficient consultant cover, although some staff said that there were times when they were stretched and could not provide one-to-one care to women in established labour. We found that the maternity service did not always respond to people's complaints in a timely manner. Although systems were in place for reporting and reviewing incidents, we did not always see evidence that appropriate action was taken. The risk register and meeting minutes we reviewed did not always demonstrate the sequence of actions taken to minimise the risk. Staff told us that current changes to the staffing structure were affecting morale and left some staff feeling undervalued.

# Maternity and family planning

## Are maternity and family planning services safe?

Patient safety in the maternity service had improved since our last inspection, but further progress was needed. Enhancements were possible, especially regarding equipment, site security and addressing potential risks. Staffing continued to be an area that could potentially create risks to patient safety and welfare.

### Patient welfare and safety

There were procedures in place to assess and manage risks to women or their unborn child at their antenatal appointments. These included both health and social risks, such as diabetes or their vulnerability to abuse. An audit conducted in July 2013 showed that the pathway for women before 18 weeks was not always followed consistently.

There were systems in place to deal with medical emergencies. The service used the Neonatal Early Warning Score (NEWS) to identify and escalate any deterioration. Staff had been trained how to use NEWS and in resuscitation. There were two unexpected admissions to SCBU in October 2013 and these cases were monitored to ensure that causes could be dealt with in the future.

### Equipment

Systems to ensure that essential equipment was available had improved, although further progress is required. At a previous CQC inspection in June 2013, concerns were raised about faulty equipment. During this visit we found that resuscitation checklist audits showed an improvement in adhering to daily resuscitation equipment checks. However, in October there were five incidents relating to parts missing from equipment, failure to check emergency equipment and equipment being inadequate or unavailable. Two people using the service said that there had been faulty cardiotocography equipment during their hospital stay between August and September 2013.

During an unannounced visit we also found that the umbilical cord blood analysis machine on the labour ward was not working. It had been reported and fixed several times. However on 22 November 2013, staff were running upstairs with blood samples to ensure that vital tests could be completed before the samples clotted. This matter needed to be addressed to ensure monitoring equipment was fit for use and that a blood analysis machine was easily accessible to labour ward staff at all times.

### Safeguarding

Staff demonstrated knowledge on how and where to report safeguarding issues. We spoke to named safeguarding leads for the maternity unit and the SCBU. The safeguarding leads liaised with the women, family, health visitor and other relevant agencies to ensure safe antenatal care and safe discharges. Staff told us they had attended safeguarding training. We saw a training matrix on the SCBU, showing that over 60% of the nursing staff had completed training for safeguarding vulnerable children.

We were told that there is work to improve cross-sector working between local authority, primary care and maternity teams to identify vulnerable families during antenatal care and to minimise any unnecessary delay in processes after birth, which can affect the woman and/or baby's length of stay.

There were security risks at the maternity unit entrance. Although a security guard was in attendance, checks to ensure visitors signed in and out upon entry and exit were inconsistent. We observed several instances over the three days of our visit where visitors entered without signing in and were allowed to leave without proper security checks. During an unannounced visit we observed the reception area for 40 minutes. The security guard failed to ensure that all visitors to the unit signed in.

### Managing risk

The hospital was learning from mistakes, but there were improvements to be made. Staff could describe the system for reporting incidents. They felt lessons to be learned from incidents were disseminated well by management. Monthly "hot topic" newsletters were displayed and included details of incidents and any subsequent changes to policies and procedures. Security issues had been identified as a risk on the maternity risk register. We also found that the way the midwife rota system was configured was difficult to understand and did not always reflect if staff had been moved to other maternity departments.

# Maternity and family planning

The trust had identified that delays in the induction of labour was a contributory factor in some cases leading to high caesarean section rates. A redesign of the induction of labour suite was due to be completed by September 2013, although this was yet to be implemented.

### Infection control

Patients were protected from the risk of infection. At a previous inspection, concerns were raised about the cleanliness of the environment. On this visit, the premises were clean. Clinical waste bins were not overfilled and communal facilities were visibly clean. Cleaning schedules and cleaning audits were completed and showed improvement. We observed staff using hand gel before and after patient care. Hand gels were available and hand gel dispensers were working properly, which was not the case at the last CQC visit. However, during our 40 minute observation of the maternity main entrance, we saw some staff leaving the premises wearing theatre scrubs but no covering protective overalls.

### Staffing levels

On occasions, staffing levels did not meet the needs of patients. At the time of our inspection there were sufficient numbers of staff to meet the needs of women on the unit. The midwife-to-birth ratio was one midwife for every 32 births, which was higher than the national guideline of 1:28 but within the trust's target. We reviewed midwifery and medical staff rotas and found that the rotas corresponded with the hospital's establishment most of the time. Consultants were available on the labour ward 60 hours a week, including weekends, as recommended by the Royal College of Obstetricians and Gynaecologists. Nursing staff told us that weekends were difficult as there was reduced cover on the SCBU.

According to the performance report for October 2013, there were only six workload-related incidents or understaffing issues recorded. However, staff seemed to think this happened more than reported. We were told that the procedure to book bank (overtime) staff took too long and sometimes resulted in shifts remaining unfilled. Women who shared their experience with us also highlighted that they had waited for a midwife to attend to them during labour and were left alone for lengthy periods. It will be useful for the provider to note that the rotas were not always amended when staff moved to other departments. We also saw that, on the night shift of 6 November 2013, there were more staff on duty than required by the trust.

There were two obstetric theatres. However, only one was used due to staffing issues. Staff told us that if a patient required an emergency caesarean section, it was difficult to get staff to enable a second theatre to operate. This was a potential risk to patient safety.

## Are maternity and family planning services effective?

The maternity service at Whipps Cross provided effective treatment to the majority of women using the service. Where there had been shortcomings in care, the service had identified risks and was in the process of responded to them. However, changes to staffing structures were impacting on the ability of staff to consistently provide effective care.

### Benchmarking and national guidelines

The service's mortality rates were within expected ranges. The service's caesarean-section rate was 27.02%, higher than the national average. The trust had identified links between failed induction of labour and the unplanned caesarean section rate, and the service was in the process of redesigning induction of labour suites to address this. Although it had been planned to open in September, the new suite was not yet in operation at the time of the inspection.

We saw that there were up-to-date policies and protocols which were available to staff on the trust's intranet. However, staff told us that they could not always access a computer and showed us printed guidelines which did not always correspond with the online guidelines.

There was a programme of clinical audit to ensure the service was providing effective care. The outcomes of these audits were shared with staff and training was provided where necessary for the SCBU. However, staff were not able to explain whether the recommendations resulting from an audit of the gynaecology pathway for hemiparesis in July 2013 had been implemented.

# Maternity and family planning

### Collaborative working

Staff collaborated with each other in the interests of patients. We observed a staff handover on the labour ward and postnatal ward. On the labour ward, handover was attended by consultants and doctors in addition to the midwives. The SCBU and maternity service, including fetal medicine, worked closely together to ensure that any potential admissions to the SCBU were identified as earlier as possible.

### Staff skills

There were enough appropriately trained staff to meet patients' needs. Midwives had statutory supervision of their practice and met a supervisor of midwives formally every year. They could approach the supervisor of midwives for advice. We were told that 14 midwives had attended a critical care course and the service aimed to enable at least one midwife on the labour ward to attend the course annually to improve critical care skills. Staff working on the SCBU were all up to date with mandatory training. Appraisals were almost completed and there were clear developmental plans for each staff member. We reviewed rotas dated between August and October 2013 and found a good skills mix. There were plans in place to start a rotational programme across the site to enable staff to gain varied experience.

### IT and administrative support

Some staff told us the service's IT systems were being changed in line with the rest of Barts Health NHS Trust and an IT consultant had been contracted on a sessional basis to support this process. They sometimes had problems with accessing IT and administration staff were undergoing training. As there was to be a reduction in administrative support, midwives felt they would spend more time on administrative tasks which would affect their ability to provide effective care.

## Are maternity and family planning services caring?

Most women told us they felt they had been well cared for. We reviewed comment cards, completed by women during our visit, and found that most had a positive experience. There was some negative feedback about the care for women who had emergency caesarean sections as they felt they did not always know what was happening and became more anxious when they saw staff rushing them to theatre. While most people were positive about the attitude of staff, four women we spoke with told us they had been waiting for discharge but had not been kept informed.

We spoke to some parents whose baby was being cared for in the SCBU. They were satisfied with the quality of care being provided. We saw rooming-in facilities for parents to use to gain more confidence in caring for their baby before discharge.

However, we heard the security staff at reception speak to members of the public discourteously.

### Privacy and dignity

Women's privacy and dignity were maintained most of the time. We observed staff speaking to women and their partners in a compassionate and professional manner. Delivery rooms on the labour ward had en suite toilet and shower facilities. The antenatal and postnatal wards had a mixture of shared bays and private rooms. On the antenatal clinic, doors were kept closed during consultation, with the exception of one episode where a midwife was giving advice loudly while the door on the staff side of the consulting rooms was kept open.

There were systems in place to provide psychological support, including a bereavement service. There were two dedicated rooms for bereaved families where people could spend the night if they wished and a separate room in the scanning department which could be used to break bad news.

## Are maternity and family planning services responsive to people's needs?

Improvements were needed to ensure that services were responsive to women's needs.

### Accessible services

Women felt that their needs had been met at each stage of their pregnancy. A home-birth service was available, which was provided by the community midwife team. However, the team told us that they were struggling to cope as their hours and working arrangements had been changed. This meant that women had to wait for long periods before a second midwife arrived to assist with a home birth.

# Maternity and family planning

### Accessible information

Women were provided with sufficient information about their care and the service. Women kept their medical notes in relation to their pregnancy up until they delivered their baby. We saw that their antenatal notes included information on who to contact if they were concerned about anything. There was a range of information leaflets available on various topics, including tests, breastfeeding and stopping smoking. Women were given a pack when they attended antenatal clinic which also included information such as posture and antenatal classes. Although all information was in English, staff told us they used Language Line document translators and the pictures in the leaflets to bridge language barriers. It would be useful for the provider to note that the packs were of a poor photocopy quality and contained information relating to legacy sites.

### Continuity of care

Women did not always receive a continuity of care. We found that, for twin pregnancies and women who had medical conditions which prevented them from having a normal birth, there was a lack of continuity of care. This was because women saw the midwife at booking and then were cared by the obstetrician without any midwife input. It would be useful for the provider to note that continuity was also an issue for women from outside the borough, as it meant that they saw their local midwife after the birth but saw the hospital antenatal team before birth.

Women who had twin pregnancies and women with medical conditions told us that they did not experience continuity of care and did not have information or a discussion about choices such as mode of birth, breastfeeding or parenting during pregnancy. This was because although they had first booked with a midwife in the community, once they were referred onto a 'complex' pathway they were cared for a team at the hospital led by an obstetrician and would not have any contact with the community maternity team until after the birth. It would be useful for the provider to note that continuity was also an issue for women from outside the borough as they also saw the hospital team during pregnancy and their local midwife after birth.

### Patients' feedback and complaints

Patients' experiences and complaints were used to improve the service and the effectiveness of treatment, although improvements were needed. The trust was in the process of using women's experiences of care to improve the service through patient surveys, complaints and comments. The 'Great Expectations' programme was launched in August 2013 to improve women's experiences. We reviewed four staff files on the labour ward and saw evidence of how the matrons had attempted to address poor staff attitudes towards the women and colleagues. It would be useful for the provider to note that not all staff were aware of this programme.

It was concerning to note that the trust was not working in partnership with the Maternity Services Liaison Committee (MSLC). The MSLC had not been consulted or involved in the Great Expectations Programme or any other initiatives to respond to and improve women's experiences.

Staff were able to explain the complaints policy and procedure but could not always show us where complaints leaflets were kept. Staff told us that, if someone made a verbal complaint, they would attempt to resolve this at the time. All complaints were escalated to the ward manager or matron.

## Are maternity and family planning services well-led?

The service was mostly well-led, but there were issues to address to ensure that leadership and working across all hospitals in the trust contributed to better services for patients.

Changes to the staffing structure were causing anxieties among staff at all levels. They felt supported to a certain extent. However, the hospital needed to involve staff at all levels to a greater degree in the proposed changes.

### Leadership

The leadership of the maternity department was evolving. There was a new head of midwifery post for the hospital, and they had had four different people in this post over

the last 18 months. We found that there were champions (or staff who were passionate about aspects of care) for areas such as breastfeeding and fetal medicine. However, there seemed to be no clear structure in place in order to allow for continuity in the absence of the named lead.

Some staff across all disciplines were anxious about proposed staffing changes and were uncertain of how the governance structure would work. Other staff felt that there was a lack of consultation or staff involvement regarding proposed changes. They reported that messages were shared with staff once decisions had already been made by senior management. Another group felt that Whipps Cross was told what to do by Barts Health without any explanation. Integration and joint working across sites was still fragmented.

Some staff told us that any concerns they raised were not always dealt with but others felt the opposite. Some staff felt victimised for speaking out about poor care. Others said they were told not to say much at the CQC inspection or felt that, if they told us anything negative, they would be victimised.

### Managing quality and performance

Quality of care and safety was monitored using monthly performance dashboards – an online performance reporting and tracking system. The dashboard showed (at 31 August 2013) low rates of natural birth at 57%, while caesarean-section rates were slightly high at 27.02%. Only 93.8% of venous thromboembolism (VTE) – blood clot assessments were completed within 24 hours of admission (95% was the benchmark).

It was difficult to establish whether lessons were learned from incidents as root cause analyses following incidents were not made available to us. Staff received a newsletter covering 'hot topics' to ensure that they were aware of the latest incidents, although this had only recently been introduced. However, for the SCBU, there was evidence that the neonatal governance dashboard was reviewed by senior staff. They were aware of the top five risks on the risk register and what action was being taken. Senior staff went back to the wards on 'clinical Fridays' to observe and evaluate care.

# Children's care

## Information about the service

Whipps Cross University Hospital provides medical and surgical services for children on an unplanned and planned attendance. This includes a general inpatient service, medical and surgical day case services and a dedicated 24-hour children's A&E service.

A&E facilities provide a five-bed children's observation bay, four children's treatment rooms and a children's resuscitation bay allocated within the main A&E resuscitation area. A designated children's ward accommodates 27 inpatient beds (16 cubicles and 11 bays), a 10-bed day case surgery unit and a four-bed medical day case unit.

We spoke with patients and staff, including doctors, nurses, senior managers and support staff. We observed care and treatment and looked at care records. We also reviewed performance information about the trust.

## Summary of findings

Overall, children's care at Whipps Cross was caring, effective and well-led. However, there were some issues around equipment checks, record-keeping and communication with families.

Parents and children were generally happy with the care they had received and felt they had been supported by caring and considerate staff. There were systems in place to ensure patients' safety and minimise risks in relation to medication management, although the effectiveness of the measures in place had yet to be determined. Equipment checks of resuscitation trolleys and records of medication expiry dates were not consistently completed. Children's care and treatment was monitored through participation in local and national clinical effectiveness audits. Facilities were appropriate to provide holistic care to children and young people, including developmental play and educational support.

Communication and information provided to families was not always responsive to their needs.

## Are children's care services safe?

Services were mostly safe, but some improvements were required.

### Staffing

There were enough trained staff to meet patients' needs. There was a dedicated team of paediatric trained nurses on the children's ward. Current nursing staff levels met national guidelines. Consistent agency staff were used to fill any gaps in rotas. Nursing staff numbers were increased during winter months in children's A&E with an additional two posts for part of the night-shift period. Some A&E nursing staff raised concerns about being under pressure when gaps in the rota could not be filled or when the department was busy. Medical staffing in A&E included paediatric consultant cover during the day and on-call support out-of-hours.

### Safeguarding children

Staff were trained in safeguarding children and had good links with the trust's designated safeguarding team. Supervision sessions were conducted by the safeguarding team to provide staff a platform for reflective learning from reported safeguarding incidents. Staff we spoke with were familiar with the escalation and reporting process if safeguarding concerns were suspected. The patient administration system automatically notified staff if a child was on the child protection register.

### Medication risk management

Systems were in place to identify medication prescribing errors. A designated paediatric pharmacist provided daily specialist input and support. This included clinical checks of medication charts. However, we noted a medication prescribing frequency error that appeared not to have been identified through the system check process. We brought this to the attention of clinical staff.

A teaching programme for junior doctors about children's medication prescribing had recently been initiated. This was to include 'before and after' audits of medication prescribing errors to monitor training effectiveness. Outcome data had yet to be collated. Training records demonstrated that nursing staff were required to pass medication competency assessment tests.

# Children's care

There were inconsistencies in the monitoring of medications. We saw that reconstitution dates of medical suspensions were recorded on bottles stored in the fridge on the children's ward. This meant that expiry dates could be monitored to ensure medication efficacy. In contrast, monitoring records did not appear to be consistently maintained in children's A&E. We observed that medication expiry checklists reported to be completed monthly had not been recorded on five occasions between February 2013 and October 2013.

### Equipment

Equipment checks were not always consistently monitored or documented in all areas. Staff on the children's ward reported that the resuscitation trolley was checked at least daily but we did not see documentation to support this. Missed checks or incomplete records were also noted on daily resuscitation trolley checklists in children's A&E. The checklist approach did not make it easy to identify if corrective actions had been taken to address any deficiencies found.

### Hygiene and environment

The children's wards and the A&E department were visibly clean. We observed examples of good hand hygiene and infection control procedures. We saw staff cleaning clinical areas including beneath the beds and patient bathrooms in accordance with cleaning schedules. Single-occupancy rooms were available for children who required barrier nursing. Disposable bedside curtains were in use and dated. Monthly infection control audit records for the department demonstrated high standards of cleanliness.

## Are children's care services effective?

Overall, children's services were effective.

### Clinical management and guidelines

Children's care and treatment was monitored. We saw that the paediatric clinical audit programme for 2013/14 was regularly updated in line with National Institute for Health and Care Excellence (NICE) professional guidelines. Records demonstrated that Children's A&E participated in a number of College of Emergency Medicine (CEM) clinical effectiveness audits, which measured the department against national standards. The Paediatric Early Warning Score (PEWS) system was used in the assessment and monitoring of children in A&E. An internal audit by the department to assess compliance with PEWS guidelines had been carried out in May 2013.

## Are children's care services caring?

Overall, children were well cared for by staff.

### Patient feedback

Most of the families and children we spoke with told us that they had been supported by caring and considerate staff and that they felt well looked after. Comments included: "Well looked after"; "Very well cared for and informed"; and "Hundred per cent happy".

### Support for children and their families

We observed many examples of compassionate and sensitive care from staff at all levels. Medical staff interacted with children and explained treatment processes at an age-appropriate level. Pre-admission clinics to prepare children and families for planned surgery were operated weekly. Facilities were available to allow parents to stay overnight with their children on the inpatient ward and parents were allowed to stay in the anaesthetic room when their child was taken to theatre. Provision was made to assist people with concessionary car parking charges when children were admitted as inpatients and when children's A&E waiting lengths were prolonged.

### Food and drink

Food and drink was provided to children attending A&E when needed and was available day and night.

Children had adequate nutrition and hydration, but some children went without food for a long time while waiting for an operation. We observed lunchtime meals being served on the inpatient ward. A limited menu was available, including alternative options to meet specific dietary requirements and cultural needs. Some parents expressed concerns about the length of time their children had food and drink withdrawn when theatre lists were delayed.

# Children's care

### Bereavement

Effective bereavement arrangements were in place. The hospital had a bereavement care policy and pathway to support families in the event of a child's death. Clear guidelines were documented for staff to follow with a checklist of actions to take. Bereavement support information and details of support services for parents and siblings were provided at the point of need. Private rooms were available for bereaved families to use. The trust's chaplaincy service accommodated all faiths and was accessible day and night.

## Are children's care services responsive to people's needs?

Improvements are needed to ensure that staff and services are responsive to children's needs.

### Assessment and care plans

Children were not always monitored. Children on the inpatient ward were assessed regularly by the medical team to update management plans according to progress. Nursing teams completed care plan documentation on admission to the ward, which was maintained during the patient's stay. Nursing staff used an age-appropriate pain management guidance system. A young person we spoke with on the inpatient ward described being in pain after a tonsillectomy. We noted that pain score assessments had not been recorded for this patient and pain relief had not been given as prescribed. We raised this with clinical staff. Other parents and children we spoke with on the day surgery unit reported to be happy with their child's clinical management. They told us that nursing staff had checked their child's temperature, blood pressure, pain relief and nutritional needs.

### Transition

Arrangements were in place for the transfer of critically ill children to specialist paediatric specialist centres by the Children's Acute Transport Service (CATS).

### Communication and information

Information for families in the urgent care assessment unit was inadequate and led to confusion and anxiety. On arrival, patients were given coloured cards that triaged people to either children's A&E or a GP-led service. This led to confusion as red cards used to stream patients to children's A&E were interpreted by some people to indicate urgent priority. One parent told us, "We had to wait 30 minutes despite the red card and had to make a fuss to be seen". Parents also said they were not made aware by triage staff of the family room available in the urgent care waiting area. This meant that children may wait to be seen in an adult urgent care environment which was inappropriate to their age.

### Education and developmental needs

Effective education arrangements were in place for children. School facilities provided in partnership with the local authority and a children's play area was available for use on the inpatient ward. The team managing the service included qualified teachers, play specialists and nursery staff. Teaching was provided during term time and educational needs determined through liaison with children's regular schools to provide supportive and appropriate educational lessons through to GCSE level. We observed that the play area was well equipped with a variety of age appropriate play equipment. Parents we spoke with commented positively on the play facilities provided. Separate facilities for older children on the inpatient ward were restricted. Staff told us that efforts were made to facilitate for children's maturity.

### Consent to treatment

Parents and children told us they were provided with enough information to give informed consent to treatment. This included information about the associated, risks, benefits and alternative options. One parent and young person described the risks of the procedure they had undergone. This correlated with the signed consent documentation in the patients file. Another child awaiting surgery said, "The doctors have told me about the risks – bleeding, vomiting, neck pain, joint pain – but it is only one percent so I should be okay".

# Children's care

## Are children's care services well-led?

Children's services were well-led.

### Managing quality and performance

Safety and quality of care were monitored and action taken to improve performance. Senior managers had a clear vision for service improvement and development of children's services. Paediatric improvement programme groups had been established to encourage service development in children's inpatient and emergency care services. We saw records of quality improvement projects which examined issues such as length of inpatient stay and discharge delays. Patient Reported Experience Measure (PREM) surveys were undertaken to provide patient feedback on specific quality of care improvements that could be made. These included the Young Inpatients Survey 2103 and Your Child's Emergency Care.

### Leadership

Children's services were well-led. However, many staff expressed their concerns about future leadership and support especially at an operational level.

Staff worked together as a team and there was good communication between A&E and the inpatient ward. Staff records demonstrated that nursing staff received annual appraisals and had access to mandatory and professional development training relevant to their roles. A comprehensive in-house training programme for A&E nursing staff had been developed by the department's practice development team. Training included skill competency assessments.

Nursing staff meetings were held regularly and provided a platform to discuss issues and provide feedback about incidents that had occurred. Minutes of the inpatient ward nursing staff meetings documented problems with use of patient-controlled analgesia pumps. We saw that instruction was provided to staff to prevent re-occurrence, pending the outcome of formal investigation by the trust. An issue relating to discharge medication and the correct procedure to follow was also circulated to staff.

# End of life care

## Information about the service

Palliative care is provided in the 11-bed Margaret Centre. There is also a bereavement service, mortuary and Macmillan cancer support shop front. Staff from the Margaret Centre provide end of life care services within the hospital.

We spoke with staff in the Margaret Centre, bereavement service, mortuary and Macmillan staff on site.

## Summary of findings

We found that the service was generally safe, effective and caring. Staff worked together well to deliver end of life care in a compassionate and effective way. The hospital was following national guidelines in relation to end of life care and had stopped using the Liverpool Care Pathway. Patients said that they felt well cared for by staff. However, the unit where end of life care was delivered was in need of refurbishment as it compromised patients' privacy and safety. In particular, there were no bathing facilities available. There was no out-of-hours palliative medical cover or speciality specific advice, although the hospital plans to put this in place in 2014.

## Are end of life care services safe?

Improvements are required to ensure people are cared for in a safe environment.

### Patient safety

Patients on medical wards who were on end of life care pathways were also supported by the palliative care team based at the Margaret Centre and we found examples of safe and effective care. On one ward, we found incorrect information on a 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) form.

### Buildings and environments

The environment at the Margaret Centre was in need of updating. Staff told us that, before our announced visit, the trust was considering the possibility of a refurbishment as they recognised it was in need of attention. The Margaret Centre was located to the rear of the main hospital building. There was no covered route between the two buildings and we observed one patient in a critical condition being transferred in the rain. The floors had started to lift in places and the decoration was tired and worn through natural wear and tear.

## Are end of life care services effective?

Care and effective treatment results in the best quality of life.

### National guidelines

The centre adhered to government guidelines. The Liverpool Care Pathway was no longer in use and the service was using a 'comfort care plan' which placed emphasis on nursing observations. This was in place at the Margaret Centre, but not on medical wards. A matron spoke to us about managing the treatment of symptoms, pain management, dignity and involvement of relatives through the comfort care plan.

### Collaborative working

We found Margaret Centre staff collaborated well with staff on the wards. As well as meeting the needs of inpatients at the centre, the team also worked with end of life patients on the wards in the main hospital. We sat in on the weekly multidisciplinary team meeting comprised of two consultants, two nurses and a psychologist. The team discussed new referrals and on-going cases they provided support for. A set format for discussions ensured that individual needs were met, including diagnosis, prognosis, family, spiritual and psychological needs. Plans of action were agreed, based on identified needs.

## Are end of life care services caring?

Staff were caring towards patients. However, the layout of the premises compromised patients' privacy and dignity.

Staff based at the Margaret Centre went onto the wards, offering support, advice and medical input to hospital ward staff delivering care to patients at the end of their life. We observed compassionate and patient-centred care provided by the team, who spoke with patients and key ward staff about patient care. All of the patients and relatives spoke very highly of the service provided by the Margaret Centre and also very highly of the staff. One

# End of life care

patient said, "they do things when they say they will and with such willingness. The care is outstanding". People had a genuine affection for the centre because of the care they had experienced.

We observed two good examples of end of life care on medical wards. Where a patient had recently died, we observed the Senior Sister contact the patient's spouse and deal with the situation in a personalised and dignified manner. Patients were supported by other ward staff and there were plans in place to follow up patients to reassure them. Staff were debriefed on the same day. In another example, we found a patient was at end stage of cancer but had made the decision to stay on the ward rather than be transferred to the Margaret Centre. The ward and palliative care team supported these wishes and worked to care for the patient on the ward.

The bereavement service was committed and compassionate. The service was contracted to a private funeral company which was staffed from Monday to Friday with an on-call service available. The bereavement officer offered support, advice and guidance as well as assisting with viewing of the body.

### Privacy and dignity

The layout of the premises compromised patients' privacy and dignity. There was no reception area and all visitors had to wait outside while their enquiry was dealt with by staff. On entry to the building, visitors would immediately enter a clinical area. Staff walked past people's open bedrooms to get to offices.

## Are end of life care services responsive to people's needs?

The service was responsive to patients' needs, although improvements were needed to the ward environment.

### Meeting patients' needs

The environment did not meet patients' needs. All accommodation at the Margaret Centre was in single rooms which did not have en suite toilet facilities. The building contained only two toilets, neither of which were accessible to wheelchairs, and only one shower. All patients used commodes due to the lack of toilet facilities rather than because of levels of independence or support needs.

There were no arrangements in place to enable medical and surgical wards to access end of life care at weekends, although there were informal arrangements. The hospital had plans to provide end of life care to wards at weekends from April 2014.

There was a clear and unimpeded pathway to the mortuary for relatives to follow when they wished to view the body. This respected people's dignity. In the event of a death on a ward, the body was taken from the ward to the basement, which was not accessible to the public, by lift.

We reviewed the end of life pathway on one ward. Staff appeared clear about the procedures to be followed at end of life stage. An extra side room had been allocated for use in emergencies which included patients who were dying. Ward staff told us that they were happy to involve relatives in end of life decisions which they felt had been restrictive under the previously used Liverpool Care Pathway.

Where people had a prognosis of end of life within three months, a 'fast track' process enabled funding and a care package to be arranged in a matter of days from the point of application. We traced some cases that had followed this pathway and found people had been swiftly enabled to go home or to a nursing home. This was in contrast to applications for non-end of life continuing care, where people experienced delays.

### Patient records and consent

The majority of the 'do not attempt cardio-pulmonary resuscitation (DNA CPR) forms we reviewed had been fully completed.

### Patient feedback

There were mechanisms in place to obtain feedback from patients and their families. The service told us that they felt the NHS Friends and Family Test was not the most suitable form of gaining feedback from people who were bereaved.

The service also distributed comment cards. We saw a lot of complimentary comments about the Margaret Centre from both of these sources. People had made negative comments about the centre's accessibility from the community and the state of the ward environment.

# End of life care

## Are end of life care services well-led?

Improvements were needed to the way that the service was led.

### Leadership

The Margaret Centre's itself was well-led and patients were cared for well by staff. However, there was a lack of support for palliative and end of life care from the senior management. Staff felt 'done to' by Barts senior management. We found that 80% of referrals came from the main hospital and 20% from the community. Due to a high hospital mortality rate and beds in the Margaret Centre being controlled by hospital bed managers, patients from the community had difficulty accessing a bed for palliative care. There were also cases where patients without palliative care or end of life needs were inappropriately placed in the centre by bed managers.

### Managing quality and performance

Quality and performance was being monitored. The trust data collection returns were submitted, but the centre did not receive feedback on performance from the trust. Staff at the Margaret Centre viewed the trust as unresponsive to the needs and challenges faced by the service.

# Outpatients

## Information about the service

A wide range of outpatient services were available at Whipps Cross Hospital. Adult services were split across five teams: medical; surgical; orthopaedic; ear, nose and throat (ENT); and oral. Children's outpatient services were also provided.

We visited the main outpatients department and spoke with patients and staff across a number of specialities. We observed care and treatment and looked at care records.

## Summary of findings

Overall, improvements are needed. Outpatient services at Whipps Cross Hospital were caring and well-led with some issues around waiting times, information governance and over-crowded clinics. Transformation projects were in place to improve waiting times and patients' experiences. The department was generally clean and hygienic but waiting rooms were overcrowded. There were long waiting times for many clinics. However, the trust was aware of these issues and had strategies in place to address them. Patients were pleased with the treatment they received and felt well informed and involved in decisions about their care. Patients' dignity and respect were maintained by staff in the outpatients department. There was evidence the department had made efforts to ensure its services were accessible and responsive to people's needs. Some people reported difficulty in re-arranging appointments that had been made for them.

## Are outpatients services safe?

Services were mostly safe, although some improvements were needed.

### Safeguarding

Staff we spoke with had received safeguarding training and were aware of the processes to follow if any concerns were suspected.

### Hygiene and infection control

The whole outpatient area appeared clean and well maintained with cleaning staff clearly visible in the department. Cleaning audits were maintained and daily spot checks performed by facilities management. Hand sanitiser was available for patients and visitors to the department with dispensers kept in each clinic reception area and spaced around various locations. The department had an infection control link nurse. Cleaning date labels on equipment and furniture in treatment rooms were visible across the department. It was noted that a changing mat in the children's outpatient area was ripped and would be difficult to clean.

### Buildings and environment

The outpatient service was provided in an accessible environment suitable for wheelchair access. We noted that some waiting areas were overcrowded with insufficient seating for people, posing potential trip hazards. We also observed an overspill of adult patients into the children's waiting area in one clinic.

### Equipment

Staff did not always have access to the equipment that they needed. Resuscitation trollies and equipment were available in the department. Some trollies were shared between outpatient areas. Staff in children's outpatients told us that they did not always have access to equipment to meet children's needs. There was no electrocardiogram (ECG) equipment in the general outpatient department. This meant that children who required ECG tests had to be directed to children's A&E. There was no trained paediatric nurse in the clinic on Thursdays, which meant children would have to go to the ward if they required an injection.

### Patients' records

Patients' records were appropriately stored, with one exception. We observed over 30 boxes of archived patient medical records stored in a corridor accessible to the public. This raised issues with both fire safety and information security. We raised this with senior staff who informed us that the issue had been formally escalated and a solution only recently identified. We were told records were due to be removed the following day for safe storage. We returned to this department a week later and observed that these records had been removed.

# Outpatients

## Are outpatients services effective?

Improvements were needed to the effectiveness of outpatient services.

### Operative function

We learned that there were long waiting times for first appointments in some outpatient clinics. The trust was aware of the issues and measures were in place to address them. Senior staff informed us that extra clinic lists had been added, including sessions in the evening and on a Saturday. Locum staff had been recruited to cover sickness and reduce waiting times. There were plans to start telephone clinics from December 2013 to further reduce waiting times.

Outpatient sessions frequently ran late. Staff told us that one of the reasons for delays was that new patient appointments, which require more time, were being allocated the same time slot length as follow-up appointments. Delays were also caused by missing information from patient records – for example, referral letters and discharge letters missing on the day of clinic. We observed that there was an escalation process in place for reporting missing information so that this could be tracked through to the relevant department.

We discussed with a clinical lead how effectiveness was monitored. We were told that clinical outcome audits were used to monitor performance against national standards.

## Are outpatients services caring?

Outpatient services were caring.

Many patients we spoke with talked about caring and approachable nurses and doctors. They were given appropriate information and support regarding treatment and felt involved in decisions about their care. One patient said, "Doctors are fine and nurses are fine – they give good information and explanations". Another person said, "The doctors and nurses are brilliant. They discuss treatment and care and speak my language not medical jargon" and "Cardiology is out of this world, fantastic".

### Dignity and respect

Patients' privacy and dignity were respected. We saw that consultations took place in private rooms with closed doors. Nurses were seen assisting patients into the clinic rooms. Conversations between staff took place in private clinical areas to maintain patient confidentiality. A lead nurse told us that attitudes on respect and dignity were a key focus at recruitment and nursing appraisal.

### Communication

Patients told us that staff kept them informed if there were delays to appointments. We observed staff updating information boards with the expected appointment delay time. Reception staff also informed people on arrival of waiting times. There was an information desk manned by volunteers to provide direction to the relevant outpatient clinic area. We observed a colour-coded department guide to assist patients in finding their way to different access points within the department and wider hospital. Information about potential outpatient clinic waiting time was provided in appointment letters. Leaflets on the complaints procedure were available in 34 different languages. Language Line, an external translation service, was used to provide interpreters for patients as needed.

### Patient support

A number of initiatives had been put in place to improve patients' experiences while waiting for their clinic appointment slots. These included a refreshment trolley providing tea and coffee free of charge, twice a day and student beauticians who visited the clinic waiting rooms twice weekly to give hand massages.

## Are outpatients services responsive to people's needs?

Improvements were needed to ensure that the outpatient department was responsive to people's needs.

### Waiting times

People we spoke with reported long waiting times in the outpatient department. Several people described that the wait could be two to three hours. Someone said, "You wait for ages if you need blood tests". A specific issue

# Outpatients

was raised regarding the orthopaedic clinic and x-ray department. One patient described an hour wait to be seen by the orthopaedic team only to find they required an x-ray for the consultation to continue. They then had a further half-an-hour wait in x-ray before returning to the clinic.

### Appointments

Staff informed us there were additional appointment slots available in clinics to allow urgent referrals to be seen promptly. Some people we spoke to found it difficult to re-arrange their appointments. One patient said they tried to call five times to re-arrange an appointment which clashed with a holiday but could not make contact with the outpatient department. We noted that one of the standards in the transformation project which was in progress aimed to ensure in the future that every patient has a telephone number for every specialist department.

### Patients' experiences

During our visit we were told by a senior member of staff about a unique project the trust had been engaged in called 'Patients as People'. The project sees patients annotate photographs taken of them with prior consent, to illustrate their hospital experiences and reaction to these. This could provide an insight for staff about the emotional experiences of people attending the hospital.

## Are outpatients services well-led?

Outpatient services were well-led.

### Managing quality and performance

There were appropriate systems in place to monitor quality and performance. Senior managers had a clear vision for service improvement and development of outpatients services. A transformation project was in progress to shape future service delivery which set out clear standards of improvement and how these were to be achieved. These standards included reducing waiting room times and the time taken for outpatient summary notes to reach GPs. A similar transformation project was also in progress to address children's outpatient services.

Some clinics had issues with patients missing appointments which meant there were vacant slots that could have been used by other people. The trust addressed this issue by sending patients a reminder letter two weeks before their appointment was due. We were told that a text messaging reminder system was also planned for the future. To reduce late clinic list cancellations, doctors are required to give six weeks' notice before their clinic can be cancelled.

# Good practice and areas for improvement

## Areas of good practice

Our inspection team highlighted the following areas of good practice:

- Staff were compassionate, caring and committed in all areas of the hospital.
- The intensive care unit (ICU) was safe, met patients' needs and demonstrated how improvements could be made through learning from incidents.
- Improvements have been made in both accident and emergency and maternity services since our last inspection and we saw some good practice in these departments.
- Palliative care was compassionate and held in high regard by staff, patients and friends and family.
- We saw some good practice in children's services, particularly in relation to education and activities for children while in hospital.
- The hospital was clean and staff adhered to good infection control practice. Staff worked well together in multidisciplinary teams.

## Areas for improvement

**Action the hospital MUST take to improve**

- Ensure staffing levels meet people's needs on all medical and surgical wards.
- Address delays to providing care. Patients' discharge from hospital is sometimes delayed. This impacts on other areas of the hospital and its effective functioning.
- Ensure that equipment on the medical and surgical wards and in ICU is always available, appropriately maintained and checked in accordance with the trust's policies and safety guidelines.
- Improve staff morale is low across all grades.
- Make changes to the culture of the organisation. There is a lack of an open culture. Staff feel bullied and unable to raise safety issues without fear.
- Make changes to the hospital environment. Some parts of the hospital do not meet patients' care needs. The hospital environment in the Margaret Centre and outpatients compromises patients' privacy, dignity and safety.
- Ensure that patients know how to make a complaint. Changes are needed to ensure that the hospital learns effectively from complaints.
- Strengthen governance arrangements. Currently, these are not always effective. Staff do not feel empowered to make changes and the governance structures hinder them at times.
- Ensure that the hospital's risk register is managed more effectively.

This section is primarily information for the provider.

# Compliance actions

## Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.<br>Improvements are needed to ensure that patients receive appropriate levels of care and welfare.<br>This relates to the issues with the way patients were cared for on the medical and surgical wards and the delays to their care and/or discharge from hospital. |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 15(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.<br>Improvements are needed to ensure that the patient environments (or 'premises') are safe and meet patients' needs.<br>This relates to the environment in the Margaret Centre, outpatients and on some medical wards. |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 16(1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.<br>Improvements are needed to ensure that equipment is appropriately maintained and available for use.<br>This relates to a lack of low-rise beds on medical wards, bedside oxygen on one ward, oxygen flow meters and suction on the surgical wards, equipment in maternity, ensuring resuscitation equipment is fit for use and the lack of a spare ventilator trolley in ITU. |

This section is primarily information for the provider.

# Compliance actions

| Regulated activity | Regulation |
| --- | --- |
| Diagnostic and screening procedures<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 19(1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.<br>Improvements are needed to ensure that patients know how to make a complaint and that complaints are dealt with appropriately. |

Barts Health NHS
NHS Trust

# Update from Barts Health

## Inner North East London
## Joint Health Overview and Scrutiny Committee

**17 February 2014**

# CQC inspection of Barts Health November 2013

- Chosen by the CQC as one of the first hospital trusts to be inspected under its new regime – led by the Chief Inspector of Hospitals
- Team of 90 CQC inspectors visited all Barts Health hospitals during w/c 4 November
- Inspectors impressed by how welcoming our staff were and our preparedness for the visit
- Summit meeting took place on January 10 2014 with commissioners, partners and CQC leads
- Reports published on 14 January and shared with local stakeholders and partners

# What the inspection found

Overall, findings were tough but fair, with much to be proud of:

- **Three warning notices** for maternity and care of the elderly issued last year at Whipps Cross have been **lifted** – a tribute to the many improvements staff have made in the last six months
- Staff provide **safe, compassionate care in clean surroundings** with excellent infection prevention and control
- Our clinical management structure, under our six Clinical Academic Groups was highlighted positively, especially for ability to implement change
- Many improvements had been made following previous inspections, including swift replacement of broken equipment
- Areas for improvement include appointment attendance rates, cancellations, complaints handling, leadership development and organisational culture
- We are fully committed to working with staff across the Trust to improve our culture and to make Barts Health a better place to work
- We are very clear that bullying and harassment has no place in Barts Health
- We have listened to staff and patients, and we will continue to listen
- **Our staff made huge efforts** before and during the inspection, and have continued to maintain standards since

# What we are doing as a result

- Drive to 95 – target to reach 95% staffing establishment in all areas by 31 March 2013:
  - Overall, currently at 90.5% (was 88% before Christmas) and some clinical areas already at 95%
  - Helps reduce reliance on temporary staff and improves quality and safety
  - Have already significantly reduced use of agency staff
- Greater visibility for our Executive Team with seven day a week presence:
  - On-call executive director out in our hospitals on the wards at weekends
  - First Fridays – greater frontline involvement by senior managers, who are out on the shop floor
- Addressing issues to improve our organisational culture:
  - Introducing a new system to provide anonymous online dialogue between staff and members of the Trust Board
  - Extending the staff partnership forum to more effectively bring in views from across the Trust
  - Increasing circulation of “pulse” survey to 4,000 staff every month
- Resolving issues more quickly

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| | |
|---|---|
| **Inner North East London Joint Health Overview and Scrutiny Committee**<br><br>17 February 2014<br><br>**London Cancer Project** | Item No<br><br>**8** |

**Outline**

This item is to provide the Committee with an update on the progress of NHS Englands proposed changes to Specialist Cancer and Cardiovascular Services in North East London and West Essex.

**Action**

The Committee is requested to give consideration to the update attached.

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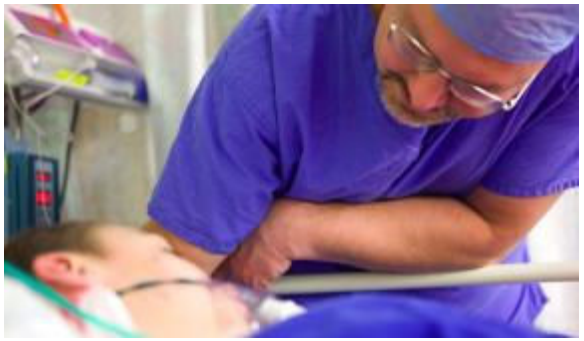
# Cancer and cardiovascular services

INEL JHOSC – 17 February 2014



THE NHS CONSTITUTION
the NHS belongs to us all

# The case for change

- Currently our specialists, technology and research spread across too many hospitals
- Evidence suggests that focused specialist centres lead to better outcomes
- Our vision is to create integrated cancer and cardiovascular systems providing care locally where possible, specialist care where necessary


- Specialist centres would work with local hospitals and GPs to improve the whole patient journey

# Engagement to-date

- 540 stakeholders sent a copy of the case for change and a link to engagement details on NHS England's website. An offer to attend meetings of local groups was extended to all stakeholders
- The summary leaflet was translated on request
- Five public drop-in sessions staffed by clinicians and commissioners. Events were publicised in 14 local newspapers
- Information on the engagement published on NHS England, UCLPartners, *London Cancer* and participating trust websites
- Media release and subsequent article in the *Evening Standard* about the proposals and engagement
- 28 meetings held with patient groups, CCGs and councils
- Patient involvement in the options appraisal workshops

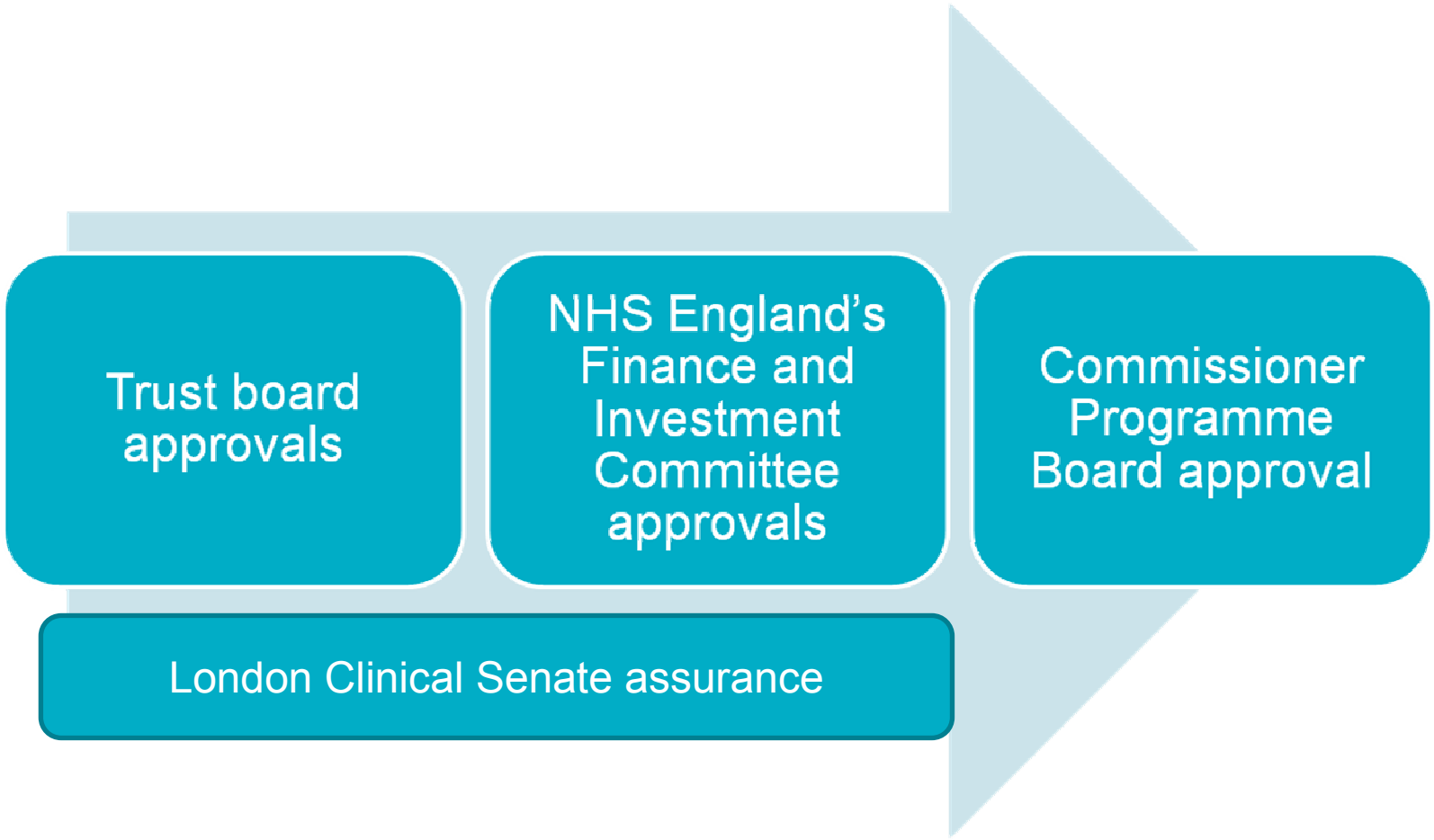
# Programme update

- A report on phase one engagement and options appraisal report will be available Feb
- London Clinical Senate assurance and equalities impact assessment underway
- Initial business case currently being developed and is expected to be published in late March / early April
- The initial business case will outline commissioners' preferred recommendations and financial implications

# London Clinical Senate

- London Clinical Senate undertaking an independent clinical assurance of the proposals
- For prostate cancer (radical prostatectomies), the Senate will review the proposals and the latest outcome data, in context of recent NICE guidance
- The outcome of this review will inform commissioners' preferred recommendations

# Initial business case approvals process



# Major trauma update

- Meeting held with clinicians on 16 December 2013 to help shape workshop to identify and address issues
- Full day clinically-led workshop held on 16 January with over 45 representatives from across the system
- Presentations from national clinical director for trauma care, Barts Health's trauma lead and a Barts Health trauma and vascular surgery consultant
- Recognition of the excellence of the current trauma service, and its significant improvements that it has made
- Clear commitment to maintain services and work collaboratively between trusts

# Major trauma: workshop outcomes

- Opportunity to breakdown walls between institutions and move away from silo working, with a collaborative focus on improving outcomes for all patient groups
- Key issues highlighted:
  - Importance of culture and interpersonal relationships to deliver excellent trauma services
  - Training, working across organisational boundaries, recognition that significant changes underway
  - Trauma services require many different specialties, skills and support services, which must continue to be available through effective collaborative working
  - All four pathways (upper GI, head and neck, urology and neuro-oncology) need to work through the specific issues raised, with potential solutions

# Major trauma: next steps

- Programme of work to be arranged between trusts, UCLPartners and commissioners to mitigate risks
- Pathway leads and clinical leads will work together to get relevant data where necessary and establish a timeframe in line with the overall programme
- This element of work will form part of the wider planning for implementation phase of the programme
- Commissioner and provider assurance and oversight frameworks to be established and completed prior to implementation, if approved

# Phase two: engagement

- Six-week engagement period following approval of initial business case (time will be added for days lost to Easter holidays)
- Plain English summary leaflet of proposals will be produced and distributed to all stakeholders
- Information available online and cascaded via trusts, CCGs and stakeholders
- Engagement events:
  - 1x prostate discussion event in outer north east London
  - 3x stakeholder advisory group meetings covering travel, whole pathway integration, and service impacts
  - Open offer to attend meetings
- Outputs of equalities impact assessment will feed into the engagement plan

# Phase two: programme-wide

- Following approval of the initial business case, phase two of the programme will commence
  - Phase two engagement
  - Planning for implementation
  - Development of commissioner assurance and oversight frameworks
  - Development of decision-making business case

- The above will support final decision-making expected in summer 2014

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