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

<table>
<thead>
<tr>
<th>Name of acute hospital site</th>
<th>Address</th>
<th>Geographical area served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newham University Hospital</td>
<td>Newham University Hospital, Glen Road, Plaistow, London, E18 8SL</td>
<td>East London</td>
</tr>
<tr>
<td>Royal London Hospital</td>
<td>Royal London Hospital Whitechapel Road, Whitechapel E1 1BB</td>
<td>North East London and Essex to varying degrees</td>
</tr>
<tr>
<td>Whipps Cross Hospital</td>
<td>Whipps Cross Hospital Ground Floor, E11 1NR</td>
<td>North East London, Redbridge, West Essex</td>
</tr>
<tr>
<td>St Bartholomew's Hospital</td>
<td>St Bartholomew's Hospital, West Smithfield, EC1A 7BE</td>
<td>City of London (as well as providing national specialist services)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P2 – Sites)

Royal London Hospital provides community services from 20 locations. These are primarily integrated sexual health outpatient’s services and nephrology/hepatology services

(Source: Routine Provider Information Request (RPIR) P2 – Sites)

Facts and data about the trust

Newham University Hospital has 302 inpatient beds, 52 maternity beds, 23 neonatal beds and 21 children’s beds.

Royal London Hospital has 730 inpatient beds, including specific surgery and critical care facilities for children, a hyper-acute stroke unit and it is also home to London's Air Ambulance.

Whipps Cross Hospital has 702 inpatient beds, including 11 end of life beds. They also have 18 neonatal cots.

St Bartholomew’s Hospital has 365 inpatient beds, including 250 cardiac beds and 58 specialist critical care beds. They also have 108 day-case beds.

(Source: Routine Provider Information Request (RPIR) P2 – Sites)
**Patient numbers**

From April 2017 to March 2018 there were:

- 2,097,074 outpatient attendances
- 193,254 inpatient admissions
- 9,741 planned elective surgical cases
- 440,526 attendances at the accident and emergency department
- 15,236 deliveries

*(Source: Hospital Episodes Statistics April 2017 to March 2018)*

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**Is this organisation well-led?**

**Leadership**

The Barts Health NHS Trust (the trust) board comprised of a group of individuals with an appropriate range of skills, knowledge and experience to perform their roles. The chief executive officer (CEO), Ms Alwen Williams, had been in post since 2015. Prior to this, her experience included being chief executive of other NHS primary care trusts and led the London region of the NHS Trust Development Authority. The chair, Mr Ian Peters, commenced his appointment at the trust in April 2017 and had broad range of both executive and non-executive experience. He was also serving as chair of two other organisations. The CEO and the chair spoke of a mutually constructive and collaborative relationship.

In addition to the CEO, the executive team included a recently appointed deputy chief executive (Aug 2018), chief medical officer (Feb 2016), chief nurse (April 2016), chief financial officer (Feb 2016), director of people (Oct 2012), director of strategy (Apr 2016), and a director of corporate development (Sept 2017). At the time of our inspection, an acting chief financial officer had been appointed due to the substantive director taking extended leave of absence due to illness.

The executive team were widely experienced and each had a broad portfolio of responsibility. From our conversations with them, it was evident that they were each suitably skilled, and were able to discharge their duties with competence and integrity. Following the appointment of the current deputy chief executive, portfolios had been reviewed.

The trust’s non-executive directors included seven individuals in addition to the chair. Specific responsibilities included oversight of the Quality Assurance Committee, Audit and Risk Committee, and the Finance and Investment Committee. From our conversations with them, it was clear that together they brought a range of skills and experience to the board. They spoke positively about the collaborative relationship with each other and with the executive team and were confident in their position to provide constructive challenge to the executive directors. They also spoke confidently about the CEO, citing her as significantly instrumental to the positive changes within the trust over the last few years. Through our conversations, our review of trust board papers and attendance at a recent board meeting, we found they had a sufficient level of involvement and influence as part of the overall leadership of the trust and clearly understood the sizeable challenges of which the trust faced. We were told that two of the non-executive directors were coming to the end of their tenures and strategic consideration would be given when considering appropriate replacements.
The trust operated as a ‘group model’, providing a large range of clinical services across four major hospital locations, two standalone birthing units and a range of community locations that included community dental services. Following the appointment of the CEO in 2015, the trust began development on a leadership operating model that established management teams at each of the four main hospital sites, including a separate management team that oversaw the delivery of the central run directorate ‘clinical support services’ (CSS). Each site leadership team included a managing director, a medical director, a director of nursing and governance, and a head of finance. The team at The Royal London Hospital also had responsibility for the provision of services at Mile End Hospital. The introduction of this leadership operating model had allowed for each hospital site to have better accountability, control and oversight of the delivery of its services, finances and had improved overall governance.

The CSS management team was structured to provide oversight of operational and quality performance of centralised services that were within its remit. These included pathology, imaging, pharmacy and therapies. Previous CQC inspections had highlighted concerns around the leadership and quality of services that were overseen by CSS. The trust’s response had been to review the services provided by CSS and consider how best they would integrate and operate with clinical services at each hospital. This had led to the recent alignment of outpatients with local management teams. We found that overall this was a positive step, and one in which staff members embraced, despite recognising that there remained scope for further improvement. For example, outpatient services at The Royal London Hospital, where the governance structure was being further reviewed and developed.

The trust had invested in improving the services that remained under the remit of CSS, this included several strategies such as consolidating and networking with other providers. There was also discussion as to how further devolve services within its remit, such as therapies.

The trust had frequently reviewed the organisational structure and had made adjustments to improve its efficacy. Each hospital site leadership team was governed by hospital management boards (HMB).

The HMBs were at different stages of maturity. The trust had recognised this and had made changes accordingly to strengthen them. For example, Whipps Cross Hospital had been through several changes amongst its HMB over the last two years, however we found that the current leadership team was better established and had evidenced this through positive changes to the quality of care and performance across the hospital. Our recent inspection of core services at Newham University Hospital raised concern as to the pace of change to addressing quality, cultural, leadership and governance matters. For example, we found that several concerns raised at our previous inspection of maternity services had still not been addressed and we found further significant quality concerns on this inspection. However, the trust had recently considered this and had again made changes to the HMB of Newham University Hospital that included the appointment of the previous trust executive director of clinical operations as new executive managing director for the hospital. The trust told us they were confident that this would bring significant and sustained improvement.

Staff spoke positively of the leadership changes that had been introduced with the introduction of site based leadership teams and the development of HMBs. Staff told us that although the overall executive team were not always visible, the site based leadership teams were, and had had a positive and encouraging impact.

The trust had seven clinical boards: cancer, cardiovascular, children’s health, emergency care, medicine, surgery, and women’s and newborn health. The clinical boards were responsible for
making sure that standards were consistent across all sites and services, including the setting of strategic direction and guiding research strategy. Clinical boards at each hospital location were led by a clinical network director, who reported to the hospital location medical director; an associate director of nursing, who reported to the director of nursing and governance; and one or more general managers (depending on the number of specialities within that division) who reported to the director of operations. Underpinning the seven clinical boards were a total of 32 clinical networks reflecting the individual specialities, the majority of which were aligned to surgery.

The clinical board leads were a highly motivated and engaged group of senior clinicians who understood the challenges within their designated clinical areas and across the trust. It was recognised by the trust that the clinical boards were also at different stages of maturity and development; however, the clinical networks were increasingly progressing improvement across services.

At the time of our inspection, the overall composition of the trust executive board was 62% male and 38% female. Of the executive board members at the trust, 11% were British Minority Ethnic (BME) and 33% were female, and of the non-executive board members 25% were BME and 38% were female.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>BME %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive directors</td>
<td>11%</td>
<td>33%</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>25%</td>
<td>38%</td>
</tr>
<tr>
<td>All board members</td>
<td>18%</td>
<td>35%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P64 Board Members - Diversity and list)

During our inspection, some staff commented to us that the board did not represent the demographics of the workforce or the population the trust served. The trust had taken steps to address this by introducing a career development programme to support BME staff into senior leadership roles. A career development programme had been introduced to specifically support female BME staff towards career development. At the time of our inspection, 310 staff members had participated in the programme and 20 per cent of those who had taken part had gone on to achieve promotion in their careers.

A broader leadership development strategy that sought to define and develop staff within leadership roles also included a dedicated induction programme for managers and new consultants; a six-month leadership transition programme for new senior managers and new consultants; talent management tools to help identify and nurture potential, and a set of competencies outlining expectations of staff that aligned with the trust values.

As part of our inspection, we requested access to the personnel files of all executive and non-executive directors to examine whether they contained evidence of all relevant checks to comply with the Fit and Proper Persons Requirement (FPPR) (Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Regulation 5). The trust had a current FPPR policy in place. We reviewed the files of executive and non-executive directors and found that they contained evidence of relevant checks to comply with FPPR.
Vision and strategy

The trust had a clear vision and set of values that prioritised the delivery of safe and effective patient care. The trust had set out its vision in the following statement: 'To be a high performing group of NHS hospitals, renowned for excellence and innovation and providing safe and compassionate care to our patients in east London and beyond'.

The trust had devised the motivational acronym ‘WeCare’ to encompass the trusts’ core values to help shape and direct organisational behaviour and underpin the vision. These were established under the following principle headings: Welcoming, Engaging, Collaborative, Accountable, Respectful, Equitable.

The ‘WeCare’ values had been extensively promoted across the trust and were clearly incorporated in trust improvement plans and in training, education and further organisational development. Nearly all of the staff we spoke with during the inspection process were aware of these values.

The trusts’ clinical and organisational strategy had been developed to encompass: the vision and values; the future direction of each clinical service area; the future direction of each of the four main sites and clinical support services, and the future direction of corporate services and the organisation’s operating model.

The clinical strategy incorporated five core themes:

1. Clinical and academic excellence
2. Reducing variation and improving productivity
3. Networking services to improve standards
4. Prevention and pathway design – such as, joining up care across primary, community and secondary care
5. Tailoring services to meet the needs of the population.

The board had overseen the overall development of the strategy which had been signed off in May 2017 to provide direction for the following four years and was published in the document entitled ‘Sustaining Safe and compassionate care’. This had been a progressive development following the initial work that the CEO had initiated following her appointment in 2015 where the priority was to change the leadership and governance model and address the large number of concerns that had been raised by CQC. Since then, the strategy had been built upon furthering quality improvement. The trust had recently developed the slogan ‘WeImprove’ to promote the next stage of their improvement journey.

The development of each clinical strategy had been led by the relevant clinical networks and boards that had engaged clinicians and other multi-disciplinary teams. Strategic progress and development was overseen by the Clinical Academic Strategic Board. Initial steps in developing the strategy involved engagement with over 700 staff.

The trust further built upon this by developing enabling strategies that included a people strategy (incorporating the workforce), an information and communications technology (ICT) strategy, a public health strategy, commercial and research strategies. Along with the clinical strategies, these were developed in context with the wider improvement objectives.

The trust spoke openly about the challenges that the organisation had faced over the previous years and the progress that had been made. Board members described the trust as being on the
cusp of a new phase now that there was a greater sense of stability across the organisation, of which further adaptation would be necessary to drive greater transformation. However, it was recognised that improvement was still necessary in several areas, also evidenced by our core service inspections where we found variations in quality, leadership and governance in some core services.

Conversations regarding strategy development recognised that each hospital would need to further develop its individual strategy and vision whilst still working together as a group. Each of the four acute hospitals were in many ways distinctively different and were also at different stages of service development. For example, St Bartholomew’s Hospital was well established as a specialist centre for cardiac and cancer treatment, the Royal London Hospital as a centre for trauma; Whipps Cross University Hospital was developing its frailty and care of the elderly services, and Newham University Hospital was developing as the central hub for the provision of orthopaedic services. The trust spoke positively about the group model and how the benefits at one site could positively influence at another, although the trust recognised that much more needed to be done in this area.

The trust was part of the north-east London sustainability and transformation partnership (STP) and were aware of the challenges within the local health economy and how to strategically plan clinical services to meet these needs. The trust had proactive relationships with local providers and stakeholders and was jointly leading the development strategy across several clinical areas. For example, the trust was working with another NHS trust to integrate neurosurgery services and was working collaboratively to improve ambulatory care.

The trust infrastructure included both large and expensive private finance initiative (PFI) buildings at the Royal London and St Bartholomew’s hospitals, and ageing estate at Whipps Cross University Hospital. This posed a number of problems that had financial implications and the trust was in the early stages of setting out a strategy with stakeholders as to how to address this for the longer term. An estates strategy had been developed although it was recognised that this could be more clearly underpinned by the wider clinical strategy.

The trust, in collaboration with an east London university, had secured agreement to provide an advanced research facility next to the Royal London Hospital at Whitechapel with the vision to becoming a leader in research and innovation in life sciences. The trust was also in conversation with NHS England and other commissioners as to how to strategically maximise the unused floor space that was available at the Royal London Hospital.

The trust had outlined their existing quality improvement priorities for the present year and had evidenced in some areas clear progress as found by our core service inspections across the trust, although there was recognition that more needed to be done to address variation in quality.

**Culture**

Staff we spoke with during our inspection and prior in arranged focus groups, predominantly spoke of good working relationships amongst colleagues and across multi-disciplinary teams. Clinical staff spoke of pride at what they achieved in sometimes difficult and challenging circumstances. Progress had been made in some areas where we previously had concern regarding the working culture, and staff working in those areas recognised the difference. For example, staff at the Royal London Hospital described a changing culture with more visible and supportive leadership teams.

However, we found that cultural concerns persisted in some areas. For example, staff working within the diagnostic service at Newham University Hospital described a common theme of
mistrust within staff to make an official complaint when concerns arose for fear of harassment. When asked to explain this, staff were unwilling to elaborate further.

The annual staff survey also highlighted that the experience of bullying, harassment or abuse from colleagues was still a concern. Some staff we spoke with shared examples of where they had either personally experienced or witnessed staff senior to them communicate without respect or respond to staff in a reactive manner to challenges that presented themselves. However, staff recognised that a lot of work had taken place to improve the working culture across the trust and the predominant message from the staff we spoke with was positive.

Staff described difference in the perceived identity and culture at each of the three main acute hospital sites that we inspected. For example, several staff at both Whipps Cross University Hospital and Newham University Hospital, across different disciplines and grades, used the phrase ‘poorer cousin’ or ‘poor relation’ on several occasions when speaking with us to describe the relationship the hospital had with the other trust locations. Staff we spoke with perceived that there were less opportunities for career development and services would be less likely to receive capital to allow for development at these hospital sites compared with the Royal London and St Bartholomew’s hospitals. However, the same staff also spoke of positive intentions and increased visibility from both corporate and local hospital management. Despite the broader cultural perception, staff at both Newham and Whipps Cross described a positive ‘family feel’ among staff at both hospitals.

Clinical staff mostly spoke of a candid, open culture that promoted speaking up in confidence about concerns and when things had gone wrong. Most staff told us they felt comfortable and supported in reporting concerns. However, administrative and clerical staff felt less confident that they would be supported if they did so.

The trust employed an external Freedom to Speak Up (FTSU) Guardian service to provide 24/7 telephone support for staff to raise concerns confidentially and one full time staff member had been appointed to facilitate this across the trust with another colleague available to support in their absence. Eighty-five staff had contacted this service in the previous 12 months. The FTSU service reported to the board monthly on issues and trends

Relevant policies and procedures were in place to guide staff, including a Whistleblowing policy and trust grievance or bullying and harassment procedures. The FTSU service also incorporated the ability for staff to converse directly with a member of the executive team whilst maintaining anonymity.

Below are results from the NHS Staff Survey 2017 which highlights questions that scored worse than average for the trust:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF11: % appraised in the last 12 months</td>
<td>78%</td>
<td>86%</td>
</tr>
<tr>
<td>KF20: % experiencing discrimination at work in last 12 months</td>
<td>22%</td>
<td>10%</td>
</tr>
<tr>
<td>KF21: % believing the organisation provides equal opportunities for career progression/ promotion</td>
<td>72%</td>
<td>85%</td>
</tr>
<tr>
<td>KF28: % witnessing potentially harmful errors, near misses and incidents</td>
<td>35%</td>
<td>29%</td>
</tr>
</tbody>
</table>
Below are results from the NHS Staff Survey 2017 which highlights questions that scored better than average for the trust:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF12: Quality of appraisals</td>
<td>3.25</td>
<td>3.10</td>
</tr>
<tr>
<td>KF13: quality of non-mandatory training, learning or development</td>
<td>4.10</td>
<td>4.07</td>
</tr>
<tr>
<td>KF6: % reporting good communication between senior management and staff</td>
<td>36%</td>
<td>33%</td>
</tr>
<tr>
<td>KF32: effective use of patient/user feedback</td>
<td>3.75</td>
<td>3.69</td>
</tr>
</tbody>
</table>

(Source: NHS Staff Survey 2017)

The trust had introduced a staff recognition programme that comprised of initiatives that included the annual ‘Barts Heroes’ awards. This had grown in popularity and now over 1000 staff members were being nominated. Quarterly ‘chairman’s lunches’ had also been introduced to invite all nominees (those who weren’t shortlisted for the annual awards ceremony) to meet with the chair and members of the board.

The trust employed a culturally diverse work force and had taken several positive steps to improve staff engagement. Staff told us that they recognised the work that the senior leadership team had undertaken, specifically citing the CEO as a driving force behind this change. However, despite
the progress, BME staff we spoke with emphasised that more needed to happen to address the concerns that were referred to in the trusts’ Workforce Race Equality Standard (WRES) metrics. The board were committed to addressing this and had developed a ‘people’ strategy that incorporated several plans and actions.

The trusts’ WRES metrics showed that BME staff were more than twice as likely to enter the formal disciplinary process when compared to figures for non-BME staff. The trust were concerned about these figures and had piloted a ‘pause and review’ process to help managers make consistently fair decisions and had since extended this approach across all services to further promote equitable decision-making processes.

The scores presented below are the un-weighted question level score for question Q17b and un-weighted scores for Key Findings 25, 26, and 21, split between BME staff, as required for the WRES. Note that for question 17b, the percentage featured is that of “Yes” responses to the question. Key Finding and question numbers have changed since 2014.

<table>
<thead>
<tr>
<th>Question</th>
<th>Your Trust in 2017</th>
<th>Average (median) for combined acute and community trusts</th>
<th>Your Trust in 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF25</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</td>
<td>White 32%</td>
<td>26%</td>
<td>29%</td>
</tr>
<tr>
<td></td>
<td>BME 32%</td>
<td></td>
<td>30%</td>
</tr>
<tr>
<td>KF26</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months</td>
<td>White 30%</td>
<td>23%</td>
<td>32%</td>
</tr>
<tr>
<td></td>
<td>BME 34%</td>
<td></td>
<td>33%</td>
</tr>
<tr>
<td>KF21</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion</td>
<td>White 82%</td>
<td>88%</td>
<td>82%</td>
</tr>
<tr>
<td></td>
<td>BME 63%</td>
<td></td>
<td>63%</td>
</tr>
<tr>
<td>Q17b</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?</td>
<td>White 10%</td>
<td>6%</td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td>BME 19%</td>
<td></td>
<td>15%</td>
</tr>
</tbody>
</table>

There was statistical difference between responses provided by BME staff and white staff in three questions above: KF26, KF21 and Q17b.

(Source: NHS Staff Survey 2017)

An equality and inclusion group had been introduced at each site, as well as CSS. Chaired by the managing director, membership included staff representatives from different services, estates, divisional and service managers, clinical reps. All staff were welcome and invited.

Staff networks were encouraged, and was structured around four sub-groups: BME, disability, LGBTQ+, and a women’s only group. There was also plans to set up a network for carers. These networks were established after staff expressed what they felt was needed. Membership was slowly increasing and an events page on the trust intranet was helping to promote awareness. Two hospital sites had introduced LGBTQ+ site representatives.
The Friends and Family Test (FFT) was launched in April 2013. It asked people who use services whether they would recommend the services they have used, giving the opportunity to feedback on their experiences of care and treatment. From August 2017 to July 2018, the trust’s performance was similar to the England average.

(Source: NHS England)

The trust had recently changed provider for the collection of FFT data, and for several months afterwards had experienced problems in gathering sufficient data. Hence, there was concern that the submitted data was insufficient in providing accurate understanding across core services.

The trust’s sickness absence levels from May 2017 to March 2018 were generally similar to the England average.
The trust had in place a guardian for safe working hours and was supported by a small team of colleagues. This was providing appropriate levels of support for doctors in training.

In the 2018 General Medical Council Training Scheme Survey, the trust performed the same as expected for all questions.

(Source: NHS Digital)

(Source: General Medical Council National Training Scheme Survey)
The trust had a strong relationship with the local medical training school and many of the faculty worked at the trust. The trust had established education leads at each of the hospital sites and were seeking to unify training and education standards across the trust. Site based faculty groups had been set up that provided support for doctors in training.

The trust collaborated with four London universities in delivering training for nurses, midwives and allied health professionals. The trust had developed a post-registration pathway for different nursing specialities and was extending the program to include other specialities, with a view to furthering nursing focus on research, teaching and delivering education.

The trust had recruited from overseas and had employed 355 nurses from the Philippines with a further 74 appointed to start with the trust in the near future. The trust had set up a dedicated training and development programme to enable overseas nurses to obtain their NMC registration and had seen a high first-time pass success rate.

The trust had reviewed their approach to staff appraisal and had piloted a new model that had been in part developed through consultation with staff, which had since been launched across the trust. The model promoted the trust values and improved discussion around career development and staff health and well-being. Staff predominantly told us that this had been a positive change, allowing the appraisal process to be more meaningful.

**Governance**

The trust had in place governance processes to support the delivery of its strategy and ensure quality and performance information was reviewed and escalated appropriately. The trust governance structure had been designed to ensure that quality and patient safety issues and concerns were identified at ward level across each hospital, discussed by each of the management teams across the four main hospital locations and clinical support services, before being reviewed and escalated to the trust board as appropriate. However, we found examples where there was insufficient oversight in some core services, raising concern that the trust board did not receive sufficient assurance.

The board had responsibility for the overall strategy, planning and oversight across the trust group of hospital sites, networks and support services. Each hospital site was responsible for the oversight and delivery of clinical services at each site, including the network services provided across other sites. Each managing director was supported by a site leadership team and governed by a hospital management board (HMB). This structure meant that the operational management, governance, clinical improvement and financial and budget management for each hospital sat with each individual site leadership and governance team. Each managing director reported directly to the CEO. The chief nursing officer and chief medical officer were the overall executive leads for safety and quality across the trust.

The trust had progressed this organisational structure since first introducing it in 2015. Overall, we found that this structure had become further embedded, and had considerably improved clinical governance. Although, our core service inspections highlighted that in some areas this needed to be strengthened. An example being the concerns we raised regarding both the leadership and governance of maternity services at Newham University Hospital where we issued a Section 29a Warning Notice (The Health and Social Care Act 2008) for the trust to address significant concerns in the quality of healthcare. Following this, the trust proactively responded by making several important changes to the maternity governance structure, including some strategic
changes to the overarching leadership of both maternity services and Newham University Hospital. The trust were confident that these changes would improve quality and oversight.

The trust had recently employed an external consultant to review the changes that the board had made to the organisational and governance structure and were acting on the recommendations, having devised an improvement plan that was in progress to meet most of its completion targets. This included plans to improve the accountability framework for quality assurance and clinical governance that would better map out lines of reporting from ward to board whilst identifying areas for further improvement.

A large committee structure was in place to further inform the board and provide assurance via the Trust Executive Committee (TEC). The Quality Assurance Committee (QAC), which was chaired by a non-executive director and convened every other month, was responsible for providing assurance regarding the quality of clinical services to the trust board, including oversight of the trust’s quality improvement plan and operational delivery. Along with the clinical boards, over 20 different sub-committees informed the QAC.

We found that the QAC could take a more systematic approach and improve the way it monitored, reviewed and reported on quality. For example, the QAC did not refer to a risk register to ensure that trust wide risks affecting quality of care were appropriately mitigated. As the QAC met bi-monthly, and considering the extent of the committee structure, this raised concern as to the ability of the QAC to have effective oversight and provide assurance to the board. The trust discussed changes that they had identified as needing to be made which were yet to be introduced at the time of our inspection.

The Finance and Investment Committee (FIC) was responsible for providing oversight of financial planning, both short term and in relation to longer term sustainability, and performance. We spoke with the non-executive lead of the FIC who could clearly discuss the challenges that the trust faced that aligned with the clear and structured approach to reporting that the committee presented to the board.

The Audit and Risk Committee (ARC) had responsibility for independently monitoring, reviewing and reporting to the Board on all aspects of governance, risk management and internal control. The trust’s Board Assurance Framework (BAF) was the primary source for informing the ARC regarding risk, along with the risks rated 20 and above identified on the corporate risk register. The non-executive chair of the ARC recognised the need to further improve the internal audit programme.

The BAF is a method of setting out the most important risks facing the organisation and sets out a control framework that organises and categorises risks and highlights where the gaps in control are. Maintenance of the BAF was the responsibility of the trust board secretary and director of corporate development. The QAC and ARC were responsible for overseeing aspects of the BAF. Following a recent review, the trust had taken steps to improve the BAF and had also began to introduce a framework for assurance at a local level and for CSS, overseen by each HMB and the CSS management board respectively.

Previous core service inspections had raised concern regarding medicines management across some services at the trust. The trust had taken steps to address this and we found evidence that improvements had been made, although it was too early to evaluate the sustainability of this. A Medicines Governance Board had oversight of all medicines use in the trust. The composition and terms of reference of this board was appropriate to its level and the lines of accountability were strong. The chief pharmacist and medicines safety officer were involved at all levels.
A partnership arrangement was in place for the provision of psychiatric liaison services with appropriate governance arrangements. The trust worked closely with a local mental health foundation trust to deliver this.

**Management of risk, issues and performance**

The trust had systems in place to identify learning from incidents, complaints and safeguarding alerts.

The safeguarding service had three coordinators, each based at three of the four main hospital sites, including one to cover the Mental Capacity Act (MCA) assessments, Deprivation of Liberty Safeguards (DoLS), and the Mental Health Act (MHA). Most staff we spoke with were positive about this change. However, staff did recognise that there were still gaps in the oversight and delivery of safeguarding within the trust, although it was improving. During our inspection of medical services at Newham University Hospital, we found staff understanding of when patients needed an assessment under the MCA and DoLS application was variable. Safeguarding leads for the trust stated they recognised that there were gaps in training and understanding for MCA and DoLS which was due to a lack of staff in the safeguarding team. We also found that DNACPR forms at Newham were not always completed correctly or consistently.

Risk registers were in place for identifying, recording and managing risks, issues and mitigating actions. We found that the trust board had a good understanding of the most significant risks and mitigating actions were clear. We found that predominantly, recorded risks at core service level were aligned with what staff said were on their ‘worry list’.

The Board Assurance Framework (BAF) was received by the trust at least three times per year to discuss and agree the principal risks to the delivery of the trust’s strategic objectives. The BAF clearly aligned to corporate objectives. Each risk identified an executive lead and stated which sub-committee was responsible. Controls and assurance was clearly set out and where there were gaps, actions to address these were clearly stated.

The trust provided a document detailing their highest profile corporate risks. There was a total of 89 risks, the risks listed below have a risk rating of 20:

**Newham University Hospital**

<table>
<thead>
<tr>
<th>Risk ID</th>
<th>Description</th>
<th>Risk score (current)</th>
<th>Last review date</th>
</tr>
</thead>
<tbody>
<tr>
<td>4845</td>
<td>Ageing ultrasound machine in Fetal Medicine</td>
<td>20</td>
<td>28/06/2018</td>
</tr>
<tr>
<td>3468</td>
<td>Condition of Fire Safety Systems at NUH</td>
<td>20</td>
<td>28/06/2018</td>
</tr>
<tr>
<td>4094</td>
<td>Lack of Capacity to Review patients in ED</td>
<td>20</td>
<td>30/06/2018</td>
</tr>
</tbody>
</table>
(Source: Trust Corporate Risk Register / Board assurance framework)

Several high-level risks on the register were associated with ageing retained hospital estate, including risks associated with fire compartmentation. The trust had committed £8.5 million to address all fire safety issues over the coming few years. The London Fire Brigade (LFB) had inspected the estate and the trust had signed a memorandum of understanding with LFB that agreed with the programme of works to be carried out. The trust had agreed a commitment with LFB that work to address fire compartmentation concerns at Newham University Hospital would commence no later than December 2018. The director of estates had responsibility for the governance and oversight of this and reported monthly to the Trust Executive Committee (TEC) and quarterly to the Finance and Investment Committee (FIC).

The trust had taken some steps to mitigate this risk. For example, staff fire safety training was being progressed across the trust. We raised particular concern regarding the critical care unit at Newham University Hospital which was considered a high-risk area, and the trust evidenced how they had sought to mitigate this by running simulation training sessions and table top exercises to ensure staff were confident in how to implement the fire plan and how to evacuate the unit.

The Risk Management Committee received reports from sites and corporate directorates on risk management, and in turn reported directly to the TEC. A recent external review of the trust organisation and governance had identified areas where the management of risk could be improved. The trust discussed this during our inspection and had identified areas for development that were being actioned. This included improving the way that the trust reported and presented risk at the relevant committees. The trust had recently produced a new risk management strategy that had been presented to the board in September. Hence, at the time of our inspection, it was too early to identify the impact of these improvements.
Divisional risk registers were standardised across the trust and were discussed at divisional monthly governance meetings, with emphasis placed on those risks that scored 15 or above. Overall, we found that core service leadership teams had a good knowledge of the risks contained within their registers and reflected the concerns that were identified during our discussions.

The trust had an effective system for the management of safety alerts. This process was overseen by the Quality Assurance Committee. Information regarding safety alerts was distributed in the trust’s monthly safety bulletin.

Incidents were reported at the trust using an online incident reporting system which utilised several stages to ensure that all steps in the process were complete before the incident could be closed.

The trust provided information outlining the incidents that had been reported in accordance with the Serious Incident Framework 2015, between February 2017 and March 2018. In total, 64 serious incidents were reported at Whipps Cross Hospital, 69 at Newham University Hospital, and 71 at The Royal London Hospital. (We did not request the information regarding St Bartholomew’s Hospital to be included in the trust’s submission.)

We reviewed a sample of ten serious incident (SI) reports during our well led inspection. We found that investigations were comprehensively carried out with detailed timelines and involvement of appropriate staff. However, only one of the ten incidents we reviewed was completed within the trust’s agreed timeframe with some having significant delay before completion. Investigation of incidents and the completion of root cause analysis (RCA) was the responsibility of each service and division. We found examples during our core service inspection, such as maternity services at Newham University Hospital, where backlogs persisted and delays to completion ran to months.

Of the ten SI reports we looked at, the investigation proforma was completed to a consistent standard, with learning points and action plans from investigations clearly recorded. However, not all action plans we reviewed had been signed off and the documentation was not clear as to who the responsibility fell to with each investigation.

We saw evidence where notable efforts were taken to both inform and engage family and carers, although overall greater engagement was needed, including involving family and carers earlier in the process.

Insufficient numbers of trained staff who were involved in the investigation process was considered a cause that influenced the quality assurance concerns outlined above. The trust recognised that closure of SI reports continued to be a challenge and an improvement plan was in place.

The trust had reported seven never events in the previous calendar year. Three of these had been reported in August - two of which were related to retained foreign objects in obstetrics. The third was accidental connection to air instead of oxygen, of which the trust had had a similar never event occur last year where extensive steps were taken to prevent such an event being repeated. Due to the recent increase in never events, the trust had taken several steps to better strengthen the review and learning process, recognising too that more could be done to better engage staff. This included the setting up of a steering group, chaired by the chief medical officer to review National Safety Standards for Invasive Procedures (NatSSIPs).

Learning from incidents and never events was shared in service level and divisional meetings. The monthly safety bulletin included information regarding incidents, SIs, and never events. The trust was emphasising a push towards greater reporting of near-misses so that action to avoid harm could be better identified.
Each hospital had in place structured Quality, Safety and Improvement Committee meetings that reviewed risk, quality and performance. These were chaired by members of the specific HMB and covered a broad agenda concerned with patient safety, for example: sepsis, serious incidents, learning from never events, medicines management, hospital acquired pressure ulcers and falls. Other performance matters were also discussed, such as statutory and mandatory training and Friends and Family Test results.

The trust was continuously active in carrying out national and other internal clinical audits across all services and departments, with a view to driving improvement of which the trust was able to give evidence. However, we still found examples where services were not taking audits as regularly as they should; for example, NEWS audits within urgent and emergency services at Newham University Hospital. It was recognised that a more strategic response to clinical auditing could be taken with greater corporate oversight to improve this process.

The pharmacy team undertook a programme of audits and acted on the results. For example, they had found that they were an outlier for missed doses and had discussed how improving communication about the out of hours service may improve the rates. Although, during our inspection we found there was some misunderstanding about the availability of the pharmacy out of hours service.

Emergency planning and continuity policy and procedures were in place. The trust’s business continuity plan provided contingency procedures to enable the trust to continue to deliver its critical activities during a business disruption. This included emergencies such as adverse weather, illness outbreak or major disaster. In 2017, the trust was subject to a cyberattack that severely impacted the trust. The event had rigorously tested the trust continuity plans and allowed for further improvement and development.

The trust provided the following summary of their financial performance:

<table>
<thead>
<tr>
<th>Financial metrics</th>
<th>Historical Data</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Previous financial year 2016/17 (000’s)</td>
</tr>
<tr>
<td></td>
<td>PRE STF</td>
</tr>
<tr>
<td>Income</td>
<td>£1,488,833</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>(115,313)*</td>
</tr>
<tr>
<td>Full costs</td>
<td>£1,604,146</td>
</tr>
<tr>
<td>Budget</td>
<td>(£82,700)</td>
</tr>
</tbody>
</table>
### Financial metrics

<table>
<thead>
<tr>
<th>Financial metrics</th>
<th>Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>This financial year 2018/19 (000's)</td>
</tr>
<tr>
<td></td>
<td>PRE STF</td>
</tr>
<tr>
<td>Income</td>
<td>£1,557,770</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>(£56,786)</td>
</tr>
<tr>
<td>Full costs</td>
<td>£1,614,556</td>
</tr>
<tr>
<td>Budget</td>
<td>(£56,786)</td>
</tr>
</tbody>
</table>

Note: Sustainability Transformation Fund (STF) funding of £45.8m was received in year, and the trust have adjusted the deficit to be consistent with other years.

(Source: Routine Provider Information Request (RPIR) – P69 Finances)

The trust was placed in financial special measures in July 2016 because the deficit was not being reduced quickly enough. Following this, a detailed recovery plan was produced and approved by NHSI that sought to fully deliver the control total. The trust had successfully delivered its recovery plan and its forecast compliance with its control total which in turn secured sustainability and transformation funding.

The trust received the majority of its patient service contracted income from its main clinical commissioners (Tower Hamlets CCG, Newham CCG and Waltham Forest CCG) and NHS England, who provided specialist commissioning for specialist services that the trust provided.

The trust had appointed a head of finance on each HMB and CSS management team. From our conversations with both the local and corporate finance teams, it was clear that they understood the financial risks affecting the trust and their localities. There was also strong financial experience represented amongst the non-executive directors and the non-executive chairs of FIC and ARC both noted that the quality of data and reporting had improved.

The trust was also taking steps to devolve financial authority to the HMBs. This was seen as a positive step and one that reflected confidence in the financial controls that were now in place. Both the interim director of finance and the chair of FIC recognised that the quality of business cases coming through to the board had improved as risk was better understood in the organisation.

The trust pioneered several services across the local health economy which were a large source of income for the trust. These included, renal services, maternity services, cardiac services, accident and emergency services and cancer services.

The trust participated in the Commissioning for Quality and Innovation Scheme (CQUIN) and had seen an improvement in delivery with an increase in income.

The trust was proactively seeking ways to improve its income and was also awaiting the outcome of several bids it had made to deliver additional services. This included extending provision of its cardiology services to another NHS provider. Strategic consideration had been given as to how best utilise the unused floor space at Royal London Hospital and several viable options were being
Discussions were taking place with NHS England regarding further specialist commissioning. Where cost improvements were taking place, there were arrangements to consider the impact on patient care and we predominantly found that changes were monitored for their potential impact on quality and sustainability. However, a delayed business case for a second theatre at Newham University Hospital to address the risk of caesarean section had still not been effectively progressed following our last inspection. We were told by some senior staff that similar delays to advancing business cases were not uncommon.

The trust was keen for greater ownership of the cost improvement programme by operational managers, understanding that operational improvements would lead to financial savings.

**Information management**

Information governance systems were in place including confidentiality of patient records. The trust had a senior information risk officer (SIRO) who was responsible for overseeing the management of information risks and incidents within the organisation. The director of corporate development held this responsibility. A ‘Caldicott Guardian’ was also in place who was responsible for the management of sensitive patient information, and a contracted data protection officer was available to support this process. Several other staff were assigned to oversee other aspects of information management, such as freedom of information requests.

The main information governance (IG) risks recorded on the risk register included information sent to the wrong recipient and compliance with the General Data Protection Regulation (GDPR) that had been introduced in May 2018. The trust had set up a working group and a 10-point action plan to improve information governance across the trust, reporting to the Information Governance Committee and ARC. The trust utilised the ‘IG Toolkit’ to assess themselves against information governance standards.

There had been two IG incidents that were reportable to the Information Commissioner’s Office (ICO) in the year before our inspection. The trust had acted quickly and appropriately to address the issues, one of which related to stolen diagnostic equipment.

Systems were in place to collect data from wards and teams using clinical dashboards and key performance indicators. A quality and safety trigger tool designed for health care settings had been introduced into clinical areas that used an app for mobile devices, allowing clinical staff to collect and review quality data using customised questions for a range of staff, patients and relatives. The app incorporated a RAG rated scoring system that helped identify actions to improve quality. This had been positively received by staff who explained the benefits of obtaining a live report that highlighted areas for learning and improvement, the results of which were also used to inform the HMBs and subsequently the trust board on performance.

A monthly integrated performance report (IPR) was produced that included both site and trust level data that provided a good level of oversight of quality and performance measures and was reviewed at trust level by the Board and TEC. The IPR outlined performance across each of the sites including target thresholds and exception triggers, and included an executive summary. The IPR was in an accessible format that identified areas for improvement and was well established as a means to providing focus for board discussion, reporting on quality and performance, finance and workforce and advising the board assurance framework accordingly.

Our core service inspection highlighted some areas where there was discrepancy and gaps in data being presented at service level governance meetings and then used to inform the board. The trust had developed a strategy to capture and correct data-errors and to provide validation,
peer review and executive oversight. The trust recognised that the processes in place were not
even to fully prevent and capture all data-errors but were working to identify the gaps and
improve this. For example, medical wards at Newham had submitted data in the routine provider
information return (PIR) that suggested over 5000 patients moved wards at night (out of hours)
between April 2017 and March 2018. We raised this as a concern and at the time of inspection
the trust stated that there were significant inaccuracies in the data submitted relating to night
moves due to inaccurate recording of time of admission and changes to the electronic patient
record used at Newham. After inspection, the trust business intelligence team re-examined the
data and found that this was a data entry problem, reevaluating the total number of ward moves at
night by almost half at approximately 2500.

As of April 2018, the trust had recommenced reporting of 18-week referral to treatment times
(RTT) following a three-and-a-half-year period where they had stopped reporting due to inability to
effectively validate the data. When we reviewed the QAC oversight of this, there was concern at a
lack of sufficient oversight of more detailed speciality data, therefore a risk that variances in
performance across the trust were not fully scrutinized. However, the trust explained that given the
importance of improving RTT data quality, returning to national reporting and ensuring recovery of
performance, this had been overseen directly by the trust board rather than delegated to a board
committee.

We found variability in the accessibility of data in some core services. For example, we were
informed by staff at The Royal London Hospital that the trust was unable to extract site level data
but then later found this not to be the case and were presented with the relevant site level
information, which led to concern around how the trust assured themselves.

The trust was working towards implementing paperless notes and most parts of the patient
records was now stored on computer. The storage of paper records was outsourced to an external
company, and the trust used an external provider to store electronic records (Cerner) which had
recently been upgraded. The trust had also recently introduced an upgraded service for pathology
and imaging. We found that in some areas agency staff did not have access to electronic records,
for example in surgery services at Whipps Cross and The Royal London hospitals.

There remained concern as to the consistent completion of patient records in some areas. For
example, incident reporting highlighted concerns in maternity services at Newham University
Hospital where incomplete patient records were an ongoing problem that had not been resolved
since our last inspection. We also found that processes were not in place to evaluate this at the
time of our inspection.

The trust had developed a comprehensive informatics strategy that clearly recognised the risks to
the organisation and outlined key developmental objectives. Following a nationwide cyberattack
that severely impacted information and communications technology (ICT) services across the trust
in 2017, the trust had improved the integrity of its ICT platform. This had included the removal of
outdated computers and servers, updates to software and cybersecurity and improvements to
continuity plans. The trust had invested £10 million last year and a further £6 million this year to
remediate risks in ICT. Ongoing investment was being allocated along with further plans for
improvement. Recent changes to the board meant that the director of strategy held executive
responsibility for ICT as part of his portfolio.

The trust did not currently have an electronic prescribing system, however a bid for this had
recently been successful. Regular medicines audits were completed that ensured that the
pharmacy department was able to monitor and manage the risks associated with the safe and
effective use of medicines.
The trust intranet was a primary tool for ensuring that staff had access to the most up to date policies and operating procedures. However, we still found examples where policies and procedures were only accessible in paper format.

The trust was required to submit notifications to external bodies, including the CQC, for which they were compliant.

**Engagement**

The trust had in place structured processes to communicate with staff and engage with people who use services and their representatives. The trust recognised that partnership working was essential in driving the strategic direction towards improving patient care and the delivery of its services.

We met with many staff across a variety of professions, teams and services to seek their views on working for the trust. Most staff we met with were able to discuss how the trust had improved staff engagement, increased accessibility and communication with senior managers, improved the staff appraisal process, had accessibility to learning and development opportunities, and had an increased confidence in reporting errors, near-misses and incidents.

The trust had conducted several listening events over previous years with staff. These had been successful in helping the trust understand the needs and challenges of its workforce. With further collaboration with senior leaders across the trust, a ‘people’ strategy had been developed that sought to address how best to develop and progress staff and enhance retention. This included working collaboratively with Health Education England, NHS Improvement and NHS England on a programme that was designed specifically to improve nurse recruitment and retention in NHS London trusts.

Other staff groups spoke positively of the improved levels of staff engagement at the trust. Doctors in training shared positive experiences about the training and education opportunities that came with working for the trust and shared examples of how they were involved in service development. However, administrative and clerical staff we spoke with had lower levels of satisfaction and engagement.

Communication systems such as the intranet and newsletters were in place to ensure staff, patients and carers had access to up to date information about the work of the trust and the services they used.

The trust was developing its approach to obtaining feedback from those who use services and their relatives with a view to collaboratively driving improvement. Clinical boards had begun to ensure that understanding patient experience was sought when designing service development. The number of patient representatives at the trust had increased. Patients were regularly invited to share their stories at monthly board meetings.

Forums had been set up to allow for patients and carers to come together regularly to discuss and share ways to improve patient experience. For example: the trust delivered acute and specialist services for children and young people, and had sought to better engage with this age group through the introduction of a ‘Youth Empowerment Squad’. This forum was made up of young people who had experience of healthcare services and had been meeting once a month since 2015, helping to advise the shaping of children’s services at the trust. Another example was the Patient Voice group that met six times a year specifically to discuss improvement at St Bartholomew’s Hospital.
Last year the trust changed the provider for obtaining patient feedback across services and this led to a significant drop in the quantity and quality of data. This impacted ability for services to gather and act upon detailed patient feedback for many months and the data presented to us showed a very low response across services. The trust had sought to address this, although there was still concern that the data was not sufficient.

Some services created their own means for patients and carers to give feedback which was collated to inform development. For example, end of life care services had improved their bereaved carers survey to better identify complaints and incidents relating to end of life care. However, the trust recognised that further improvements to engagement with patients and carers to better understand their experience could be made, and we found examples where opportunities for feedback were limited in some areas and patient engagement was low.

The trust had established collaborative relationships with several partner organisations across the north-east London STP. There was increasing population growth across north east London and demographic differences across the boroughs that brought with it further challenges and demands on the delivery of services. Working with local clinical commissioning groups (CCG) in Tower Hamlets, Newham and Waltham Forest, across primary, community and social care, the trust was working to address how services met the needs of a changing health economy. CCGs spoke positively of their relationship with the trust and described how this had improved and become increasingly collaborative, with greater transparency.

The trust worked closely with Healthwatch to be actively involved in reviewing and advising on how services could better improve patient care. For example, the Whipps Cross HMB met regularly with local Healthwatch representatives. Working groups were established and regular visits by Healthwatch helped inform areas for improvement. The trust had also invited Healthwatch to carry out peer reviews that were instrumental in improving care. This included a programme of patient-led assessments of care audits (PLACE) which were regularly carried out to assess hospital facilities and had led to greater involvement of patient representatives.

The trust worked closely with the ‘Barts charity’, a charity that specifically supported the work of staff and researchers across the trust, providing funding for research, equipment and innovative healthcare projects. Members of the public could volunteer to work with the charity in staffing the charity hub, distributing leaflets and providing information for patients and visitors, and supporting volunteers who were taking part in fund raising activities. We saw Barts charity magazines were available to patients and visitors across the wards.

**Learning, continuous improvement and innovation**

The trust actively sought to participate in national quality improvement and innovation projects with each of its four main hospital sites involved in implementing a wide variety of ventures aligned to the services they provided that included active participation in clinical research studies. However, some hospital sites and clinical teams were more engaged with this process than others.

Staff were encouraged to make suggestions for improvement and gave examples of ideas which had been implemented. The trust quality improvement (QI) programme was overseen by a steering group chaired by the chief medical officer. The QI programme aligned with the trust's strategic quality objectives. The development of the methodology had led to the creation of the slogan ‘WeImprove’. Each hospital site had established improvement teams to oversee local QI projects. A growing number of staff across the trust had received training in improvement methodologies.
St Bartholomew’s Hospital provided several specialist services, including the treatment of cancer and heart problems. Clinical teams collaborated globally leading research that transformed the treatment of cancer and cardiac conditions, for example: clinical teams in collaboration with other organisations developed pioneering stem cell treatment for heart failure; a team of consultant cardiologist had developed an innovative procedure to treat mitral regurgitation; the Barts Cancer institute researched new approaches to the screening of breast and ovarian cancer. Many other projects had been recognised by external organisations for their innovative benefits and awards had been given to individuals and teams across services.

A diabetes team at Newham University Hospital was one of seven projects chosen nationally by an independent health charity in October 2017 to take their health care innovation and develop it on a larger scale to better impact patient outcomes, increasing patient attendance rates. The team were working with commissioners and NHSI with a view to rolling this out nationally.

Whipps Cross Hospital had improved the way its rheumatology clinics operated, including the use of technology to improve patient access and information. The hospital had also introduced a Virtual Biologics Clinic (VBC) to improve evidence-based prescribing of high-cost medications in routine clinical practice, reduce treatment delays and variations in patient experience.

The Royal London Hospital provided a full range of local and specialist services, which included one of the largest children’s hospitals in the UK with one of London’s busiest paediatric Accident and Emergency departments. The Royal London is one of the leading trauma and emergency care centres and hyper-acute stroke centres in the London region, home also to London’s Air Ambulance. Trauma teams at the hospital were widely recognised for the work and research that they carried out and the innovative approach to developing treatment. Recent developments had seen the introduction of London’s first specialist burns service attached to a major trauma centre, staffed by an expert small team of plastic surgery and burns consultants and a specialist nurse, and the launch of a successful Robotic surgery programme.

The hospital was leading many research projects looking at oral involvement of Behcets disease. They were part of a team developing a national standardised clinical data set for the disease.

The trust had a planned approach to take part in national audits and accreditation schemes and shared learning. The audit programme included internal local audits to better understand the impact of care and national audits, both mandatory and to ensure alignment with NICE guidelines. The trust used the outcomes from audits to inform their clinical objectives; however, the trust considered that the internal audit process could be more strategic in its approach to improving services.

The trust was involved in the Commissioning for Quality and Innovation (CQUIN) scheme, intended to bring quality improvements and transformational change to services. The trust recognised that this worked best when aligned to sustainability and transformation (STP) plans across the wider health and social care economy. Overall trust performance was at 87%. The trust performance for the timely identification and treatment of sepsis in emergency departments and acute inpatient settings was low, hindered by variations in access to electronic recording.

The trust had developed a public health team to support health promotion for patients. This included the implementation of software within the electronic patient record which allowed automatic referral of patients who were smokers for specialist help. This has led to several thousand patients referred over previous years and development of smoking cessation services on some sites.
The trust was developing its approach to identifying and learning from unanticipated deaths. All trusts were expected to develop their practice following the NHS National Quality Board guidance on Learning from Deaths, 2017 and the 2016 CQC report ‘Learning, candour and accountability’ which requires NHS trusts to produce and publish an updated policy on learning from death.

The trust had assigned a medical examiner to the bereavement office at both Royal London and Whipps Cross hospitals, recognising the need for compliance to the above guidance and that the trust had scope to improve the quality of experience for the bereaved. This had led to improved oversight of potential avoidable deaths and had also led to more timely processing of necessary documentation. The trust was also building a module into the incident reporting system that would allow for improved reporting of deaths.

The trust had in place regular mortality and morbidity (M&M) meetings. Although they didn’t follow a standard format, there was evidence from the examples we reviewed that an appropriate level of discussion identifying learning was carried out. However, it was not always clear as to how this would then be actioned and the results evidenced.

We also carried out a table-top review of a select number of deaths that had been reported to STEIS over the last few years. A recurring theme was related to inconsistently completed National Early Warning Scores (NEWS) and subsequent delays in escalation of care. The trust had actioned several steps to address this, such as improving awareness with staff; however, our recent inspection found that this was still a concern in some services.

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months:

<table>
<thead>
<tr>
<th>Question</th>
<th>In days</th>
<th>Target performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your internal target for responding to complaints?</td>
<td>Three working days</td>
<td>83%</td>
</tr>
<tr>
<td>What is your target for completing a complaint</td>
<td>10-60 working days</td>
<td>45%</td>
</tr>
</tbody>
</table>

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

The trust received 1,783 complaints from April 2017 to March 2018. A breakdown of complaints by site is shown below:
### Site breakdown

<table>
<thead>
<tr>
<th>Site</th>
<th>Total complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal London Hospital</td>
<td>724</td>
</tr>
<tr>
<td>Whipps Cross Hospital</td>
<td>533</td>
</tr>
<tr>
<td>Newham University Hospital</td>
<td>280</td>
</tr>
<tr>
<td>St. Bartholomew’s Hospital</td>
<td>234</td>
</tr>
<tr>
<td>Mile End Hospital</td>
<td>11</td>
</tr>
</tbody>
</table>

The top three subjects were;

- Diagnosis/treatment – 645 (36%)
- Communication – 357 (20%)
- Delays in care – 297 (16%)

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

The trust received 558 compliments from April 2017 to March 2018.

The site breakdown of compliments was;

- Whipps Cross Hospital – 235
- Royal London Hospital – 216
- Newham University Hospital - 39

(Source: Routine Provider Information Request (RPIR) – P62 Compliments)

The trust was compliant in acknowledging complaints within three working days as stated in the recently updated complaints policy (Sept 2018). The policy advised negotiation with the complainant to agree appropriate time scales for a final response and the trust had defined timescales depending on the complexity of the complaint. For example, a complaint linked to a serious incident would be expected to be completed within 60 days, whereas a less complex complaint would be addressed and closed in a shorter 10 to 40-day timeframe.

It was evident that not all complaints were completed within agreed timeframes with variation across sites. The response rate for Newham University Hospital was less than 25% compared to St Bartholomew’s at over 70% (against trust target of 45%). The trust recognised this was not acceptable and told us that commissioners were keen for response rates to be at 80%.

Approximately 8% of complaints at each site were reopened. The trust saw this in part as a need to review the quality of the initial response and improve staff training.

Each complaint was addressed by the relevant site governance team, overseen by the local director of nursing who in turn reported to the head of compliance. Complaints data was included in each site integrated performance report (IPR). Quarterly and annual reports were collated and submitted to the local Quality and Safety Committee who then reported to board via TEC and QAC. However, we found during our inspection that specific core service complaints data was not always provided.
NHS trusts are able to participate in several accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The trust was involved in the following accreditation schemes current at the time of our inspection:

<table>
<thead>
<tr>
<th>Accreditation scheme name</th>
<th>Details of any services, labs, units or wards that have achieved accreditation (including date accreditation was achieved).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Advisory Group on Endoscopy (JAG)</td>
<td>Whipps Cross Endoscopy Unit 23/05/2018</td>
</tr>
<tr>
<td>Clinical Pathology Accreditation and its successor Medical Laboratories ISO 15189</td>
<td>Pathology specialties on all sites independently CPA accredited until September 2018</td>
</tr>
<tr>
<td>European Federation of Immunogenetics (EFI)</td>
<td>Clinical Transplantation Laboratory accredited October 2017</td>
</tr>
<tr>
<td>Joint Accreditation Committee ISCT (Europe) (JACIE)</td>
<td>Stem cell 27/11/2015</td>
</tr>
<tr>
<td>ISO 9001 Quality Management Systems</td>
<td>SBH Radiotherapy Services (Jan 18), Fertility (Nov 17), Medical Physics (Jan 18) and Clinical Engineering (Renewed Dec 17)</td>
</tr>
<tr>
<td>MacMillan Quality Environment Award (MQEM)</td>
<td>SBH Radiotherapy Services (Dec 16) and Chemotherapy Services (Dec 16)</td>
</tr>
<tr>
<td>RLH Accredited endometriosis centre - annual accreditation, first accredited in 2013</td>
<td>Gynaecology - last accreditation in May 2017. The 2018 accreditation result due at the time of inspection.</td>
</tr>
<tr>
<td>British Society of Echocardiography Departmental Accreditation</td>
<td>Awarded Transthoracic, Transoesophageal, Stress Echocardiography and Training/Education accreditations (March 2018)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Accreditations tab).
This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.
The emergency and urgent care department (ED) at Newham University Hospital sees 155,000 patients per year. Initial assessment and streaming is delivered by an integrated team of GPs, emergency nurse practitioners (ENP), advanced nurse practitioners (ANP), emergency doctors and nurses, and emergency department assistants (EDA).

The urgent treatment centre (UTC) is overseen by the clinical director for urgent and emergency care, and staffed by ENP and GPs, plus cross cover from the emergency department medical staff. Case mix for UTC includes minor injuries, minor illness, gynaecology, paediatrics, and mental health. It is open 8am to 11pm. After closing, patients are managed by either the emergency department or the on-site out of hours GP service.

The emergency department consists of a separate paediatric area with six cubicles and one HDU (high dependency unit), an adult’s area 17 cubicles including a mental health secure cubicle, and a 7 bed resuscitation room with a dedicated paediatric bay. The site has a trauma unit, and sees the full range of adult and paediatric emergencies.

Next to the emergency department is a paediatric clinical decision unit (PCDU), adult CDU, ambulatory CDU (run by the emergency department) and the medical assessment unit (MAU). The PCDU is in the paediatric area; the adult CDU and MAU are found on the observation ward.

Medical staffing consists of 10 whole time equivalent (WTE) consultants who are on-site from 8am to 10pm seven days a week. The junior doctor / advanced nurse practitioner staffing is a total of 42 WTE, comprising of junior and senior trainee doctors, clinical fellows and ANP. There is a senior trainee doctor (ST4 or equivalent) on-site at all times. The psychiatric liaison service (RAID) is found within ED 24 hours, seven days a week, staffed by psychiatry liaison nurses and psychiatry consultants. The psychiatry doctor on-call is based at the nearby mental health unit and attends to review patients in need of admission.

The total nursing establishment is 82.69 WTE (46.66) WTE in the emergency department and 30.64 (26.41) WTE in observation unit.

(20180517 RPIR Acute - NUH Documents – Context)
Total number of urgent and emergency care attendances at Barts Health NHS Trust compared to all acute trusts in England, July 2017 to June 2018:

From July 2017 to June 2018, there were 440,983 attendances at the trust’s urgent and emergency care services as shown in the chart above.

(Source: NHS England)

The percentage of A&E attendances at this trust that resulted in an admission increased in the most recent year compared to the earlier year. In both years, the proportions were lower than the England averages.

(Source: NHS England)
Urgent and emergency care attendances by disposal method, from April 2017 to March 2018:

- Admitted to hospital: 84,546
- Discharged*: 219,503
- Referred*: 47,450
- Transferred to other provider: 26,770
- Died in department: 273
- Left department#: 15,300
- Other: 22,043
- Not known: 25,098

* Admitted to hospital includes: no follow-up needed and follow-up treatment by GP
^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional
# Left department includes: left before treatment or having refused treatment

(Source: Hospital Episode Statistics)

Is the service safe?

Mandatory training

Newham Hospital set a target of 85% for completion of mandatory training. Nursing staff told us they were encouraged to maintain their mandatory training levels. They received e-mails to remind them of training which was to expire and training sessions were arranged as a rolling programme to ensure they could attend. They thought the training provided by the hospital was of a satisfactory quality. There was a nurse practice educator that supported staff working in the department with recognising what their training needs were and organising additional training when needed.

The trust told us that education about the recognition and management of sepsis was mandatory for all doctors and nurses. We saw that staff were reminded about the importance of prompt management of sepsis at the morning handover and in safety briefings.

A breakdown of compliance for mandatory courses as of the 4 June 2018 for nursing staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Transfusion</td>
<td>12</td>
<td>12</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>93</td>
<td>95</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Working at Barts Health</td>
<td>91</td>
<td>95</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness</td>
<td>91</td>
<td>95</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety</td>
<td>88</td>
<td>95</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>87</td>
<td>95</td>
<td>92%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fraud Awareness</td>
<td>86</td>
<td>95</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Security</td>
<td>85</td>
<td>95</td>
<td>89%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Emergency Planning</td>
<td>85</td>
<td>95</td>
<td>89%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Name of course</td>
<td>Number of staff trained (YTD)</td>
<td>Number of eligible staff (YTD)</td>
<td>Completion rate</td>
<td>Trust Target</td>
<td>Met (Yes/ No)</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
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<td>--------------------------------</td>
<td>-----------------</td>
<td>--------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Privacy and Dignity</td>
<td>84</td>
<td>95</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Complaints</td>
<td>84</td>
<td>95</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation - Basic Life Support</td>
<td>74</td>
<td>84</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Harms - Catheter Acquired Infections</td>
<td>83</td>
<td>95</td>
<td>87%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Harms - VTE</td>
<td>83</td>
<td>95</td>
<td>87%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Harms - Pressure Ulcer Prevention</td>
<td>82</td>
<td>95</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Early Warning Systems</td>
<td>82</td>
<td>95</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Clinical Documentation</td>
<td>82</td>
<td>95</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Nutritional Care</td>
<td>82</td>
<td>95</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Harms - Slips, Trips, and Falls (Patients)</td>
<td>81</td>
<td>95</td>
<td>85%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention and Control - Clinical</td>
<td>81</td>
<td>95</td>
<td>85%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>81</td>
<td>95</td>
<td>85%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Investigation of Incidents</td>
<td>28</td>
<td>33</td>
<td>85%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk Assessment for Managers</td>
<td>27</td>
<td>33</td>
<td>82%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>76</td>
<td>95</td>
<td>80%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Medical Gas Safety</td>
<td>66</td>
<td>83</td>
<td>80%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling - Patient Handling Low Risk</td>
<td>74</td>
<td>95</td>
<td>78%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention and Control - Non- Clinical</td>
<td>28</td>
<td>40</td>
<td>70%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Consent</td>
<td>28</td>
<td>40</td>
<td>70%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing and midwifery staff exceeded the 85% completion target for 22 out of 27 mandatory training modules.

A breakdown of compliance for mandatory courses as of the 4 June 2018 for medical staff in urgent and emergency care is shown below:

Nursing and midwifery staff exceeded the 85% completion target for 22 out of 27 mandatory training modules.

A breakdown of compliance for mandatory courses as of the 4 June 2018 for medical staff in urgent and emergency care is shown below:
<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>27</td>
<td>40</td>
<td>68%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Clinical Documentation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Harms - Pressure Ulcer</td>
<td>27</td>
<td>40</td>
<td>68%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Prevention</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Privacy and Dignity</td>
<td>27</td>
<td>40</td>
<td>68%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Security</td>
<td>27</td>
<td>40</td>
<td>68%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>4 Harms - Catheter Acquired</td>
<td>27</td>
<td>40</td>
<td>68%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infections</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Harms - Slips, Trips, and</td>
<td>27</td>
<td>40</td>
<td>68%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Falls (Patients)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early Warning Systems</td>
<td>26</td>
<td>40</td>
<td>65%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fraud Awareness</td>
<td>26</td>
<td>40</td>
<td>65%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Emergency Planning</td>
<td>26</td>
<td>40</td>
<td>65%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Nutritional Care</td>
<td>26</td>
<td>40</td>
<td>65%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Dementia Awareness</td>
<td>26</td>
<td>40</td>
<td>65%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Working at Barts Health</td>
<td>25</td>
<td>40</td>
<td>63%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation - Basic Life</td>
<td>22</td>
<td>40</td>
<td>55%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Gas Safety</td>
<td>9</td>
<td>19</td>
<td>47%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical staff met the 85% completion target for three out of 24 mandatory training modules; the lowest scoring module was medical gas safety with 47%. We were not made aware of any initiatives undertaken to improve the compliance with the mandatory training.

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

**Safeguarding**

Staff told us they referred adults who attended the ED with injuries that may be because of domestic violence to the safeguarding team. Where these adults had children, then the children were also referred to safeguarding on the basis that they were a witness to domestic violence within the family. Staff also gave examples where they reported cases of poor pressure ulcer care delivered by district nursing team or local care homes noted on patient’s presence.

The safeguarding team at Barts Health NHS Trust provided visible and active leadership across the trust with a lead named nurse, a named nurse for each of the three acute sites and a team of three specialist advisors. The team offered ready access for all staff to advice and guidance through a 24-hour on-call advice line, staffed on a rotational basis by each of the named nurses. Thereby, operational staff and managers were given prompt guidance which supported good judgements about the safety of patients.

The safeguarding team had set out a comprehensive audit programme for 2018/19. This followed challenges highlighted during our previous inspection around recognition of safeguarding and lack of proper response due reduced staffing levels. It was too early to see the impact of this work.

Paediatric nurses and doctors we spoke to had a good knowledge of safeguarding protocols and awareness of issues they should be concerned about when treating children and young adults. They spoke of appropriate examples were safeguarding protocols were initiated by members of staff. They were also aware of who to contact should they need advice in relation to safeguarding.

Children and young people receiving statutory support due to their vulnerability were flagged appropriately by the electronic records system that has been in place since March 2018. This supported early identification and alerting of partner agencies.
The safeguarding team across the trust were using information from the Tower Hamlets Multi-Agency Child Sexual Exploitation (CSE) Group to record on the system when a child was known to be at risk of CSE. This was still in its infancy and the safeguarding team recognised further work was needed to ensure all staff were aware of the information being on the system.

When ED staff were registering a child or young persons on arrival in the ED they were to complete a checklist. It included a section which noted the patient was 0-19 years old, which triggered an initial safeguarding assessment form on the electronic patient record system. We checked six records and noted that in two cases this section was not completed and the safeguarding assessment was not started by staff as the field to show patient was less than 19 years old was not highlighted by them. Overall there was inconsistency in the completion of the electronic ED triage safeguarding template. Although child protection field was mandatory and safeguarding concerns were named and recorded in the free text of the assessment, the safeguarding template which offered descriptive areas of the presenting concern were not always completed (three of the further seven records checked). There was no indication that it had impacted on children concerned but did indicate all information was not available to the next clinician reviewing the record.

Three safeguarding cases reviewed evidenced direct contact had been made with the named social worker and contact details recorded. Staff had access to female genital mutilation (FGM) protocol that included information about supporting women and girls who have undergone or who were at risk from FGM. They were aware of the walk-in FGM clinic managed by the trust in a local hospital. THE clinical offered cervical screening tests and support offered by specialist gynaecologist, psycho-social practitioner, an FGM specialist midwife, a female FGM trained sample taker and had access to an interpreter.

Newham Hospital set a target of 85% for completion of safeguarding training. A breakdown of compliance for safeguarding courses as of the 4 June 2018 for nursing staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Level 1</td>
<td>93</td>
<td>95</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>85</td>
<td>95</td>
<td>89%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>67</td>
<td>75</td>
<td>89%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>80</td>
<td>95</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 3</td>
<td>32</td>
<td>41</td>
<td>78%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing and midwifery staff exceeded the 85% completion target for three out of five safeguarding training modules.
A breakdown of compliance for safeguarding courses as of the 4 June 2018 for medical staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Level 1</td>
<td>38</td>
<td>40</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>37</td>
<td>40</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>34</td>
<td>38</td>
<td>89%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>30</td>
<td>40</td>
<td>75%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 3</td>
<td>9</td>
<td>26</td>
<td>35%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical staff exceeded the 85% completion target for three out of five safeguarding modules. The lowest scoring module was safeguarding children level 3 with 35%.

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

**Cleanliness, infection control and hygiene**

There were housekeeping staff for cleaning all areas of the emergency department and we found most areas were maintained to a good standard of cleanliness. The contractor responsible for maintaining the environment undertook cleaning audits. Patients and relatives told us they were satisfied with the level of cleanliness in the department. Most areas we visited were tidy, clean, and uncluttered. Disposable curtains hung around examination beds were clean and included a replacement date. The plaster room was visibly clean and fit for purpose.

The service had set up systems for infection prevention and control, which were accessible to staff. These were based on the Department of Health’s code of practice on the prevention and control of infections, and included guidance on hand hygiene, use of personal protective equipment (PPE) such as gloves and aprons, and management of the spillage of body fluids.

There was easy access to personal protective equipment (PPE) such as aprons and gloves in all areas we inspected and all staff used PPE as needed. There was also sufficient access to hand gel dispensers, handwashing, and drying facilities. Hand washing basins had a sufficient supply of soap and paper towels. Services displayed signage prompting people to wash their hands and gave guidance on good hand washing practice. However, we noted that the department did not use a standardised system for placing hand sanitising gel dispenser near entrances to allow staff and visitors to sanitise their hands as soon as they arrived at the department or clinical area. We observed staff were bare below the elbows when in clinical areas, staff we saw had no jewellery on their hands.

Although, we saw staff adhering to hand hygiene. Audits, as presented below, showed that hand hygiene audits were not always undertaken. It was not clear what action if any had been taken to improve the compliance and frequency of the audit.

**Hand Hygiene Audits - January to August 2018**

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E NUH</td>
<td>0%</td>
<td>85%</td>
<td>100%</td>
<td>100%</td>
<td>0%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Observation Unit</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Urgent Treatment Centre</td>
<td>48%</td>
<td>0%</td>
<td>82%</td>
<td>0%</td>
<td>0%</td>
<td>78%</td>
<td>85%</td>
<td>62%</td>
</tr>
</tbody>
</table>
Clinical waste management practices, including those for contaminated and hazardous waste were safe and in line with national standards. There was a colour-coded system for disposal of waste, and clear segregation of clean and dirty equipment. Sharps bins were available in treatment areas where sharps may be used. This was in line with health and safety regulation 2013 (The sharps regulations), 5 (1) (d). We saw labels on sharps bins with signatures of staff, showed the date it was assembled, and by whom.

**Environment and equipment**

The main waiting area had sufficient seating available and it was visibly clean. There were no screens or signs which would show the waiting time

Waiting areas for children under 16 years old were separate in the children’s emergency department. We noted that the nursing station there was located on the back of the corridor which meant staff did not have direct oversight of the waiting area. Nurses said that they raised the issue with their managers and were provided with a camera system and a 12-inch screen, mounted under the ceiling opposite their station, which displayed image from four cameras installed in the department. They also relied on sound carried across the corridor. The trust installed windows in the main triage room with direct visibility of the waiting room, to address this. This room was used for triage and we were told it was occupied by a nurse most of the time but were unable to verify it at the time of inspection.

Entrance to children’s ED was by secure access. The overall environment was child friendly, toys were available, and it was well maintained. It had sufficient activities and was supporting a positive experience for the child while waiting to be seen.

There were toilets that were accessible to people with mobility difficulties and nappy changing facilities for parents that had to take their children to the ED.

Medical equipment inspected was serviced and tested for electrical safety with labels showing when the next test was due or last test carried out. This included clinical equipment, fire extinguishers and medical gas cylinders. We noted that not all electronic office equipment had stickers showing the date of last test. This included office equipment in the reception area, computers in the resuscitation area or paediatric ED were labels were not visible. We saw some office equipment where labels showed the electrical safety test was overdue since June 2018 and in two cases since 2016. We asked staff about an equipment register, which would indicate what equipment was in stock, when it was tested and when next test was due. However, staff told us they did not have access to it and were not sure if this was in existence.

Staff reported that they had no issues with maintaining equipment and the team responsible for repairs responded promptly.

The resuscitation trollies checked were securely sealed and the seal number was recorded so it was clear if someone had accessed the resuscitation equipment. They were checked daily and we saw that all equipment was present, including equipment for smaller or paediatric patients.

The hospital took part in the patient-led assessments of the care environment (PLACE) in 2018. This assessment focuses on the care environment. Where shortcomings were found these were addressed through an action plan. The department passed all categories related to condition, appearance and maintenance.

In the paediatric emergency department, staff used a side room to nurse children and adolescents who required support for their mental health conditions. The room was located opposite nursing station and staff said that often one to one support would be provided to ensure child patient safety.
The ED room had two designated psychiatric liaison rooms that the RAID (rapid assessment interface and discharge) team used. The assessment room had one door and had heavy furniture. The other room for use by adult’s mental health patients had two doors, which could open outwards. A strip alarm was fitted to enable staff to ask for support if needed. The department had completed work to reduce potential ligature anchor points in the room, including removing a sink that was previously in the room. Staff had completed a risk assessment, including a review of potential ligature anchor points, of the room. The ED sometimes used the room for patients without mental health needs when the department was short of rooms to place. Staff told us that mental health patients had priority usage of the room, and they responded to the needs of patients in the department at any time.

Staff could see patients in the room through an observation window connecting to the RAID office and through windows in the room. Staff could see all parts of the room from using the different viewing panels. Staff told us the trust also planned to install a camera (CCTV system). The rooms did not have en-suite facilities. Staff supported patients to use other facilities in the department. The assessment room and en-suite were visibly clean. The walls to both rooms were stark and clinical.

Assessing and responding to patient risk

Patients who self-presented to the department were booked in at reception. Reception staff were provided with a list of complaints which indicated that urgent medical help was needed. It included patients presenting with chest pain, patients with sickle cell disease or pregnancy. Patients were initially assessed by a nurse or a junior doctor and streamed to the most appropriate area. The assessment nurse took a brief history and basic observations.

To assess risk the department streamed patients to ensure they were sent to the correct area of the department which best met their needs. It included a walk-in centre staffed by GPs, the urgent treatment centre that dealt with minor injuries or majors area for dealing with immediately life-threatening illnesses and injuries. Patients who were to be seen for a follow up, a few days after their discharge from ED, presented directly at the ambulatory care department which was open during the day. Paediatric patients were streamed in the same area as adults before being directed to paediatric ED.

There was an observation area with armchairs available. It was staffed by a nurse and was used for patients who were awaiting test results or needed further monitoring before being discharged home or admitted to a hospital ward.

Once patients were booked, the four-hour target time started, in line with the Department of Health’s standard for emergency departments that 95% of patients should be admitted, transferred, or discharged within four hours of arrival in the ED.

Patient’s risk was assessed using nationally validated tools. For example, we saw the risk of falls and the risk of pressure damage was assessed using standardised tools. We saw risks were mostly updated with appropriate risk management actions. The ED used a system of national early warning scores (NEWS for adults and PEWS for children) to alert staff to the deteriorating patient. Each patient check was to include vital signs checks (i.e. temperature, pulse, blood pressure, respiratory rate, responsiveness, and oxygen levels), NEWS and pain scores, a falls risk assessment for patients over 65 years of age. Checks also included sepsis screening and a pressure area screen for older patients as well as those with conditions likely to increase the risk of pressure ulcers. Staff escalated appropriately high NEWS scores to prevent patient’s health deterioration.
We observed handovers of patients from ambulance crews. It took place at the designated ‘fast track’ station where a doctor was available to assess patients and to talk to paramedics who supported patients. The information shared by medical professionals involved was sufficiently detailed and the handover was carried out promptly.

There was no information easily available, such as large screen in the majors’ area, to all ED staff that would show if ambulance was on its way or if there were some waiting for the handover. There was also no real-time information to show how the department performed in relation to any potential delays in handover times or time taken to assess patients within the department.

The paediatric resuscitation bay was in the majors’ resuscitation area, accessed through joined corridor.

The trust told us that all shifts during the past 12 months had a nurse with paediatric life support training on duty in line with RCEM guidance (Royal College of Emergency Medicine). PILS (paediatric immediate life support) was a standard resuscitation training for all nurses in the department, and most senior nurses (with an exception of two) had completed EPLS (European paediatric life support), APLS (advanced paediatric life support) or both.

The trust scored about the same as other trusts for all five Emergency Department Survey 2016 questions relevant to safety.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?</td>
<td>7.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>5.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?</td>
<td>6.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q33. In your opinion, how clean was the emergency department?</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

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

The median time from arrival to initial assessment was worse than the overall England median over the 12-month period from July 2017 to June 2018. In the latest month June 2018, the median time to initial assessment was 11 minutes compared to the England average of 7 minutes.
Ambulance – Time to initial assessment from July 2017 to June 2018 at Barts Health NHS Trust

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

Percentage of ambulance journeys with turnaround times over 30 minutes for this trust.

From June 2018 to June 2018, there was a stable trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Newham Hospital. Performance ranged between 72 and 80% for turnaround times over 30 minutes.

Ambulance: Number of journeys with turnaround times over 30 minutes – Newham University Hospital

(Source: National Ambulance Information Group)
Number of black breaches for this hospital

<table>
<thead>
<tr>
<th>Date</th>
<th>Reason for black breach</th>
</tr>
</thead>
<tbody>
<tr>
<td>06/01/2018</td>
<td>8 ambulances in 1 hour including 2 Blue Calls - 5/1/18</td>
</tr>
<tr>
<td>03/03/2018</td>
<td>Very busy day with 565 patients 343 Type 1s 99 ambulance cases. 111 breaches. Department full with no capacity. 05/03/2018</td>
</tr>
<tr>
<td>10/03/2018</td>
<td>2 Ambulances within 4 minutes (1 a blue call) 81 ambulance cases. 254 Type 1s performance 86.77%</td>
</tr>
<tr>
<td>24/03/2018</td>
<td>25/03/2018 - 4 ambulances in 1-hour early morning</td>
</tr>
</tbody>
</table>

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

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. From April 2017 to March 2018 the hospital reported four days where “black breaches” occurred.

ED staff arranged psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. All patients arriving in the department had an initial triage to identify if they needed to be assessed by the RAID team. ED staff contacted the mental health liaison team when there were concerns that a patient may be at risk of self-harm or suicide.

ED staff told us they worked with the mental health liaison team and contracted security staff to ensure the safety of staff and patients. An additional nursing staff member could be arranged to observe a patient when necessary. Staff told us that they rarely arranged for additional staff because of the amount of time it took for them to be booked; often staff would arrive on site when they were no longer needed. Security staff told us that they felt under pressure to observe patients. They told us they felt they had not received sufficient training to be able to understand the needs of patients with mental health needs. They had worked with managers in the department and told us that the number of ‘watches’ they were asked to complete around the time of the inspection had reduced. Staff told us that the trust had recently given extra funding to pay for staff to provide enhanced care for patients.

Staff said they followed a set procedure if a patient went missing from the ED, which included a search of the immediate area by security staff. From 1 August 2017 and 31 August 2018 (13 months), staff in the RAID team reported 21 incidents categorised on the trust’s electronic incident reporting system as ‘absence without leave’.

Staff we spoke to understood safeguarding and made appropriate referrals. For example, in July 2018, staff in the RAID team made three referrals.

The team had a policy in place for the usage of intra-muscular rapid tranquilisation that was in line with national guidance. Staff from the RAID team could advise staff on its usage. Staff had not used intra-muscular rapid tranquilisation on a mental health patient recently. Staff had been trained in the use of restraint.

Staff had been provided with some specialist training in how to respond to patients in mental health crisis. The ED had run a simulation training course on acute psychiatric emergencies, which included training on breakaway techniques.

In the paediatric emergency department, staff used a side room to nurse children and adolescents who required support for their mental health conditions. This room and its en-suite shower room
was not risk assessed for ligature risks and had many ligature points including handles, door closures and taps.

**Nurse staffing**

Newham Hospital reported the following nurse staffing numbers for urgent care and emergency services in March and April 2018. The hospitals fill rate remained below 90% in March and April 2018.

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care and Emergency Services</td>
<td>90.4</td>
<td>114.9</td>
<td>78.6%</td>
<td>94.0</td>
<td>114.9</td>
<td>81.8%</td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request)*

From May 2017 to April 2018, Newham Hospital reported a vacancy rate of 21.4% for nursing staff in urgent and emergency care services, this was higher than the trust target of 6.3%. The hospital reported a turnover rate of 16.6% for nursing staff in urgent and emergency care services, this was higher than the trust’s target of 13%.

<table>
<thead>
<tr>
<th>Paediatric ED nursing numbers and vacancy</th>
<th>Band</th>
<th>Establishment (WTE)</th>
<th>In post (WTE)</th>
<th>Vacancy (WTE)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Band 7</td>
<td>1.00</td>
<td>1.00</td>
<td>0.00</td>
</tr>
<tr>
<td></td>
<td>Band 6</td>
<td>7.62</td>
<td>6.83</td>
<td>0.79</td>
</tr>
<tr>
<td></td>
<td>Band 5</td>
<td>7.62</td>
<td>4.52</td>
<td>3.10</td>
</tr>
</tbody>
</table>

During the same period Newham Hospital reported a sickness rate of 5.5% for nursing and midwifery staff in urgent and emergency care services, this was higher than the trust’s target of 3%.

Newham Hospital had a total of 7,185 nursing staff shifts from May 2017 to April 2018. A breakdown of bank and agency usage and unfilled shifts is shown below:

<table>
<thead>
<tr>
<th>Bank/ agency</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank</td>
<td>3,959 (55.1%)</td>
</tr>
<tr>
<td>Agency</td>
<td>1,140 (15.9%)</td>
</tr>
<tr>
<td>Not filled</td>
<td>644 (9.0%)</td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request)*

At the time of the inspection there was enough staff on duty to meet needs of the patients. The department reviewed staffing establishment in August 2018 and increased number of posts to ensure patients’ needs were met always. The numbers of staff planned, and on duty were displayed on the wall. Staff allocation differed throughout the day considering patients’ needs and reflecting the peak activity times.
Bank and agency staff were used to maintain numbers and an appropriated skill mix of nursing staff in the department.

We saw there was a robust induction for agency staff, which the senior nurse on duty went through and signed off before they went on the floor. Agency staff we spoke with felt part of the team and said they felt valued team members. They had access to IT systems and were allocated to tasks that matched their skills.

The nursing establishment and skills mix was set in 2013 using the ‘baseline emergency staffing tool’ (BEST). It took into consideration ED attendance numbers and patients’ acuity to recommend appropriate staffing levels. The trust told us the staffing review in August 2018 used data from the BEST tool, the unpublished NICE guidelines for emergency department staffing, plus a review of attendance and acuity data. To meet the current demands on the department, the hospital was staffing the emergency department to the levels recommended in the August review, in anticipation of the revision of the establishment and budget.

**Medical staffing**

Staff we spoke with told us they felt there were enough medical staff. Medical staffing level was reviewed in 2018 and 2 additional consultant’s posts were added to ensure all shifts were covered and sufficient support was available at all times. There was an on-site consultant cover on-site 8am to 10pm. All consultants had built into their job plans covering late finishes and work done when on-call. On-site cover was often extended until midnight, depending on the needs of the department.

On-call cover was provided from 8am Saturday to 8am Monday and between 10pm and 8am Monday to Friday. There was an expectation of a 30-minute return to site if needed for critical patients or safety of the department.

Doctors were allocated to work in specific areas such as ambulance handover station, clinical decision unit, or resuscitation area. It was clearly indicated so all staff were aware.

There were four specialist paediatric emergency medicine consultants out of a total of 10 (WTE). All the emergency department consultants were trained in paediatric emergency. The consultant in charge covered all areas of the department, there was no separate consultant shift for cover within paediatric areas. Allocation for consultant in charge of paediatric ED was allocated at the handover. The trust told us they aimed to expand the consultant workforce to allow dedicated paediatric ED cover 8am to 10pm daily.

There was a middle grade or senior trainee paediatric ED doctor (CT3) cover at all times in addition to foundation year two trainee doctor.

Newham Hospital reported the following medical staffing numbers for urgent care and emergency services in March and April 2018. The hospitals fill rate reached establishment in April 2018.

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care and Emergency Services</td>
<td>42.9</td>
<td>47.3</td>
<td><strong>90.7%</strong></td>
<td>47.5</td>
<td>47.3</td>
<td><strong>100.4%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)
From May 2017 to April 2018, Newham Hospital reported a vacancy rate of 19.2% for medical staff in urgent and emergency care services, this was higher than the trust target of 6.3%. The hospital reported a turnover rate of 0% for medical staff in urgent and emergency care services, this was lower than the trust’s target of 13%. The trust told us there was no consultant shifts unfilled in the last 12 months and where required they have covered with locum doctors.

Newham Hospital reported a sickness rate of 3% for medical staff in urgent and emergency care services, this was the same as the trust’s target of 3% (May 2017 to April 2018).

From May 2017 to April 2018, Newham Hospital had a total of 5,658 medical staff shifts. A breakdown of locum and agency usage and unfilled shifts is shown below:

<table>
<thead>
<tr>
<th>Locum/ agency</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Locum</td>
<td>2,540 (44.8%)</td>
</tr>
<tr>
<td>Agency</td>
<td>1,148 (20.2%)</td>
</tr>
<tr>
<td>Not filled</td>
<td>507 (8.9%)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request)

The proportion of consultant staff reported to be working at the trust in urgent and emergency care was the same as the England average and the proportion of junior (foundation year 1-2) staff was lower.

Staffing skill mix for the 176-whole time equivalent staff working in urgent and emergency care at Barts Health NHS Trust.

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>0%</td>
<td>15%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>48%</td>
<td>33%</td>
</tr>
<tr>
<td>Junior*</td>
<td>22%</td>
<td>23%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)
Records

Records were a mix of electronic and paper. We reviewed 12 paediatric patient records. Most included mandatory fields such as paediatric early warning scores (PEWS for children) to alert staff to the deteriorating patient; sepsis information; weight and observation. Some areas were not consistently captured; for example, there was no safeguarding information recorded on two records.

Children were asked about their ethnicity at booking and in the majority of records the information was consistently recorded (five out of six records checked for this purpose). This meant that staff could consider cultural sensitivity in care of the child. However, we noted that primary language was not consistently recorded (three out of six records).

The recording of the child’s father details was not consistent and there was no detail in three of seven records checked for that purpose. Although it was possible to record this as free text it was not always undertaken. This meant that the child was not seen within the context of the family unit and documents did not provide comprehensive information of who holds parental responsibility. The person accompanying the child was consistently recorded in the ED records.

We reviewed 14 adult patient records in the adult emergency department and found that there was inconsistent recording of information. For example, early warning scores were not recorded on five of notes and pain scores were not recorded on some. Sepsis screening was not recorded on eight sets of records we looked at for this purpose. Dementia status was not always recorded and staff told us there was no need to formally assess patient for dementia in the emergency department. An early diagnosis can help people with dementia to get the right information and support, and help those close to them prepare and plan for the future. Although, it is often difficult to establish confirmed diagnosis of dementia within emergency settings published guidance recommends that an assessment is undertaken on arrival specifically for older people so they can be, where appropriate, referred on to specialist services.

We read five sets of patient records for patients referred to the mental health liaison team. The records included a psychosocial assessment of the patient, which explained their current mental health needs and social circumstances. Records included a risk assessment and a management plan to ensure the safety of the patient. In one of the five records, the plan for the patient, who was intoxicated, was not recorded.

Medicines

Some prescription medicines are controlled under the Misuse of Drugs legislation (and subsequent amendments). These medicines are called controlled medicines or controlled drugs and their storage and dispensing are regulated by legislation. Controlled drugs should be kept in a separate locked cupboard with those keys kept separately from the main medicines cupboard keys; counted twice daily and when dispensed, signed by two members of staff in a separate controlled drugs register. We checked controlled drugs and confirmed that this procedure was following safety guidelines.

Intravenous fluids were stored safely, off the floor and were in date. Water and saline for injections were also stored safely.

Fridges in all areas were recorded daily and the log showed they remained within safe temperature range.

Staff highlighted that temperature in one of the rooms were medication was stored was often at 26 or 27 centigrade, it was above the recommended by medicines producers 25 centigrade. Senior nurse told us that they have raised the issue with the estate management team and were told that
air conditioning unit was ordered to resolve the issue. They checked temperature daily and kept record of it.

Emergency medicines were readily available on emergency trolleys, which were secure, sealed and checked regularly.

Nursing staff told us that pharmacists visited regularly, and medicines were received when requested. Pharmacy technicians visited daily and provided regular top ups to ensure that stock did not run out. Pharmacy staff provided an on-call service out of normal opening hours.

Medicines information was available to clinical staff via the intranet and was easily accessible.

**Incidents**

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

From August 2017 to July 2018, the trust reported no incidents classified as never events for urgent and emergency care at Newham University Hospital.

In accordance with the Serious Incident Framework 2015, the trust reported seven serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from August 2017 to July 2018.

The types of incident reported were:

- Diagnostic incident including delay meeting SI criteria (including failure to act on test results): four incidents
- Treatment delay meeting SI criteria: two incidents
- Radiation incident (including exposure when scanning) meeting SI criteria: one incident

Staff we spoke with knew how to report an incident using the trust’s electronic system. They provided examples where feedback was given after incident was investigated and spoke of lessons learnt. Incidents were discussed at staff meetings to prevent occurrence and key issues related to serious incidents.

The duty of candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. Staff we spoke to were aware of their responsibilities under duty of candour, which ensured patients and/or their relatives were informed of incidents that had affected their care and treatment and they were given an apology. They spoke of examples where they followed the principles of openness and transparency in situations where care and treatment were not delivered in line with expectations or when errors were made.

**Safety thermometer**

The safety thermometer is used to record the prevalence of patient harms and to give immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.
Data collection takes place one day each month. A suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of the suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported five new pressure ulcers, 32 falls with harm and two new urinary tract infections in patients with a catheter from June 2017 to June 2018 within urgent and emergency care.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Barts Health NHS Trust

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

(Source: NHS Digital - Safety Thermometer)

Is the service effective?

Evidence-based care and treatment

The emergency department used a combination of National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine (RCEM) guidelines to determine the treatment that was provided.
The policies, care and treatment pathways, and clinical protocols we reviewed were based upon recognised guidance, including that of NICE and RCEM. They were stored on the trust intranet and available to staff via their mobile devices for ease of access. Doctors we spoke to told us that they found it easy to use and could do it when with patient without the need to step away to look at the computer screen.

Staff used a national early warning score (NEWS) to identify deteriorating patients to ensure they were escalated to the medical team or critical care outreach team in line with National Institute of Health and Care Excellence (NICE) Guideline - CG50 -that covers recognising and responding to deteriorating patients. Clinical policies and guidance were available on the trust intranet and staff could access these easily.

NEWS audits provided by the trust showed that audits within the ED were not taken regularly. Audits help to ensure compliance with clinical guidance in relation to escalating cases were patient's health is rapidly deteriorating. The department did not take part in NEWS audit in April and May of 2018. In months when they had taken part the compliance with records completion and adherence to guidance was very low. For example, the department achieved only 41% in December 2017 which was the lowest score from 13 clinical areas taking part in this internal hospital audit. There were no action plans to address low compliance and improve frequency of the audit.

Trust provided a list of audits document, however, most audits related to emergency medicine were listed as ‘pending’, ‘report due’ or ‘in progress (26 out of 29).

Clinical audits were carried out to check how the trust performed against national guidelines or to confirm compliance with them. The trust made us aware of 29 clinical audits, carried out July 2017 to September 2018, which were related to emergency medicine. The trust wrote down key actions following the audit for only three cases. This were related to: new sepsis tool that combines rapid screening, exclusion, treatment, and escalation; review of the jaundice and umbilical cord pathways and policies which was overview since November 2017; improvement in pain assessment during children’s triage and reassessment which trust was to re-audit in November 2018.

**Nutrition and hydration**

In the CQC Emergency Department Survey, the trust scored 5.5 for the question “Were you able to get suitable food or drinks when you were in the emergency department?” This was worse than other trusts.

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

Patients we spoke with were satisfied with the level of fluids they were offered. However, staff were not always proactive as they were busy with attending to patients’ medical needs. There was no hot food offered to patients who stayed over 4 hours in the department. We did not see any of the staff offering hot drinks or snacks to patients waiting or being attended to in the department. Staff said that they could access snacks or hot drinks and those were provided on request.

Patients were referred to a dietician if there were concerns with their weight or food intake.

**Pain relief**

We observed that patients did not always receive pain controlling medication promptly. On one occasion a patient arriving via ambulance who was visibly in pain waited 20 minutes for
medication to be offered. In another case a patient waiting in the majors waiting room was not offered a medicine to control pain and they told us they were in pain.

Staff did not always use pain scoring tool accurately. In one case patient was given a high dose of pain controlling medicine, however, their records showed that they were assessed to not to be in pain.

In the CQC Emergency Department Survey, the trust scored 5.6 for the question “How many minutes after you requested pain relief medication did it take before you got it?” This was the same as other trusts.

The trust scored 7.4 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was the same as other trusts.

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

Patient outcomes

The 2016/17 Royal College of Emergency Medicine (RCEM) Moderate and acute severe asthma audit, showed that Newham University Hospital’s emergency department did not meet three of the national standards.

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

- Standard 3 (fundamental): High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the emergency department. This department: 49%; UK: 25%.
  - Standard 5a (fundamental): within 60 minutes of arrival (acute severe). This department: 38.5%; UK: 19%.
  - Standard 5b (fundamental): within 4 hours (moderate). This department: 63.5%; UK: 28%.
  - Standard 9 (fundamental): Discharged patients should have oral prednisolone prescribed as follows:
    - Adults 16 years and over: 40-50mg prednisolone for 5 days
    - Children 6-15 years: 30-40mg prednisolone for 3 days
    - Children 2-5 years: 20mg prednisolone for 3 days
    This department: 87%; UK: 52%.

The department’s results for the remaining three standards were all between the upper and lower UK quartiles.

List of standards in this audit that are agreed for inclusion in inspection reports:

- Standard 1a (fundamental): O₂ should be given on arrival to maintain sats 94-98%. This department: 20%; UK: 19%.
  - Standard 2a (fundamental): As per RCEM standards, vital signs should be measured and recorded on arrival at the emergency department. This department: 25%; UK: 26%.
  - Standard 4 (fundamental): Add nebulised Ipratropium Bromide if there is a poor response to nebulised β2 agonist bronchodilator therapy. This department: 74.1%; UK: 77%.
The 2016/17 Consultant sign-off audit, showed Newham Hospital’s emergency department failed to meet any of the national standards.

The department’s results for all four standards were all between the upper and lower UK quartiles:

- **Standard 1** (developmental): Consultant reviewed: atraumatic chest pain in patients aged 30 years and over. This department: 14%; England: 11%.

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

- **Standard 3** (fundamental): Consultant reviewed: patients making an unscheduled return to the emergency department with the same condition within 72 hours of discharge. This department: 9.7%; UK: 12%.

- **Standard 4** (developmental): Consultant reviewed: abdominal pain in patients aged 70 years and over. This department: 12.1%; UK: 10%.

In the 2016/17 Severe sepsis and septic shock audit, Newham Hospital emergency department did not meet any of the national standards.

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

- **Standard 5**: Blood cultures obtained within one hour of arrival. This department: 22%; UK: 44.9%.

The department’s results for the remaining seven standards were all between the upper and lower UK quartiles.

List of standards in this audit that are agreed for inclusion in inspection reports:

- **Standard 1**: Respiratory rate, oxygen saturations (SaO₂), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival. This department: 70%; UK: 69.1%.

- **Standard 2**: Review by a senior (ST4+ or equivalent) emergency department medic or involvement of critical care medic (including the outreach team or equivalent) before leaving the emergency department. This department: 54%; UK: 64.6%.

- **Standard 3**: O₂ was initiated to maintain SaO₂>94% (unless there is a documented reason not to) within one hour of arrival. This department: 9.8%; UK: 30.4%.

- **Standard 4**: Serum lactate measured within one hour of arrival. This department: 62%; UK: 60%.
• Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given within one hour of arrival. This department: 48%; UK: 43.2%.

• Standard 7: Antibiotics administered: Within one hour of arrival. This department: 40%; UK: 44.4%.

• Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival. This department: 12.2%; UK: 18.4%.

(Source: Royal College of Emergency Medicine)

From July 2017 to June 2018, the trust’s unplanned re-attendance rate to A&E within seven days was worse than the national standard of 5% and worse than the England average. In the latest month June 2018, trust performance was 9.3% compared to an England average of 7.9%.

(Source: National Episode Statistics)

Competent staff

From April 2017 to March 2018, 73 members of medical staff were eligible to receive an appraisal. They achieved an 88% completion rate against a trust target of 90% (64 members of staff received an appraisal).

The trust has not provided a core service breakdown for non-medical staff therefore we are unable to provide any completion rates.

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

Junior and trainee nurses worked adequately supervised and any new staff worked supernumerary shifts. Nurses we spoke to felt they were provided with good development opportunities and felt competent to perform tasks needed to provide effective care and treatment. Nursing staff told us that they attended a trust induction programme. All permanent and agency staff working on the unit for the first time were given a general induction to their working environment. Agency staff were given opportunities to learn additional skills when working
frequent shifts. They also said they felt part of the team, able to contribute to discussions and challenge their colleagues should there be a need.

Clinical practice educator was available to support nurses with their competency assessments and staff we spoke to said they found their support very useful.

Doctors told us there was a good culture of teaching and learning in the department. Training was consultant led, pre-planned and tailored to the needs of the emergency department. All we spoke with saw it as a priority and trainee doctors said they received support to attend training sessions. Consultants supervised trainee doctors in both ED and urgent treatment centre (UTC), but without dedicated shifts purely in UTC.

There was no separate paediatric nursing rota for UTC. UTC practitioners had paediatric illness and injuries incorporated in the training pathway. Most of the emergency nurse practitioners had worked in paediatric ED in previous posts. All new starters were given a competency pack to complete and get signed off on the management of children. The trust told us that staff received in-house training on streaming of children.

### Multidisciplinary working

Doctors and nurses told us that multidisciplinary team (MDT) working within the department was well embedded part of their work. Nurses, healthcare assistants and doctors spoke of teamwork and joint working and the way in which it enhanced good working relations as well as improved patient safety. We observed positive culture where discussions were held and all staff could openly contribute.

Doctors from other specialties worked alongside ED staff and could be approached for any advice related to specialist care and treatment. Staff were aware of how to contact other specialities doctors during out of hours.

We noted a positive approach to multiagency working within the paediatric ED. They hosted a weekly psycho-social meeting with a range of internal and external practitioners attending. Named nurse, consultant, child and adolescent mental health services, health visitors, adult ED nurse, and social care service representative. The meeting coordinated care of vulnerable children and young people who have attended ED and supported joint working.

Children and young people admitted for self-harming behaviour benefited from joint coordinated approach to discharge planning following the introduction of a discharge planning protocol endorsed by the local social service department and a safeguarding board prepared in response to findings from a serious case review. Evaluation of the protocol was built into the new process; however, it did not include feedback from patients.

Where patients were returning home, staff communicated with the patient, their family, the GP, and other agencies as necessary. In the case of patients transferring to another health setting, such as an inpatient mental health ward, staff ensured that the receiving ward received appropriate information.

### Seven-day services

The emergency department provided care and treatment 24 hours per day Monday to Sunday.

The service had arrangements, known to all staff on duty, to meet patients’ urgent or emergency mental health care needs, including outside office hours and in an emergency.

There was an on-site consultant weekend cover on-site 8am to 10pm. All consultants had built into their job plans covering late finishes and work done when on-call. On-site cover was often
extended until midnight, depending on the needs of the department. The trust told us there was no consultant shifts unfilled in the last 12 months.

On-call cover was provided from 8am Saturday to 8am Monday and between 10pm and 8am Monday to Friday. There was an expectation of a 30-minute return to site if needed for critical patients or safety of the department. There was no allocation for paediatrics and the on-call consultant covered all areas of the department.

The urgent treatment centre (UTC) was contracted to be open 8am to 11pm but stayed open until 1am to support the main ED after midnight. ED and UTC run separate rotas, but there was a cross cover in both directions for surges and escalation when needed.

There was a GP out-of-hours service co-located with the emergency department that was provided by another organisation. The out of hours service had GPs managing face-to-face consultations, telephone advice, home visits and 111 direct referrals.

There was 24 hours a day seven day a week access to diagnostics, x-ray, computer tomography (CT) and endoscopy in the emergency department. There was also access to the rapid assessment psychiatric liaison service as well as child and adolescent mental health service (CAMHS) team.

Pharmacy technicians visited daily to check top up the medicines’ stock. Pharmacy staff provided an on-call service out of normal opening hours.

**Health promotion**

There was a variety of leaflets to promote good health within the department. Health care assistants told us they discussed healthy eating with patients, particularly those with diabetes or a heart condition.

Staff signposted patients to specialist and community health services on discharge, including for smoking cessation and the management of alcohol and drug use.

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

The ED staff we spoke with understood their responsibilities in relation to patients who lacked the mental capacity to make decisions about their care and treatment and the key principles of the Mental Capacity Act 2005 (MCA). They understood their duty to act in the patient’s best interests.

Staff in the RAID team (rapid assessment interface and discharge) had also piloted an innovative approach to assessing patients, which varied the length of assessment based on the patient’s needs. This meant that patients who needed to be signposted or referred to services, but did not need in-depth assessments, could be discharged quicker.

Staff had clear pathways for when mental health patients should use the observation unit. One pathway was for those awaiting mental health assessment but might have been intoxicated. The other pathway was for patients who had overdosed and needed continuing medical observation. In this case, staff completed parallel assessments.

There were appropriate arrangements to ensure children and young people who harm themselves were seen and assessed by suitable mental health professionals. Children and young people were first seen in the ED at NUH for their presenting medical condition, then assessed by a child and adolescent mental health services’ (CAMHS) clinician. Two records seen showed appropriate management and plan of care recorded. The CAMHS information was relayed verbally as the CAMHS service used a different electronic patient record system and it could not be added to the notes directly by the CAMHS practitioner.
There was no procedure to ensure that each time a child or young person with mental health condition was to be cared for in paediatric ED a risk assessment was undertaken on the environment and room used by them.

MCA and Deprivation of Liberty Safeguards (DoLS) training was included in safeguarding adults Level 2 training, which was part of trust’s statutory and mandatory training. The trust reported that 84% for medical staff and 87% of nursing staff had up to date training in September 2018, the trust’s target was 85%.

**Is the service caring?**

**Compassionate care**

The trust’s urgent and emergency care Friends and Family Test performance (% recommended) was generally better than the England average for the first four months of the reporting period, however from December 2017 to July 2018, the trust’s performance was worse than the England average.

*There is no data available for November 2017.

(Source: NHS England Friends and Family Test)

Staff we spoke with showed understanding and a non-judgmental attitude when talking about patients with mental health needs, learning disabilities, autism, or dementia. The RAID team (rapid assessment interface and discharge) asked patients for feedback. In August 2018, 29 out of 30 patients or carers who responded said they were likely or extremely likely to recommend the service to family and friends. Twenty-five responded that staff ‘always’ treated them with kindness.

The windows to the psychiatric liaison room could not be covered to protect patients’ privacy. Staff supported patients who became distressed by using de-escalation techniques, engaging in conversation, and helping them to support their privacy and dignity.

We observed several interactions between staff and patients and saw staff treated patients with compassion and kindness. Feedback from patients and relatives was generally very good and they felt they were treated with courtesy, respect, and compassion by staff. Patients felt able to speak about their worries and said staff at the hospital were compassionate. Patients told us they
could discuss their personal details without being overheard as the reception desk was a distance from the seating area.

We observed staff ensuring patients’ privacy and dignity was respected when providing care by closing the door to side rooms and drawing curtains in bays. Doctors and nurses introduced themselves to patients and carers and explained what their role was. Patients told us they appreciated this.

**Emotional support**

Patients had access to the hospital multi faith chaplaincy service. They offered pastoral, psychological, and spiritual support together with a befriending service. The team included, Christian and Muslim weekly services and patients and their relatives had access to faith leaders from many other communities. The trust provides a 24-hour service and the appropriate on call chaplain could be contacted via switchboard.

Patients had access to bi-lingual advocacy service located on site during the day.

Staff told us there was usually a team debrief whenever there was a traumatic death in the department. This was done with the whole team involved and led by a senior doctor. It involved discussing emotional impact of the incident on the team, individual staff members, the patient and their relatives or carers. It also gave them opportunity to consider potential psychological support options available to the patient involved, their relatives or carers.

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

We observed staff involving patients and relatives in care planning and decision-making process. It was demonstrated by staff in all specialties and roles. Patients told us that their views were considered by staff and they felt involved in decisions made by clinical teams. Staff made sure patients and relatives understood the assessments being done and the likely diagnosis and treatment plan. Patients and relatives were given opportunities to ask questions and staff gave them time to do this.

Staff and the care systems they followed helped to provide the right care to patients in need of additional support. ED staff made early referrals to the mental health liaison team for advice and support. From care records, it was clear that staff also spoke with the patient’s family to clarify their needs. Care and treatment plans showed that staff had considered the psychosocial needs of the patient.

Seeking the child’s view adds meaning and context to the assessment. Recording of the child’s voice was evidenced in several records, in particular in the nursing records of the young people presenting with mental health issues. In these cases, the child’s views were also represented in the external referrals made.

The trust scored about the same as other trusts for 22 out of the 24 Emergency Department Survey questions relevant to the caring domain. The trust scored worse than other trusts for the remaining two questions.

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you told how long you would have to wait to be examined?</td>
<td>3.7</td>
<td>About the same as</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.3</td>
<td>other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse</td>
<td>7.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>explain your condition and treatment in a way you could understand?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>examining and treating you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q17. Did doctors or nurses talk to each other about you as if you weren't</td>
<td>8.4</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>there?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q18. If your family or someone else close to you wanted to talk to a</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>doctor, did they have enough opportunity to do so?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>about your condition or treatment was given to you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of medical</td>
<td>7.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>or nursing staff to help you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one thing and</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>another will say something quite different. Did this happen to you in</td>
<td></td>
<td></td>
</tr>
<tr>
<td>the emergency department?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about</td>
<td>7.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>your care and treatment?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q44. Overall, did you feel you were treated with respect and dignity</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>while you were in the emergency department?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q15. If you had any anxieties or fears about your condition or treatment,</td>
<td>7.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>did a doctor or nurse discuss them with you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q24. If you were feeling distressed while you were in the emergency</td>
<td>6.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>department, did a member of staff help to reassure you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q26. Did a member of staff explain why you needed these test(s) in a</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>way you could understand?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q27. Before you left the emergency department, did you get the results</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>of your tests?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q28. Did a member of staff explain the results of the tests in a</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>way you could understand?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q38. Did a member of staff explain the purpose of the medications you</td>
<td>9.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>were to take at home in a way you could understand?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>Q39. Did a member of staff tell you about medication side effects to watch out for?</td>
<td>5.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?</td>
<td>5.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department?</td>
<td>4.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?</td>
<td>5.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?</td>
<td>6.0</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q45. Overall... (please circle a number)</td>
<td>7.7</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

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

**Is the service responsive?**

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

Staff worked together to improve outcomes for patients. Staff from Barts Health Trust, a local mental health NHS trust and other agencies had worked on a project to reduce ED attendances by frequent attenders. Staff identified patients who attended Newham ED frequently. They met together to discuss these patients’ needs and developed joint plans to address them. Over the course of the project, these patients made 121 fewer attendances to the ED when compared to before the project, a 62% reduction. Staff planned to continue this work with further cohorts of patients to improve patient care and reduce the amount of time these patients needed support in the ED.

Patients considered at ‘risk’ or with complex needs, which included those living with dementia and those with learning disability, were ‘fast tracked’ from the time they booked into reception. The streaming nurse was made aware of their presence when in the waiting area and they were usually provided with rapid assessment. Staff told us that they offered secluded space whenever possible and tried to minimise any potential distress by providing prompt care and treatment.

There was an enough seating in the general waiting area. Patients registered at reception, then waited to be called by a streaming nurse. The department catered for a culturally diverse population in which many different languages were spoken. There was a telephone and face-to-face interpreting service available.

**Meeting people’s individual needs**
The trust performed about the same as other trusts for all three Emergency Department Survey questions relevant to the responsive domain.

<table>
<thead>
<tr>
<th>Question – Responsive</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency department last?</td>
<td>6.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

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

Access to a psychiatric liaison team was available for patients within the hospital. Staff told us this team was contacted for any patients with specific mental health needs.

Some patients had to wait extended periods to receive MHA assessments (Mental Health Act) because of the time it took for a local authority employed approved mental health professional (AMHP) to attend the department and complete assessments. For example, one patient whose records we reviewed waited six hours from arrival until they were admitted.

Staff completed parallel assessments when patients had both physical and mental health needs. This meant that patients received the care and support they needed quicker.

The trust had a dementia and delirium team. This team provided support and advice to the team on how to support patients with these needs. Staff in the team had provided a patient-friendly ‘engagement box’ holding advice and equipment which allowed engaging in activities with patients living with dementia.

The trust told us that following targets were applied to all patients aged 75 and over following emergency admission to hospital:

- to identify at least 90% of patients who have an existing diagnosis of dementia, a clinical diagnosis of delirium or who may be more forgetful
- to clinically assess at least 90% of those patients who may be more forgetful or who have delirium
- to refer at least 90% of those patients who appear to have memory problems on to their GP or a specialist psychiatric liaison service

The trust did not provide information on how they performed in relation to meeting those targets.

There was a screening tool within the electronic record which was completed by the in-patient teams on admission. Staff within the emergency we spoke with told us there was no need to formally assess patient for dementia in the emergency department. Although it is often difficult to establish confirmed diagnosis of dementia within emergency settings published guidance recommends that an assessment is undertaken on arrival specifically for older people so they can be, where appropriate, referred on to specialist services.

Staff had access to special trolley with resources for patients with dementia found within the clinical decision unit as well as to a ‘grab bag’ within the emergency department. Both contained specific tools and activities to help patients with dementia when they were feeling stressed and agitated in an unfamiliar environment, for example, playing cards, dominos, books, or other games.
The hospital took part in the patient-led assessments of the care environment (PLACE) in 2018. This assessment checks, among other key subject, if the environment is adapted to meet needs of those living with dementia. Overall the department passed all categories related to suitability of the environment and the report highlighted that flooring was consistent, matt, non-reflective and lighting was suitable or the door frames colour were contrasting walls. There were a few issues the department needed to improve, this included: installation of handrails in corridors and on approaches to bathrooms and toilets; ensuring that toilet seats, flush handles and rails were in a colour that contrasted with the toilet/bathroom walls and floor; not all taps were clearly marked as hot/cold e.g. by using red and blue colours.

There was clear and prominently displayed signage in the reception area and other areas used by the department showing the department's name.

Staff had access to translation services for patients for whom English was not a first language, which could be provided face-to-face or was available via the telephone. The bi-lingual advocacy team members, based at the hospital, told us they often were engaged with ED patients. The team consisted of staff that could translate from many languages including Romanian, Bengali, Hindu, and Chinese amongst others. Patients, if this was their preference, were often supported by relatives or utilised members of staff who could also communicate in their language.

Staff used a ‘learning disabilities staff resource and information pack’ to support them with finding out how to meet needs of patients with learning disabilities. It included examples of how they might consider the differences in practical, everyday situations and what to consider ensuring equal access, care and treatment for patients living with disability. There was a lead consultant for adults with learning disabilities, and a lead consultant for children with complex needs within the department. There was also a trust lead nurse for learning disabilities.

Patients with mobility difficulties had access to accessible toilets and the areas we visited were accessible to people that used a wheelchair. Staff had access to hoists and other mobilising equipment and were trained in using it. Staff also had access to specialist bariatric equipment such as hoist or large trolley bed.

**Access and flow**

The ED team used a protocol as a guide to conditions that required streaming to the urgent treatment centre or emergency department for both adults and children. The protocol clearly listed conditions that needed ‘fast tracking’ and those that needed triggering a call for an emergency aid. The streaming and initial assessment process was supported with vital signs, urinalysis, ECG, and blood tests as needed to ensure emergency conditions and deteriorating patients were identified on arrival.

Staff used appropriate discharge arrangements for people with complex health and social care needs. Where patients were returning home their follow-up needs were addressed. Staff communicated with other agencies as necessary and ensured appropriate information was shared to support seamless transition.

The paediatric clinical decision unit, a single side room within the paediatric ED, had been in place since 2008. Staff reported that it had a significant positive impact on the 4-hour standard for the paediatric pathway.

In March 2018 the department converted part of the adult's clinical decision unit space to an ambulatory area with a view to improve a flow within the department. The trust reported that it helped the department to achieved over 90% compliance with the four-hour standard.
From March 2016, hospitals urgent treatment centre had sustained 99% Type 3 performance with 45% of all patients being seen at the centre (minor injuries and illnesses, such as stomach aches, cuts and bruises, some fractures and lacerations, and infections or rashes).

All referrals from UTC to ED for advice, review, or patients for clinical decision unit pathways were reviewed by consultant, or a senior trainee doctor (ST4+) during out of hours.

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust did not meet the standard for five months over the 12-month period from July 2017 to June 2018.

From July 2017 to June 2018, the trusts performance generally followed the national trend, although in December 2017 the median time to treatment was 55 minutes compared to the England average of 62 minutes.

The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred, or discharged within four hours of arrival in the emergency department.

The department achieved 91.7% between May 2017 and May 2018 and performed better than other ED departments managed by the trust. For example, in August 2018, the performance was recorded at 91.03% at Newham’s ED department, 85.05% at Whipp's Cross Hospital’s ED department, and 86.36% at the Royal London Hospital’s ED. The hospital consistently achieved
the standard within their paediatric ED between October 2017 and August 2018.

From August 2017 to July 2018, the trust did not meet the four-hour standard and generally performed worse than the England average.

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

From August 2017 to July 2018, the trust’s monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was generally worse than the England average.

Percentage of patients waiting more than four hours from the decision to admit until being admitted - Barts Health NHS Trust
Over the 12 months from August 2017 to July 2018, one patients waited more than 12 hours from the decision to admit until being admitted. The highest numbers of patients waiting over four hours were in March 2018 (1,759), January 2018 (1,721) and October 2017 (1,645).

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients waiting more than four hours to admission</th>
<th>Number of patients waiting more than 12 hours to admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aug-17</td>
<td>1,056</td>
<td>0</td>
</tr>
<tr>
<td>Sep-17</td>
<td>1,191</td>
<td>0</td>
</tr>
<tr>
<td>Oct-17</td>
<td>1,645</td>
<td>0</td>
</tr>
<tr>
<td>Nov-17</td>
<td>1,484</td>
<td>0</td>
</tr>
<tr>
<td>Dec-17</td>
<td>1,570</td>
<td>0</td>
</tr>
<tr>
<td>Jan-18</td>
<td>1,721</td>
<td>0</td>
</tr>
<tr>
<td>Feb-18</td>
<td>1,351</td>
<td>1</td>
</tr>
<tr>
<td>Mar-18</td>
<td>1,759</td>
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<td>1,217</td>
<td>0</td>
</tr>
<tr>
<td>Jun-18</td>
<td>828</td>
<td>0</td>
</tr>
<tr>
<td>Jul-18</td>
<td>499</td>
<td>0</td>
</tr>
</tbody>
</table>

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

From July 2017 to June 2018, the monthly percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment was similar to the England average. In the latest month June 2018, the percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment was 2.5%, compared to the England average which was 2.4%.
From August 2017 to July 2018, the trust’s monthly median total time in A&E for all patients was higher than the England average. In the latest month June 2018, the trust’s monthly median total time in A&E for all patients was 187 minutes compared to the England average of 148 minutes.

Clinical staff had access to the RAID team (rapid assessment interface and discharge), mental health liaison service, 24 hours a day and seven days a week. One nurse and an on-call doctor provided out-of-hours support. The RAID team provided assessments of patients aged 16 or over presenting to the ED with mental health needs. They also provided advice, assessment, and brief psychological interventions for adults, including older people, on wards in the hospital.

The mental health service had an operational policy, due for review in June 2019. This set out the target times for the team to respond to referrals. The target response time was one hour for ED.
ED staff told us that the mental health liaison team responded to referrals very promptly. The care records we looked at confirmed that patients had been seen within the one-hour target time. The RAID team responded within one hour to at least 87% of referrals for each of the four months from April 2018 to July 2018. This was below the trust's [challenging] target of 95%.

<table>
<thead>
<tr>
<th></th>
<th>April 2018</th>
<th>May 2018</th>
<th>June 2018</th>
<th>July 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>91%</td>
<td>89.0%</td>
<td>88%</td>
<td>88.00%</td>
<td></td>
</tr>
</tbody>
</table>

The RAID service received approximately 260 referrals each month from the Newham ED.

<table>
<thead>
<tr>
<th></th>
<th>April 2018</th>
<th>May 2018</th>
<th>June 2018</th>
<th>July 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>259</td>
<td>236</td>
<td>276</td>
<td>285</td>
<td></td>
</tr>
</tbody>
</table>

For patients under the age of 16, the department could access support from local child and adolescent mental health service (CAMHS) team. ED staff told us that they could easily access advice and support in relation to patients with learning disability or autism from specialist staff.

**Learning from complaints and concerns**

We saw leaflets informing patients' how to complain were displayed in visible places. Complaints were discussed at staff meetings. They were monitored and outcomes recorded with details of action points and learning identified. Staff communicated any learning points during ‘safety huddles’, they also discussed complaints during regular staff meetings. Staff provided examples where they adjusted their practice in response to the feedback provided by patients and their relatives.

From September 2017 to September 2018, the hospital received 52 complaints related to ED and 8 for UTC. There were also 14 GP alerts for ED and two for UCC – mainly about being asked to order investigations (a considerable number of these have been refuted) or related to inaccurate discharge information. The trust told us that 53% of those were responded to within required period as prescribed by the trust policy.

The trust told us that a common theme of complaints was that reception staff had not responded appropriately to patients who were unwell. Reception staff reported that on occasions their requests for clinical help had not been received positively by the clinical team which might have delayed the response process. In response to these complaints the department had introduced a ‘communication skills simulation day’ for reception staff. In addition, it was emphasised to all clinical staff that requests for help from reception must be responded to rapidly, and simulations of ‘collapses’ of newly arrived patients were carried out to train staff in response procedures.

There have been many complaints about long waiting times at night. Trust recognised that attendances to the department had increased significantly over the last few years. This put the night team under pressure and at times led to unacceptable waiting times. Staffing reviews of both medical and nursing teams were undertaken and the number of staff for both groups was increased in response.

We reviewed how trust responded to three formal complaints. We saw communication with complainants to agree extensions to the response deadline if this was needed. Quality of
responses to complaints made was good and written communication with patients and/or their carers and families was considerate, individualised and information provided in letters was comprehensive.

Is the service well-led?

Leadership

A clinical director, general manager, and an associate director of nursing led the division. They were responsible and accountable for patients’ experience, delivering clinical outcomes and budget. They reported directly to the leadership of the Newham University Hospital that included director of operations, medical director and the director of nursing and governance. We met with some of the speciality leads and divisional leaders and found them to be knowledgeable, and capable of managing their areas of activity. The general manager was new to the post and there was no permanent matron in post for the ED. The hospital was in the process of seeking a permanent candidate for the vacant post.

During the inspection staff we approached spoke positively about members of the senior management team. They said they were visible, approachable, and aware of problems faced by the front-line staff. However, many nursing staff we spoke to were not aware who the executive leaders of the organisation were and could not name hospital directors. They did not feel the executive management team were visible but they felt they could find out who to approach should they have a need.

Vision and strategy

The department reviewed their five-year strategy in November 2017. It focused on providing a core emergency service, focussing on the needs of emergency patients, and targeting the delivery of high quality emergency care. It also clearly highlighted pathways and areas were emergency departments involvement needed to be minimised i.e. management of chronic conditions or primary care provision. The document highlighted interdependencies and links with other strategies such as children department’s strategy or woman division’s strategies. It also identified basic enablers and followed the overall trust’s clinical and organizational strategy principles.

The strategy identified key priorities which were linked to pathway standardisation across all three EDs managed by the trust, staff training and development, increasing productivity and meeting needs of the local population amongst others. A programme director and an allocated project manager were tasked with overseeing the implementation of those priorities and responsible for monitoring strategy and improvement plan’s implementation.

Staff were aware of the trust’s vision to ‘be a high performing group of hospitals, renowned for excellence and innovation and providing safe and compassionate care to our patients in east London and beyond’. They also knew of the ‘WeCare’ values developed by the trust in 2016. The department’s local vision was ‘to deliver first class emergency care services for adults and children’.

Culture

We found that individual teams were well motivated and focused on delivering quality care. Despite changes in leadership of the trust and the divisional structures change undertaken across 2017/2018 staff we spoke to were positive and optimistic about the future of the trust. They felt proud being part of a larger organisation and felt they had good relationship with other EDs run by the trust and could use it to share learning and their experiences.
Nurses and doctors, we spoke to felt able to speak up when necessary and address poor behaviour or performance in line with the trust values, regardless of seniority and without a fear for retribution.

The ED’s divisional leads were aware of the key findings from the NHS staff survey 2017 for their departments and planned to improve mandatory training compliance and appraisal rates in response to it. They also focused on maintaining staff well-being by reviewing staffing establishment, reviewing staffing skill mix, or organising a staff party.

**Governance**

Department used ‘lesson of the week’ for sharing lessons from incidents and complaints. They also shared feedback from monthly governance meeting and its annual summaries with all staff; it was included in induction and staff communication book.

Divisional quality monitoring group, which consisted of divisional leaders, met monthly. Its members reviewed quality performance report consisting of finance report, quality improvement plan, ‘people’s report and key performance indicators report. The division improved the way they monitored actions agreed during the meeting by setting out who handled individual actions, however, they did not always allocate timescales or minuted reasons for delays to completion on agreed actions. Monthly performance reports were detailed and consisted key information needed to support decision making process. They allowed divisional leaders to review department’s performance in relation to cost improvement programmes, overall financial performance, staff recruitment, staff compliance with mandatory training, or reviewed risk assessments and mortality and morbidity meeting outcomes.

Divisional and local leaders were clear about their roles and knew which areas they were accountable for and to whom. They told us they had suitable systems to allow them to effectively perform their tasks and support delivery of the service.

During our previous inspections staff felt not fully accustomed with trusts governance systems and structures and did not feel they had suitable accountability structures to effectively support service delivery. This had improved and nurse and doctors felt they had the support required to manage complaints, serious incidents, monitor safety alerts, risks, and performance.

Divisional leaders participated in number of monthly or fortnightly meetings that reviewed quality and effectiveness. This included quality and safety performance board, clinical effectiveness meeting, performance review meeting, risk assurance meeting, or quality governance performance board meeting. Those meetings were informed by other departmental meetings such as monthly departmental governance meeting, attended by senior doctors and nurses, governance team and general and service managers, or the mortality and morbidity monthly meetings which also took place monthly.

**Management of risk, issues, and performance**

The trust had a service level agreement with local mental health NHS Trust for mental health (MH) liaison. Staff in both the rapid assessment interface and discharge team, employed by the MH trust and the wider ED told us that they had a very good working relationship. They met regularly and worked together to improve the experience of mental health patients attending the ED. There were partnership meetings every two months involving ED managers and the mental health liaison team to look at security issues, clinical governance issues and the clinical pathways for patients.

Staff knew the clinical governance arrangements. When incidents occurred, they worked together to identify any areas that needed improvement.
Risk register was reviewed monthly during divisional performance meetings. The trust told us that the top five risks for the department included:

- Lack of capacity and inadequate clinical resource to match the demand. This was addressed through review of nursing and medical staff establishment and development of clinical decision and ambulatory care units.

- Risk to patient safety due to inadequate monitoring in resuscitation and majors’ areas. There was only one monitor in majors which was not centrally visible. Department relayed on staff ‘vigilance’ in majors. In resuscitation area only three monitors per six cubicles could deliver full monitoring which included CO2 monitoring for intubated patients. The department were unable to buy required equipment as they were awaiting funds allocation.

- Point of care testing (PoCT) devices were not linking to the electronic health information system used across the hospital. The PoCT committee was to decide how to manage the issue and if interface needed upgrading.

- Potential violence and aggression from members of public. Doors were installed but not locked to the intercom system. Trust was reviewing their ‘red card policy’ to ensure it was meeting needs of the department.

- Delays in mental health assessment due to demand exceeding capacity, in particular regarding children and adolescents. The hospital reached agreement with a neighbouring mental health unit for MH patients which allowed transfer after psychiatric liaison nurse assessment without a need for a second review.

Overall the department’s risk register consisted of 17 entries. Only one risk item had been entered onto the register in 2018 and one in 2017 others were more than 2 years old. One entered in 2013 (single exit in resus room; rated low), two in 2014 (potential risk of radiation exposure to staff due to lack of led lining of the resus walls; medium risk; inadequate monitoring due to lack of equipment; high risk), and three in 2015 (inadequate ED resus capacity; unavailability of the out of hours dedicated injury service; lack of central telemetry on observation ward).

Divisional leaders were able to make decision based on up to date performance information. They had access to daily key performance indicators data such as that related to delayed transfers of care, attendance patterns and activity level trends information, treatment and discharge waiting times. They could also view information which affected their performance but they did not have direct control over improving such as bed utilisation across the hospital, diagnostic waiting times, or referral to treatment standard compliance data. This allowed prognosis and prevention of any potential blockages to admission or discharge of ED patients.

Complaints and incidents were also regular reviewed during staff meetings and reported on and monthly divisional performance report. Staff we spoke to were aware of patterns and trends in incidents and complaints. Three investigation reports reviewed indicated that the trust took on average six months to produce the investigation report. Investigation reports suggested authors sought assurances that the Duty of Candour was fulfilled and that the hospital provided person involved with right information in an open and transparent way.

Investigators analysed root causes and contributory factors and recommended best ways for shared learning, however, shared learning routes mentioned were not incident specific. In each report investigators made generic statement such as “national reporting and learning service [system] will be used for promotion of wider learning”. It was not recorded if patient or their relatives had an opportunity to contribute to terms of reference or engage in the investigation process. Action plans were comprehensive and individual actions were allocated to lead persons.
We were unable to assess if action plans were fully implemented as the incidents reviewed were still under investigation or investigation reports were newly completed.

**Information management**

Patients experience information gathered through Friends and Family test was used as department’s performance indicator alongside key metrics related to financial performance, waiting times data or ambulance handover times. The trends were analysed and early indicated in quality performance reports reviewed.

The department submitted reports through available systems such as the National Reporting and Learning System (NRLS) and the Strategic Executive Information System (StEIS) promptly to support shared learning and to share information with external bodies.

The department used information available through performance reports and local audits to inform and improve service planning. This was easily available and easy to understand for staff involved in care and treatment delivery, the information was also timely and relevant.

Information was shared effectively across variety of care settings. For example, children and young people benefited from community practitioners being alerted to their attendance at ED through daily electronic transfer of attendances to Newham local authority who were commissioned to deliver community services. The LA then managed the transfer of information. This meant that, GPs, health visitors and school nurses could consider the attendance in the context of what they know about a child or family to enable opportunities for early help to be provided. Where paediatric ED staff raised a safeguarding concern, the notification was also sent to the safeguarding team for quality assurance and oversight, a number of these were seen during the inspection.

The trust had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients at their admission, for example, details of their current medicine. Rapid assessment interface and discharge staff had access to both the mental health NHS trust’s and Barts Health’s computer systems. They entered vital information into the Barts Health’s system to ensure staff had access to it.

We noted that individual patients’ records quality was variable with some patients’ records missing valuable information which should be routinely included. For example, no safeguarding information recorded on two children records, parental responsibilities were not always clearly stated, for adults early warning scores and pain scores were not always recorded correctly.

We were not made aware of any data security breaches that occurred at the hospital within the past 12 months prior the inspection.

Access to individual patient’s records was restricted to authorised staff who had varied access rights and editing privileges granted in accordance with their job role. Electronic records were stored in line with data security standards and entries made in patient’s records could be easily ascertained to person creating them.

**Engagement**

The trust engaged patients by encouraging them to take part in surveys such as Friends and Family. The results were reported at governance meetings. Some nurses when asked about feedback for their individual speciality area were unable to provide information. We noted that data was not available for November 2017. Since December 2017 the paper collection system for Friends and Family Test feedback had been replaced by a text message system. The Friends and
Family data collected in January and February 2018 was analysed and the department had drawn up improvement plans where there were areas of development identified.

The department also carried out patient satisfaction survey analysing patient satisfaction with the front door service i.e. the process from reception to seeing the GP streamer. It found that the majority of patients were satisfied with the process and with the communication and instructions given by the GP streamer. Areas that patients showed improvement was needed were the long wait to be seen following the streaming process. The developments of the ambulatory care unit and the rapid assessment team were put in place to reduce waiting times. New patient chairs had also been purchased in response.

The trust monitored feedback collated on the NHS Choices website and summarised themes to support improvement within the department.

The department engaged with social media which provided them with an opportunity to gather public feedback and for announcing any new initiatives undertaken by the department.

The hospital held Schwartz rounds, a forum for hospital staff to talk about the emotional and social challenges of caring for patients. The aim was to offer staff an environment in which they could share their stories and offer support to one another. The framework also aimed to improve staff wellbeing, reduce hierarchy, and improve teamwork and staff engagement.

Staff told us they felt engaged in the day to day operation of the department and could influence changes. They had regular staff meetings which they used to share information related to complaint or incidents, for learning and sharing examples of good practice and to provide support to one another.

Learning, continuous improvement and innovation

The trust received Post Graduate Medical and Dental Education award for innovative simulation training for managing miscarriage.

They organised a ‘virtual fracture clinic’ were doctors reviewed referrals within 72 hours and managed cases with telephone advice if suitable, reducing the need for attendance.

The department used an electronic system for recording and sharing practice that improved outcomes and should be shared. It was used to ensure staff did not only focus on error but also on excellent practice and learn lessons across all aspects of the patient experience.

The department introduced a system of standardised evidence-based single page guidelines for adult and paediatric emergencies. Trust guidelines were available via smart phones in case of IT failure and to support self-directed learning off-site.

The department supported development of advanced care practitioner programme, with dedicated consultant educational supervisors, integrated teaching and rota with middle grade doctors, bespoke training days and credentialing programme. They also were in a process of initiating the physicians associate programme in emergency medicine, with trainees starting in autumn 2018.

The hospital was involved with development of new roles for junior doctors to encourage recruitment and retention, including General Medical Council approved CESR programme (Certificate of Eligibility for Specialist Registration), teaching fellow, simulation fellow, quality fellow and resuscitation fellow programmes.

The trust planned to introduce NEWS 2 version of the early warning score tool used to identify deteriorating patients.
Medical care (including older people’s care)

Facts and data about this service

Medical services involve assessment, diagnosis and treatment of adults by means of medical interventions rather than surgery.

The Medicine Division at Newham University Hospital comprises the following services:

- Older People’s and Stroke Services
- Acute Medicine & Ambulatory Care
- Diabetes & Endocrinology
- Gastroenterology & Hepatology
- Respiratory Medicine
- Cardiology
- Neurology (Outpatients / Liaison Services)
- Nephrology (Outpatients / Liaison Services and satellite unit)

There is a medical admissions unit, the Observation ward, which cares for patients in the first 24 hours of a patient’s admission. Consultant cover is from 8am to 7pm. All patients are reviewed with a consultant acute physician throughout the day as they are admitted.

The hospital provides medical ambulatory care between 9am and 5pm, Monday to Friday. This takes referrals directly from GPs, from the emergency department (ED) and from ward-based teams to facilitate early discharge.

There are four inpatient wards for Older People’s Services and Stroke: Thistle, Tayberry, Silvertown and Heather Ward. There are three inpatient wards for Specialist Medicine: Coronary Care Unit, Plashet Ward and Stratford Ward.

The division provides outpatients services across all specialities. The majority of these take place at Newham University Hospital. There are outpatient clinics for respiratory medicine and diabetes at our Shrewsbury Road clinic.

The division also provides diagnostics in relation to endoscopy. In addition, cardiology diagnostics and respiratory function testing are provided at Newham University Hospital through the Bart’s Health group’s networked cardiology service.

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

The trust had 87,427 medical admissions from April 2017 to March 2018. Emergency admissions accounted for 42,691 (48.8%), 5,040 (5.7%) were elective, and the remaining 39,696 (45.4%) were day case.
Admissions for the top three medical specialties across the trust were:

- General medicine: 24,413
- Gastroenterology: 22,946
- Cardiology: 11,059

(Source: Hospital Episode Statistics)

Medical care at Newham University Hospital was last inspected in July 2017 when it was rated good for effective, caring, responsive, and well led, and requires improvement for safe. Medical care was rated as good overall. Areas for improvement that were found during the last inspection included ensuring the nutritional and hydration needs of patients are met, ensuring premises and equipment are clean and secure, ensuring safe staffing levels, and ensuring learning from infection prevention and control audits is communicated to staff.

We carried out our inspection at Newham University Hospital medical wards from 11 to 13 September 2018. During our inspection we visited seven wards: the Observation Unit, Thistle Ward, Tayberry Ward, Silvertown Ward, Heather Ward, Plashet Ward, and the Coronary Care Unit (also Medical High Dependency Unit). We also visited the endoscopy unit, the ambulatory care unit, and the discharge lounge.

We spoke with 12 patients and three relatives, and reviewed 30 sets of patient records. We also spoke with 73 members of staff, including qualified and student nurses, matrons, consultants, doctors, senior managers, and support staff.

Is the service safe?

Mandatory training

The trust set a target of 85% for completion of mandatory training (although the trust policy stated 95%).

A breakdown of compliance for mandatory training courses as of the 4 June 2018 for nursing staff in medicine core service is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality and Diversity</td>
<td>157</td>
<td>157</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling - Inanimate Loads</td>
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<td>100%</td>
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<tr>
<td>Moving and Handling - Patient Handling Low Risk</td>
<td>10</td>
<td>10</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Working at Bart’s Health</td>
<td>157</td>
<td>157</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness</td>
<td>156</td>
<td>157</td>
<td>99%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Harms - Pressure Ulcer Prevention</td>
<td>154</td>
<td>157</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Nursing and midwifery staff exceeded the trust’s 85% completion target for 27 out of 29 mandatory training modules, four of which achieved a 100% completion rate.

A breakdown of compliance for mandatory training courses as of the 4 June 2018 for medical staff in the medicine core service is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality and Diversity</td>
<td>69</td>
<td>72</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
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</tbody>
</table>

71
<table>
<thead>
<tr>
<th>Topic</th>
<th>Completion</th>
<th>Target</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Safety</td>
<td>69</td>
<td>72</td>
<td>96%</td>
</tr>
<tr>
<td>Moving and Handling - Patient Handling Low Risk</td>
<td>68</td>
<td>72</td>
<td>94%</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>51</td>
<td>55</td>
<td>93%</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>66</td>
<td>72</td>
<td>92%</td>
</tr>
<tr>
<td>Dementia Awareness</td>
<td>63</td>
<td>72</td>
<td>88%</td>
</tr>
<tr>
<td>Early Warning Systems</td>
<td>62</td>
<td>72</td>
<td>86%</td>
</tr>
<tr>
<td>4 Harms - VTE</td>
<td>61</td>
<td>72</td>
<td>85%</td>
</tr>
<tr>
<td>Clinical Documentation</td>
<td>61</td>
<td>72</td>
<td>85%</td>
</tr>
<tr>
<td>Consent</td>
<td>61</td>
<td>72</td>
<td>85%</td>
</tr>
<tr>
<td>4 Harms - Pressure Ulcer Prevention</td>
<td>60</td>
<td>72</td>
<td>83%</td>
</tr>
<tr>
<td>4 Harms - Slips, Trips and Falls (Patients)</td>
<td>60</td>
<td>72</td>
<td>83%</td>
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<tr>
<td>Nutritional Care</td>
<td>60</td>
<td>72</td>
<td>83%</td>
</tr>
<tr>
<td>Privacy and Dignity</td>
<td>60</td>
<td>72</td>
<td>83%</td>
</tr>
<tr>
<td>4 Harms - Catheter Acquired Infections</td>
<td>59</td>
<td>72</td>
<td>82%</td>
</tr>
<tr>
<td>Security</td>
<td>59</td>
<td>72</td>
<td>82%</td>
</tr>
<tr>
<td>Emergency Planning</td>
<td>58</td>
<td>72</td>
<td>81%</td>
</tr>
<tr>
<td>Fraud Awareness</td>
<td>58</td>
<td>72</td>
<td>81%</td>
</tr>
<tr>
<td>Working at Bart’s Health</td>
<td>58</td>
<td>72</td>
<td>81%</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>57</td>
<td>72</td>
<td>79%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>54</td>
<td>72</td>
<td>75%</td>
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<tr>
<td>Infection Prevention and Control - Clinical</td>
<td>53</td>
<td>72</td>
<td>74%</td>
</tr>
<tr>
<td>Resuscitation - Basic Life Support</td>
<td>43</td>
<td>72</td>
<td>60%</td>
</tr>
<tr>
<td>Medical Gas Safety</td>
<td>14</td>
<td>25</td>
<td>56%</td>
</tr>
</tbody>
</table>

Medical and dental staff exceeded the trust’s 85% completion target for seven out of 28 mandatory training modules.

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

The trust had a target for completion of mandatory training of 85%. Any of the nursing staff we spoke with on inspection stated they were up to date with their mandatory training. Completion of training was monitored by managers, and staff were informed by email when their training was due to expire and informed of upcoming dates.
A significant number of medical staff were not meeting the trust target of 85% in their mandatory training modules, include key modules such as Basic Life Support (60%), and Infection Prevention and Control (74%). The trust did not have an action plan to address this issue.

**Safeguarding**

The trust set a target of 85% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses as of the 4 June 2018 for nursing staff/medical and dental staff in the medicine core service care is shown below:

**Nursing and midwifery staff**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Level 1</td>
<td>157</td>
<td>157</td>
<td>100%</td>
<td>85%</td>
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</tr>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>154</td>
<td>157</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>147</td>
<td>157</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>122</td>
<td>134</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Nursing and midwifery staff exceeded the trust's 85% completion target for all four safeguarding modules.

**Medical and dental staff**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>71</td>
<td>72</td>
<td>99%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 1</td>
<td>71</td>
<td>72</td>
<td>99%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>48</td>
<td>53</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>62</td>
<td>72</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Medical and dental staff exceeded the trust’s 85% completion target for all four safeguarding modules.

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

The safeguarding team stated in interview that there had recently been a restructure in the service, and that there was recently concerns about the staffing levels within the team. As recently as March 2018, the trust had one safeguarding coordinator covering the whole trust. This meant their time was very limited, and the team stated this impacted the completion of training, oversight of reported safeguarding concerns and incidents, and monitoring deprivation of liberty safeguards.
(DoLS) applications. As of October 2018, the team now had three coordinators: one at each of the
main hospital sites, including one who started in October 2018 to cover the Mental Capacity Act
(MCA) assessments, DoLS, and the Mental Health Act (MHA). Staff in the safeguarding team felt
that this staffing issue meant that there were still gaps in the oversight and delivery of
safeguarding within the trust, but that this was improving.

Staff on the wards demonstrated an awareness of the trust’s safeguarding procedures and knew
the escalation process to raise a safeguarding concern. Staff were also knowledgeable about what
safeguarding meant in practice.

The trust had policies and reporting structures in place for specific safeguarding concerns that
may be identified on wards. The trust had specific procedures for identifying and reporting female
genital mutilation (FGM), child sexual exploitation (CSE), and a domestic violence pathway (DV).
Staff we spoke with stated they were aware of these policies and would follow them if they
identified an at-risk patient.

Safeguarding policies and procedures were accessible to all staff via the trust intranet. We
observed that information on how to contact the safeguarding team was displayed on wards. The
safeguarding team also stated that they attend safety huddles across wards to pick up on some
safeguarding issues and provide advice.

Staff completed safeguarding referrals on the intranet, which was then sent to the safeguarding
team for screening. The safeguarding team then sent the referral to the local authority. The
safeguarding team also reviewed reported incidents to pick up potential safeguarding concerns,
for example, pressure ulcers.

Cleanliness, infection control and hygiene

The environment on the medical wards and areas we visited was visibly clean and tidy. Signed
cleaning schedules were visible on most of the wards indicating when cleaning had been done
and when it was due.

Staff followed the trust’s infection control policy, for example washing their hands in between
attending to patients, using personal protective equipment such as gloves and aprons, and
adhered to the trust’s ‘bare below the elbow’ policy. We saw generally good compliance across
medical wards for staff hygiene and use of antibacterial hand gel.

The trust completed audits of hand hygiene on each ward as part of the monthly divisional
infection control data reports. Data from April 2018 to August 2018 showed between 80% and
100% compliance on medical wards, with performance lowest on Thistle Ward (80%).

There was a site-based infection prevention and control (IPC) team to provide support and advice
to staff, and to monitor performance in relation to IPC. The team developed an annual program of
work each year which included audits of performance, awareness campaigns of IPC standards,
and training for staff.

Staff used green ‘I am clean’ labels to indicate when an item had been disinfected and was ready
for use. We saw these stickers in use across wards.

Staff managed waste and sharps safely on the medical wards we visited. We saw that bins on
medical wards had the appropriate bags, and sharps bins were not filled above the appropriate
line.

The wards used disposable curtains to provide privacy and space between patient beds while care
was being given. These curtains were labelled with dates and we found no examples of curtains
past their expiry date.
Side rooms were available on most wards for the isolation of patients. Where patients had been isolated, staff used warnings on the door indicating what precaution need to be taken, and we saw good use of personal protective equipment (PPE) by staff entering these wards. However, isolation rooms did not have negative or positive air flow to control the risk of infection from patients with potentially contagious illnesses. This was a particular risk for patients where there was a possibility of cross-contamination.

A review by an external consultancy of the endoscopy service found that although the decontamination machines were due for replacement and this limited both their current effectiveness and room for increasing capacity, “the decontamination area was clean and the technicians clearly well trained”. This meant the trust was decontaminating reusable medical devices in line with national guidance. However, the consultancy’s report also stated that the decontamination machines should be replaced and the infection control environment improved as a matter of priority to meet the needs of the next Joint Advisory Group (JAG) accreditation visit.

We reviewed 30 sets of patient records and found Methicillin-resistant Staphylococcus aureus (MRSA) screening was not completed properly or not completed at all on medical wards. This was also identified in the previous inspection report. The trust reported 9 incidents of MRSA bacteraemia to the trust in the last annual infection prevention and control report (November 2017), however none of these applied to medical wards at Newham.

The trust completed audits of MRSA screening for each ward as part of the monthly divisional infection control data reports. Ten patient records were randomly selected for each clinical area to check if MRSA screening was documented within the first 24 hours of admission. Data provided from April 2018 to August 2018 showed performance was variable, most notably on Plashet Ward and Thistle Ward. From audit results it was also identified that staff were using the wrong swabs to screen so tests would not be processed. The infection control team and ward managers had since taken steps to inform staff of the correct process.

**Environment and equipment**

Ensuring the ward was secure was identified as an area for improvement at the time of the last inspection. On this inspection we found the ward environment to be secure. Each ward we visited had a locked door requiring a key card for access, and some wards had reception areas requiring sign-in.

Equipment was maintained and checked regularly to ensure it continued to be safe to use. The equipment was clearly labelled stating the date when the next service was due. All mobile electrical equipment that we looked at had up to date Portable Appliance Testing (PAT) certification.

We found that signposting to medical wards could be improved, as we found on inspection the signage reflected the ward names prior to refurbishment for fire safety. For example, Stratford ward had moved to their medical speciality Tayberry ward however this was not reflected in the new signage. This meant that patients or family members may easily become lost in relation to the ward they wanted.

We examined the resuscitation equipment on medical wards and units. Staff had carried out daily checks of resuscitation equipment and documented evidence of the checks in line with guidance from the Resuscitation Council.

Staff told us there was sufficient access to equipment to meet the needs of patients receiving care. Staff were able to access computer terminals to access patient test results as well as policies and
guidelines via the intranet. Several wards also had computers on wheels which allowed electronic records to be updated quickly after patient interactions.

The Acute Stroke Unit had a number of facilities to improve rehabilitation opportunities for patients. This included a large gym space, occupational therapy kitchen and creative therapies room. The therapies team we spoke with were positive about the facilities available to carry out rehabilitation with patients.

While some wards had been decorated to help orientate dementia patients, other wards had yet to introduce this, including wards that had significant care of the elderly admissions. Staff stated that that following the refurbishment of some wards they hoped to improve ward environments in accordance with national dementia guidance. Medical wards had access to a sensory garden specifically for dementia patients and their families, which was opened in May 2017.

The trust provided evidence of annual self-assessment audits on each medical ward relating to “work environment and equipment”. Although overall performance in relation to meeting the environmental standards of the audit, almost all medical wards were not routinely ensuring Control of Substances Hazardous to Health (COSHH) assessments were up to date and maintained, or that appropriate mitigation for managing hazardous substances was in place.

Assessing and responding to patient risk

Staff assessed patients in key safety areas such as falls, skin integrity, venous thromboembolism (VTE), and nutrition on admission using national risk assessment tools. Risk assessments were completed and recorded in the patient record.

In the 30 patient records we looked at, risk assessments were not consistently completed. Risk assessments for falls, pressure ulcers, and National Early Warning Scores (NEWS) were not consistently recorded. This meant that oversight of patient risk was not consistent, and patients may have been at unnecessary risk without sufficient safety or monitoring measures in places. It also meant patients at risk of deteriorating may not be picked up as quickly as possible.

The trust conducted a monthly audit of completion of NEWS scores for deteriorating patients in eight random records per ward. The audit examined if the patients’ vital signs were all checked, if the NEWS score was correctly tallied, and if the patient was then appropriately escalated. Data provided by the trust between August 2017 and May 2018 showed that performance in escalating and recording vital signs was between 85-100%, however patients having a physiological monitoring plan (i.e. clear instructions to the nursing staff when to call for assistance for further review) was consistently incomplete.

Monthly audits were also carried out for the completion of VTE assessments and for pressure ulcer assessment. Data provided by the trust showed that between July and September 2018, compliance on medical wards for pressure ulcer assessments was between 93% and 97%, and VTE compliance across medical wards was 97% for August 2018.

There was evidence of the use of the sepsis care bundle (Sepsis Six) for the management of patients with presumed or confirmed sepsis. Each ward we visited had a sepsis trolley to allow staff to quickly start the sepsis six care bundle if a patient was identified as a risk, and risk was monitored using a sepsis proforma. Each hospital site within the trust had a sepsis group who audited and monitored performance in relation to sepsis management.

The trust provided data on sepsis screening and response times for managing patients identified as a high risk. In the last twelve months prior to inspection 74% of patients admitted to Newham Hospital had evidence of screening in their records, compared to 63% at the rest of the trust. Of
the patients identified as a high risk, 52% were receiving antibiotics within 1 hour of deterioration, compared with 56% across all hospital sites.

The trust completed monthly audits of sepsis screening for inpatient admissions at Newham Hospital, and audits of the percentage of patients receiving antibiotics within an hour of deterioration. Data provided from the trust from August 2017 to August 2018 showed that sepsis response had improved significantly. The number of patients receiving screening was up from 73% in 2017 to 89% in 2018, and the number of patients receiving timely intervention was up from 20% in 2017 to 72% in 2018.

The hospital had established a local multidisciplinary sepsis team, which included a consultant, intensive care outreach nurse specialist, and an anti-microbial/Sepsis pharmacist. The sepsis team were responsible for coordinating sepsis promotion and education at the hospital, monitoring sepsis outcomes, and delivering sepsis specific improvement projects.

Sepsis training was included as part of deteriorating patient training (including sepsis) during nursing preceptorship meaning all new nursing staff received this training. The hospital had also begun to provide on-going sepsis training through nursing study days and simulation training. As of September 2018, 30% of nursing staff had received sepsis training. The trust also planned to introduce an updated deterioration monitoring system (NEWS2) by December 2018 which would include further sepsis awareness modules. Sepsis training was also delivered at induction for junior doctors.

Staff we spoke with were positive about the Critical Care Outreach Team (CCOT), which had just become available 24 hours a day, seven days a week. Staff we spoke with stated they responded quickly when contacted and were available to provide advice and support when needed.

**Nurse staffing**

Newham University Hospital reported the following nurse staffing numbers for medical care in March 2018 and April 2018. The hospitals fill rate remained below 90% in both March 2018 and April 2018.

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>Medical Care</td>
<td>155.7</td>
<td>178.5</td>
<td>87.2%</td>
<td>151.5</td>
<td>180.7</td>
<td>83.8%</td>
</tr>
</tbody>
</table>

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

From May 2017 to April 2018, Newham University Hospital reported a vacancy rate of 14.3% for nursing and midwifery staff in the medicine core service, this was higher than the trust target of 6.3%.

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

From May 2017 to April 2018, Newham University Hospital reported a turnover rate of 15.4% for nursing and midwifery staff in the medicine core service, this was higher than the trust target of 13%.
From May 2017 to April 2018, Newham University Hospital reported a sickness rate of 5.6% for nursing and midwifery staff in the medicine core service, this was higher than the trusts target of 3%.

From May 2017 to April 2018, Newham University Hospital had a total of 14,614 nursing staff shifts. A breakdown of bank and agency usage and unfilled shifts is shown below:

<table>
<thead>
<tr>
<th>Bank and agency</th>
<th>Number of shifts (% of total shifts)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank</td>
<td>6,635 (45.4%)</td>
</tr>
<tr>
<td>Agency</td>
<td>1,114 (7.6%)</td>
</tr>
<tr>
<td>Not filled</td>
<td>628 (4.3%)</td>
</tr>
</tbody>
</table>

The service used an acuity tool in order to plan staffing levels. The hospital used a system that allocated staff in advance based on pre-determined nursing demand. The site manager and senior nursing team reviewed staffing levels daily through visiting wards and by reviewing staffing levels and skill mix. This information was then used at the daily site safety huddles to establish if nursing levels needed to be flexed based on occupancy and acuity of patients on the wards. Staff informed us they would aim to use their resources in house to ensure wards were adequately staffed before going to bank and agency staff.

Although the vacancy rate within medical wards was higher than the trust average, local and divisional leadership had mitigated the risks associated with temporary staff well. The trust favoured using regular bank staff (45%) over agency staff (8%) as they would be more familiar to the ward and could receive a more involved induction. The trust had a training and induction policy for bank and agency staff that was used to ensure temporary staff were provided with as much support as possible.

The trust had a number of strategies in place to recruit new nurses to wards. The trust had been recruiting internationally, had a rolling advert programme for nursing vacancies, and worked closely with local universities to attract student nurses after qualifying. The trust also aimed to attract return to practice nurses with a view to progressing them towards re-qualification.

The trust offered an 18-month preceptorship programme to newly qualified nursing staff, which included support from mentor, clinical rotation, as well as further education opportunities. The trust also provided health care support workers with the opportunity to develop as nurse associates, which support their development to apply for registered nursing courses.

Medical staffing
Newham University Hospital reported the following medical staffing numbers for the medicine core service in March and April 2018. The hospitals fill rate was over establishment in both March and April 2018.
<table>
<thead>
<tr>
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<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Care</td>
<td>88.6</td>
<td>82.5</td>
<td>107.4%</td>
<td>84.9</td>
<td>84.1</td>
<td>101%</td>
</tr>
</tbody>
</table>

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

From May 2017 to April 2018, Newham University Hospital reported a vacancy rate of 0.1% for medical and dental staff in the medicine core service, this was lower than the trust target of 6.3%.

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

From May 2017 to April 2018, Newham University Hospital reported a turnover rate of 9.5% for medical and dental staff in the medicine core service, this was lower than the trusts target of 13%.

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

From May 2017 to April 2018, Newham University Hospital reported a sickness rate of 0.4% for medical and dental staff in the medicine core service, this was lower than the trusts target of 3%.

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

From May 2017 to April 2018, Newham University Hospital had a total of 1,873 medical staff shifts. A breakdown of locum and agency usage and unfilled shifts is shown below:

<table>
<thead>
<tr>
<th>Locum and agency</th>
<th>Number of shifts (% of total shifts)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Locum</td>
<td>545 (29.1%)</td>
</tr>
<tr>
<td>Agency</td>
<td>477 (25.5%)</td>
</tr>
<tr>
<td>Not filled</td>
<td>271 (14.4%)</td>
</tr>
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</table>

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

In March 2018, the proportion of consultant staff and the proportion of junior (foundation year 1-2) staff reported to be working at the trust was lower than the England average.

Staffing skill mix for the 713 whole time equivalent staff working in medicine at Bart’s Health NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>is Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>41%</td>
<td>43%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>4%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>36%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>19%</td>
<td>22%</td>
</tr>
</tbody>
</table>
Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
Registrar Group = Specialist Registrar (StR) 1-6
Junior = Foundation Year 1-2

Source: NHS Digital - Workforce Statistics - Medical (March 2018)

Consultants provided cover for medical wards Mondays to Fridays between 8am and 7pm. Consultant were then on-call from 7pm to 8am the next morning. At weekends, there were two consultants present on site for 7 hours each day, which included a morning ward and an evening round ward round. This weekend consultant was then on-call for the remainder of the 24 hours both weekend days. Medical staff we spoke with were positive regarding the shift patterns and felt it met the needs of the wards. The availability of medical staff meant medical wards were meeting the London quality standards for patients to be seen by a relevant consultant within 12 hours of admission or within 14 hours of the time of arrival at the hospital.

A consultant covered the ambulatory care unit 10am to 7pm Monday to Friday. Out of these hours ambulatory care patients would be covered by the Emergency Department.

There were consultant roles on-site and on-call to manage specific patient emergencies. For example, there was a designated consultant responsible for managing emergency gastrointestinal (GI) bleeding 24 hours a day, seven days a week. This cover was on site from 9am to 5pm Monday to Friday and available by telephone after 5pm, Monday to Friday, and at the weekend. This consultant was contactable directly by phone for advice, and attended to perform endoscopy with an on-call endoscopy nurse when required.

Consultants we spoke with stated there was a good relationship between the consultant body within medical wards at Newham Hospital. Staff stated they were well supported by colleagues and felt there was a strong sense of collaborative working. Staff also stated that they felt there was positive working with consultants and staff in other directorates as well.

Trainee doctors were positive about the level of training they had access to. Junior doctors stated there was good access to training opportunities, and were particularly positive about the simulation training experience.

Medical staff stated that the induction process was well structured. New staff were given a corporate induction which included mandatory training and learning the trust values, and inductions varied depending on staff groups to meet the needs of new starters. Staff also stated that each received a ward induction, which reflected the specialities of patient that will be treated there and the needs of the specific wards.
The trust had partnered with a local university to develop a training course for physicians' associates, which started in January 2017. The physicians' associate could help with taking medical histories, performing examinations, diagnosing illnesses, analysing test results and developing management plans.

**Records**

The hospital had a predominately paper records system for documenting patient care, with some assessments, referrals, and discharge information completed electronically. This included records of treatment, care plans, risk assessments, medicines administration, and patient history. Staff we spoke with stated the medical wards would shortly move to the trust electronic records system. Discharge summaries were completed electronically.

During the inspection, we examined 30 sets of patients’ records across medical wards. We found that patients’ records were well completed for medication charts, however there were inconsistencies across wards in performance for recording risk assessments. Some areas we visited did not complete the risk assessment sections, but recorded some concerns in the interaction notes, meaning it would be difficult to pick up.

Some staff we spoke with on medical wards stated they had not received any specific training in the use of the patient record, and that there was inconsistency in how it was being completed. Staff did state that good record keeping was covered in the induction booklet. Staff were also not sure if they would receive specific training relating in how to use the electronic records system when it was introduced. Senior staff stated that all staff are trained in using the booklets on induction and when the booklet was first introduced the trust ran training for a number of staff on each ward (as well as all the senior nurses) who can act as superusers for their area.

On several occasions we found patient records trolleys unsecured and patient record booklets unattended in corridors, as well as computer terminals unlocked. This lack of security presented a risk to patient confidentiality, as well as clinical records being lost.

The trust completed an annual record keeping audit to establish the quality of completion of paper case notes and electronic records, however we were not provided with the specific quality outcomes of this audit in relation to medical wards. Senior staff we spoke with stated that monitoring of the quality of patient records would be done through a newly introduced ward monitoring software, however the information related to records quality was not provided.

**Medicines**

Staff were aware of policies and protocols in relation to the administration of medication, and could show us how to access them.

On site pharmacy cover was available during normal working hours Monday to Friday, with a limited service on weekends. If medication was required out of hours, staff informed us that they would contact the site manager to access the emergency cupboard. The site manager would then contact the on-call pharmacist if needed.

Controlled drugs (CDs) were managed safely and securely, checked regularly and controlled drug audits were undertaken by the pharmacy team. Staff followed the trust policy requiring CDs to be signed for in the presence of two staff members. Emergency medicines were available on emergency trolleys which were secure, sealed and checked regularly.

Fridge and room temperatures in medicines rooms on medical wards were monitored and recorded daily. The trust had an escalation policy when temperatures were recorded outside of the normal range.
The pharmacy team completed several divisional and trust-wide medicines audits which included medical wards. This included quarterly CD audits, missed dosages, review of anti-microbial prescriptions, medicines reconciliation and documentation audits. The pharmacy team produced reports relating to audits for quality and safety committees, and helped to develop actions plans to address any areas of poor performance.

Medical wards at Newham reported 306 medication incidents within the last twelve months. Staff we spoke with, particularly the pharmacy team, stated that they were encouraged to report incidents so they could be investigated and performance improved.

We observed 30 sets of patient records across medical wards and found medication charts to be consistently completed. Records made note of patient allergies as also had a separate medication chart for some complex needs (e.g. diabetes).

Each medical ward had access to a pharmacy technician team who led on dispensing and reconciling medication. However, the observations ward did not have an on-ward technician, which pharmacy staff stated could cause delays in dispensing and reconciling medication.

**Incidents**

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

From August 2017 to July 2018, the trust reported no incidents classified as never events for medical care at Newham General Hospital.

*Source: NHS Improvement - OBIEE NRLS STEIS*

In accordance with the Serious Incident Framework 2015, the trust reported 15 serious incidents (SIs) in medical care which met the reporting criteria set by NHS England from August 2017 to July 2018.

The types of incidents reported were:

- Pressure ulcer meeting SI criteria: seven incidents
- Sub-optimal care of the deteriorating patient meeting SI criteria: four incidents
- Abuse/alleged abuse of adult patient by staff: one incident
- Medication incident meeting SI criteria: one incident
- Slips/trips/falls meeting SI criteria: one incident
- Treatment delay meeting SI criteria: one incident

*Source: NHS Improvement - OBIEE NRLS STEIS*

Medical wards investigated all incidents and used learning from investigations to improve the delivery of care. Incidents were reported on and discussed through the divisional governance structure and, resulting from this, actions were identified to minimise the risk of repeat occurrences. Each serious incident (SIs) was investigated with a root cause analysis to identify contributing factors, and this informed action plans. We reviewed three root cause analyses for recent serious incidents on medical wards and we found the investigations were thorough and contained actions to reduce future risks to patients.
Staff used an electronic incident reporting system, which could be accessed on the hospital’s computers. Staff were aware of how to report incidents and could show us how to access the online system.

There were 1908 incidents reported from 1st September 2017 to 31st August 2018. Of these 442 related to pressure ulcers, 322 to patient falls, 306 to medication errors, and 202 to staffing issues.

Staff told us they were encouraged to report incidents by managers, and we found there was a positive attitude towards raising concerns. This was consistent across wards and staff disciplines, and incidents would be treated seriously when reported.

Learning from incidents was disseminated through several means. Following discussions of incidents and investigations at team meetings, staff would be informed of outcomes and learning in team meetings, daily staff safety huddles, emails, and on information boards. Learning was also often used to inform training.

The duty of candour (DoC) is a regulatory duty that relates to openness and transparency. It requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. Staff we spoke with demonstrated good knowledge of the DoC, and senior staff were clear about their responsibilities in relation to DoC. We also saw evidence in incident reports and complaints response which showed DoC processes being followed and being recorded.

**Safety thermometer**

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

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

Data from the Patient Safety Thermometer showed that the trust reported 70 new pressure ulcers, 37 falls with harm and 30 new urinary tract infections in patients with a catheter from June 2017 to June 2018 for medical services.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Bart’s Health NHS Trust**

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

1. **Total Pressure ulcers**
   - (70)

2. **Total Falls**
   - (37)
Ward level safety information was displayed on a notice board on each medical ward we visited. The information was displayed in a clear and readable format for patients and visitors to see how well the wards were performing. Data for the safety thermometer was collected by the relevant matron for each ward, and hospital had begun to record safety thermometer data using an app, although this was in the early stages of implementation.

**Is the service effective?**

**Evidence-based care and treatment**

We observed care on medical wards during our visit and found it was delivered in line with evidence-based guidance such as those published by National Institute for Health and Care Excellence (NICE), the Royal Colleges and other relevant bodies, and was supported by local guidelines and standard operating procedures.

Most of the policies and procedures we viewed were reviewed regularly, although we found some to be out of date. Most of the policies we reviewed on inspection were in date, available through the staff intranet, and easy to read for staff. Divisional and speciality leads reviewed policies and updated ones that required review or needed to reflect new guidance or legislation. However, there were out of date policies on the intranet for mandatory training, pressure ulcer management, and clinical audit.

New policies and clinical guidelines were disseminated to staff by email and in team meetings. The hospital undertook a programme of clinical and operational audits to ensure practice was meeting the standards of the national guidance and best practice. Where non-compliance was found, the clinical effectiveness lead submitted an action plan within a deadline to deliver improved alignment with best practice. This action plan was then monitored by the clinical effectiveness directory to ensure the actions were being implemented and delivering improvement.

Patient assessments were based on national tools, such as the Malnutrition National Screening Tool (MUST) and the National Early Warning Scores (NEWS). Care pathways based on national guidance was in place for conditions such as sepsis, diabetes, cardiology, and stroke.

Patients received screening and assessment for sepsis on medical wards and were managed in line with national guidance. A sepsis screening and management tool was in use across wards and each ward had a sepsis trolley, which allowed staff to start the sepsis 6 care bundle quickly for any patient identified as being a risk.

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**Source:** NHS Digital - Safety Thermometer

1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only
Sexual health services were delivered in line with national standards set by the British Association for Sexual Health and HIV (BASHH) and The STI Foundation. This included a comprehensive program of audit to measure performance in relation to the standards, as well as local audits to ensure practice met the needs of the local population.

Medical wards at Newham Hospital were meeting the NHS Seven Day Services Clinical Standard for ensuring patients were seen by a consultant twice daily and a consultant-delivered ward round at least once a day, seven days a week. This was facilitated by two consultants being available on medical wards on weekends to support a morning and afternoon ward round.

The endoscopy service had not achieved Joint Advisory Group (JAG) accreditation because of the age and effectiveness of the Endoscope Washer Disinfectors (EWD) and lack of availability of additional restroom areas for enema patients. JAG Accreditation is the formal recognition that an endoscopy service has demonstrated that it has the competence to deliver against the measures in the endoscopy Global Rating Scale (GRS) Standards). The service has now successfully secured a capital investment following a business case to improve decontamination facilities and process, and convert the old decontamination space into a third procedure room to meet expect increase in demand by 2020. The service has also worked with an external consultant who provided a quality report on the current service, and provided suggestions on how the capital investment could be best utilised to meet the JAG standards.

**Nutrition and hydration**

Staff used national guidance tools to assess patients’ hydration and nutrition needs that were set out in an up to date nutrition and hydration policy. These standards included screening of patients at risk of malnutrition using a national malnutrition universal screening tool (MUST). Staff informed us that the MUST score was completed on admission and reviewed on medical wards.

Ensuring the nutritional and hydration needs of patients were met was identified as an action from the last inspection. In the 30 records we reviewed we found MUST scores were consistently recorded. Patient records also showed contributions in the notes from dieticians.

The trust provided evidence that the completion of MUST scores in patient records was audited monthly. Data for the most recent month (September 2018) showed that most wards had a completion rate for MUST scores of between 85% and 97%. However, scores for Plashet (42%), Stratford (54%), and Thistle Ward (71%) were considerably lower than the other wards.

During the inspection some family members of patients were concerned that patients who needed assistance eating were not supported to do so by staff, and so were not finishing meals. We observed nursing staff taking meals to patients and discussing supporting patients to eat, but also observed patients with meals that were not able to eat without support. We identified these patients to the nurse in charge on the wards, who stated they would provide staffing assistance.

Red trays and jugs were used to indicate patients who needed help at mealtimes, and we observed staff supporting these patients with feeding if needed. The trust had several volunteers who could support patients to eat meals. The trust also had a protected mealtime policy to allow patients to have their meals without disruption.

Patient feedback on the food provided was generally positive. Most patients we spoke with told us the food was good. There was a choice of various food options available at mealtimes, and the medical wards could cater to any cultural or dietary requirements of patients.

Speech and language therapists (SALTs) worked closely with nursing and medical staff in assessing and supporting patients with eating, drinking and swallowing needs. The SALT team
had a system for seeing priority patients: high risk or complex needs were seen next day, patients requiring review were seen in three days, and lower risk patients were seen in five days.

**Pain relief**

The patient records contained a section for completion on pain and comfort. In the records we viewed we found this to be inconsistently completed or not completed. This meant that pain management for some patients may not be as effective as it could be.

Patients we spoke with generally felt they were provided with pain relief when they raised it as a concern with staff. Staff stated they would regularly check with patients if they were in pain, and if they needed any medication to relieve this. The wards used a specific pain assessment tool for when patients were not able to communicate verbally.

The trust had a dedicated acute pain management team whose role was to manage the needs of patients with acute and chronic pain in the hospital. Clinical nurse specialists in this team provided support and advice to staff, as well as specialist pain management for patients if necessary.

**Patient outcomes**

From March 2017 to February 2018, patients at Newham University Hospital had a higher than expected risk of readmission for elective admissions, and an average risk of readmission for non-elective admissions when compared to the England average.

- Patients in gastroenterology, general medicine and respiratory medicine had a higher than expected risk of readmission for elective admissions

- Patients in general medicine and gastroenterology had a similar to expected risk of readmission for non-elective admissions. Geriatric medicine had a higher than expected risk of readmission.

\[\text{Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.}\]
Following inspection, the trust provided additional information on readmission rates for medical specialties at Newham, which examined avoidability of readmission for patients. An independent audit on readmissions commissioned by Newham CCG and Barts Health NHS Trust looked at readmissions for the 2016/17 financial year. This found that 14% of readmissions were concluded as avoidable. Of this figure, approximately 20% (total 2.8% of readmissions) were found to have been readmitted because of substandard treatment and inadequate discharge plan.

Newham University Hospital was part of the most recent SSNAP audit (April 2018 – June 2018). The hospital received an overall score of “B”, with a “B” for patient-centred key indicators, and an “A” for overall team-centred key indicators.

(Source: Royal College of Physicians London, SSNAP audit)

The trust participated in the 2017 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 78.2%, which did not meet the audit aspirational standard of 90%. The 2016 figure was 72.3%.

In the 2017 audit the proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 23.4%. This is good practice. The 2016 figure was significantly better than the national level.

In the 2017 audit, the proportion of fit patients with advanced (NSCLC) receiving Systemic Anti-Cancer Treatment was 81.3%. This is good practice. The 2016 figure was not significantly different from the national level.

In the 2017 audit, the proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 74.9%. This is within the expected range. The 2016 figure was not significantly different to the national level.

The one-year relative survival rate for the trust in 2017 is 40%. This is within expected range. The 2016 figure was not significantly different to the national level.

(Source: National Lung Cancer Audit)

The crude proportion of patients who had a vision assessment (if applicable) was 73%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 8%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients with mobility aid in reach (if applicable) was 50%. This did not meet the national aspirational standard of 100%.

(Source: Royal College of Physicians)

Newham Hospital participated in the National Diabetes Inpatient Audit Quality NaDIA, with the most recent available report from 2017. Although there were areas for improvement the hospital performance in relation to 2015 and 2016 was significantly improved, both in relation to specialist staffing and availability of service. The Newham diabetes team had also successfully bid to be one of 20 services in the UK to be part of the National Diabetes Inpatient Audit Collaborative Quality Improvement project (NaDIAQIC). This project would focus on reducing the frequency of avoidable
causes of patient deterioration, specifically inpatient hypoglycaemia. The project will run throughout 2018 with a view to sharing learning across the country once it has been completed.

**Competent staff**

Data provided by the trust shows as of December 2018, appraisal rates of nursing staff on some wards in the Emergency and Acute Medicine division did not meet the trust target of 90%, with the lowest ward being 70%. 90% of permanent medical staff had been appraised, while 100% of junior doctors in training had been appraised. The trust stated that they are introducing new electronic arrangements for recording appraisal compliance and these are expected to be implemented by September 2018.

Most of the staff we spoke with had an appraisal in the last twelve months, and felt that it had been valuable to their roles. However other staff had not had an opportunity to formally discuss their continuing professional development and performance in an appraisal, and felt this could be more structured. Data provided by the trust showed that consultants job plans had been reviewed and agreed throughout 2018 by all medical specialities.

The trust had several personal and professional development courses available to staff which were available on the intranet. The medicines division had three Practice Development Nurses (PDNs) who were available to provide advice and support on available courses and education opportunities, as well as deliver training. PDNs also provided tailored support for nurses revalidating, student nurses and return to practice nurses. Staff we spoke with stated the PDNs were easy to access and supportive, and we observed PDNs working on the wards to provide bespoke training.

Staff were provided with an induction to the hospital as well as to medical wards when they first started employment. This included completing a completion of mandatory training, information on the trust values, and competency assessments where necessary. Staff we spoke with felt they were well supported when starting employment with the organisation.

Clinical nurse specialists across wards provided bespoke training to staff to improve the delivery of care to patients. Throughout medical services, staff had access to clinical nurse specialists in different areas, such as stroke, dementia, tissue viability, pain, and palliative care to provide advice and support for patients and staff.

**Multidisciplinary working**

Throughout our inspection we saw consistent evidence of multidisciplinary team (MDT) working across all disciplines and wards. The delivery of patient care included healthcare professionals from all backgrounds necessary, and MDT input was well reflected in patient records. Staff we spoke with were positive about the relationship between different disciplines on medical wards, and stated they were supported by colleagues when they needed specialist support and advice.

Staff we spoke with were also positive about MDT working with colleagues at other hospital sites within the trust. There were regular meetings between specialities which were shared across multiple sites, and staff stated they felt communication and cross-site working was well embedded within the trust. Many trust consultants had clinical responsibilities at multiple hospitals, and this facilitated closer working between the trust sites.

During our inspection we saw regular consultant-led multidisciplinary meetings and ward rounds attended by various disciplines. Daily MDT meetings were in use seven days a week to review patients, and we observed that they were attended by a consultant, nurse in charge, discharge co-ordinator, bed managers, junior doctors, social workers, and therapies co-ordinator.
Staff we spoke with were aware of how to make a referral for therapy input into patients’ care, and we observed therapies staff to be active in the delivery of services on medical wards. Staff stated that therapies colleagues were very accessible, and happy to provide support and advice where needed.

Due to some MDT staff not being available out of hours, medical wards were not meeting the London Quality Standards for a clear MDT assessment within 14 hours and a treatment or management plan to be in place within 24 hours. This meant patients in some specialities admitted on the weekend would wait until Monday for an assessment and treatment plan to be developed.

**Seven-day services**

Medical wards at Newham Hospital had access to diagnostic imaging 24 hours a day seven day a week through the emergency department. Staff we spoke with stated they felt there were no issues in accessing these services at any time of the day.

The ambulatory care unit was open Monday to Friday 9am-5pm, with consultants on-site during these hours. Out of hours, cover was provided by the emergency department.

The hospital pharmacy department was open Monday to Friday 9am-5pm, Saturdays and Sundays 10am-1:30pm. An emergency 24/7 on call service was also provided.

Most therapy services (occupational therapy, dieticians, speech and language therapy) were available during normal working hours Monday to Friday. The physiotherapy team provided a seven-day service including out of hours. There was also access to the Rapid Assessment, Interface & Discharge (RAID) psychiatric liaison through the emergency department seven days a week.

The endoscopy unit operated Monday to Saturday between 8am and 6pm and was closed on Sundays.

**Health promotion**

The trust had a public health team to identify opportunities for health promotion for patients. This team worked across site and with clinicians to identify areas for improving patients’ health.

The trust had a referral process for patients to seek specialist help for smoking cessation. Although Newham Hospital did not have a smoking cessation clinic on site, staff told us that patients would be encouraged and supported to access clinics at other trust sites if needed.

Medical wards and hospital provided several activities to increase public understanding of health during national awareness campaigns. For example, the hospital ran an information stall for public awareness during World Sepsis Day Week.

We saw information on health promotion clearly displayed around medical wards and the hospital. There were consistent advertisements for initiatives on the flu vaccine, recognising the signs of sepsis, and smoking cessation displayed. The trust became a smoking free site at the start of January 2018.

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

We found that recording of capacity assessments and decisions on deprivation of liberty safeguards (DoLS) were not consistently documented appropriately in patient records. The nursing record contained a proforma pathway for assessing if a patient needed a DoLS application, however this was not being used consistently. We found information on capacity and
DoLS may be recorded in patients’ notes with little contextual information rather than using the specific capacity proforma, or not documented at all in the record. This meant it was not sufficiently clear which patients had received a capacity or DoLS assessment.

Staff understanding of when patients needed an assessment under the Mental Capacity Act (MCA) and DoLS application was variable. Some staff were not able to demonstrate awareness of when MCA and DoLS assessments would be necessary. Safeguarding leads for the trust stated they recognised that there were gaps in training and understanding for MCA and DoLS which was due to a lack of staff in the safeguarding team. MCA and DoLS training was covered as part of the safeguarding level 2 course.

Safeguarding leads we spoke with stated that a lead safeguarding coordinator for MCA, DoLS, and the Mental Health Act would be starting in October 2018. Safeguarding leads stated there had been a delay in the local authority providing outcomes from DoLS applications and they hoped this new coordinator could help to improve this. Currently the safeguarding lead for Newham attended daily safety huddles, and was supported by the trust safeguarding team one day a week.

The hospital did not complete any audits of capacity assessments in patient records or DoLS applications to identify issues in performance. The safeguarding team recognised this meant they were currently reactive to concerns that were raised regarding the MCA and DoLS. The team stated they intended for this to be addressed when the safeguarding coordinator with responsibility for MCA and DoLS started in October. Although the safeguarding team had a risk register, issues regarding MCA and DoLS were not on it.

Is the service caring?

Compassionate care

The trust did not provide the overall results for the Friends and Family Test (FFT) for medicine at Newham Hospital as the trust had changed the FFT provider at the end of November 2017. From December 2018 to September 18 the trust had been collecting satisfaction in house. The data from this period shows that from 681 responses the trust had an overall positive satisfaction rate of 83%

The Friends and Family Test response rate for medicine at Newham University Hospital was 7% which was worse than the England average of 25% from July 2017 to June 2018.
Across medical wards we observed generally positive interactions between staff, patients and family members. Staff were supportive to patients and treated them with dignity and respect. Interactions between staff and patients were friendly, and staff made time to ask if patients needed anything or had any questions.

We spoke with 17 patients during the inspection across medical wards, who were generally positive about the care they received and the staff they had met. Patients we spoke with recognised that staff were very busy and they may need to wait for a response, however patients felt staff were supportive when available. One patient said: “I think the nursing staff are very helpful and made me feel welcome”. Another patient said: “I am very impressed with the staff”.

We saw that medical wards displayed “Thank You” cards that they had received from patients following discharge.

Some medical wards or specialities completed local patient satisfaction surveys to inform practice. For example, the endoscopy unit completed a patient survey twice a year, and used the feedback they received to improve services. Results from the endoscopy survey were displayed in the endoscopy waiting areas.

Patients we spoke with stated that staff respected their dignity and privacy, and we observed this on the wards we visited. Staff used curtains around beds to provide privacy for patients receiving treatment and we observed staff explaining the care that they were providing to patients.

While on inspection, we were informed that an escalation ward had been opened overnight to meet increased attendances in the emergency department and on medical wards. To open the escalation area, approximately ten beds had been moved into the reception area of the ambulatory care unit, which were still there when patients were arriving for appointments. While this did not appear to present any risks to patient safety, the beds did provide an obstacle for patients attending appointments, and would have presented a particular challenge for patients with mobility issues. Hospital porters removed these beds to another area by 11am, and the ambulatory care unit returned to normal operation.
Emotional support

The hospital had a Macmillan information centre on-site, where cancer patients could receive free information, support and benefits advice from a dedicated clinical Macmillan support team. Cancer services at Newham also used an information prescriptions tool (a national programme between the NHS and several cancer charities) for professionals to prescribe personalised information to patients to support them at key points during their care pathway.

There was 24/7 religious support available for medical patients and their families through the hospital multi-faith chaplaincy service. The chaplaincy service could provide access to religious services and had a prayer room/quiet room for religious observances, and could also provide support during a bereavement. Staff we spoke with stated the chaplaincy service was available to provide advice to the wards to ensure patients religious needs were met.

Psychological support for medical wards was delivered by the liaison psychiatry service provided by a neighbouring mental health trust (based within the emergency department). The team consisted of medical and nursing staff as well as therapists, who were available to provide advice to staff as well as assessments for patients on wards 24/7, and were as involved in discharge planning when required. Staff referred patients for assessment to the liaison team, or patients could self-refer. Staff we spoke with were aware of the process of accessing the liaison psychiatry service. While this provision was available as crisis support for patients with mental health needs, there was a lack of rehabilitation psychology on some wards e.g. Stroke.

The bereavement service provided support to families following a death of a patient. Bereavement administrators provided necessary paperwork for families, and arranged viewings for families if requested. The service also facilitated a death certificate to be released as soon as possible to meet their specific needs of quick burial for religious requirements, this included the release of the body out of hours. Bereavement leaflets were available for patients on the wards we visited.

Understanding and involvement of patients and those close to them

Most patients and their family members we spoke with stated they had been well involved in their care and their relative’s care. Patients stated that their care planning included a number of clinicians input, but also was patient centred.

We observed staff taking time to speak with patients and their families and explain their treatment. Patients and their relatives were given time to ask questions about their care and progress. We also saw written evidence in patient records that included discussions with the patient’s family where appropriate.

Staff and senior leads informed us that monthly clinical boards, which included several medical specialties, included representation from patients or family members who have used those service. Clinical staff we spoke with were very positive about the input of the patient experience contributors, and felt that they helped to ensure the patient voice was appropriately considered when discussing changes to service delivery or performance.

The trust had developed a trust carers policy which allowed flexible visiting hours for carers of people with complex needs (such as dementia), and a carer’s care plan to ensure their needs were being met.
Is the service responsive?

Service delivery to meet the needs of local people

Medical wards at Newham Hospital provided and had access to several clinical nurse specialists to meet the needs of local patients. This included access to a dementia team, psychiatric liaison, critical care outreach, palliative care team, and various oncology nurse specialists.

Medical wards provided care for patients aged 18 or over. However, staff informed us that there could rarely be patients who were aged between 16-18, particularly on the observation ward. Staff stated that any patient under 16 admitted to a medical ward would be done so to improve their access to more appropriate treatment and they would be care for in isolation.

There were several specialist staff available to medical wards to support patients with complex needs. This included a dementia and delirium team who supported the dementia and delirium pathway, and a specialist learning disability nurse (shared across sites) that supported patients diagnosed with a learning disability and/or autism spectrum disorders.

Between August 2017 and August 2018, medical wards at Newham reported 22 mixed sex breaches. On site we saw patients being cared for in line with best practice relating to single sex bays. Staff on each ward told us bays could be changed depending on the balance of patients.

For medical non-elective patients, the average length of stay was 6.1 days, which is lower than the England average of 6.4 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients in cardiology and gastroenterology is lower than the England average.
- Average length of stay for elective patients in clinical haematology is higher than the England average.

Note: Top three specialties for specific trust based on count of activity.

Average length of stay for non-elective specialties:

- Average length of stay for elective patients in general medicine is lower than the England average.
- Average length of stay for elective patients in geriatric medicine and cardiology is higher than the England average.
From April 2017 to March 2018 the average length of stay for medical elective patients at Newham University Hospital was 13.1 days, which is higher than England average of 6.0 days.

For medical non-elective patients, the average length of stay was 5.4 days, which is lower than England average of 6.4 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients in gastroenterology and general medicine is higher than the England average.
- Average length of stay for elective patients in rehabilitation is lower than the England average.

Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in general and geriatric medicine and gastroenterology is lower than the England average.
Meeting people’s individual needs

Staff on medical wards stated they could access interpreting services for patients whose first language was not English, and were familiar with the process of how to do so. Translation services could be arranged by telephone or in person. Some staff also spoke other languages and could provide support to patients in translation if needed. The trust also had a bilingual health advocacy and interpreting service (which supported several community languages) that could support patients in their decision making with clinicians.

The trust had an operational dementia and delirium strategy to provide more consistent care and therapeutic environments for patients with dementia. A multidisciplinary dementia and delirium team provided support for patients across the trust, and we observed this team working on the wards. The ‘Forget me not’ document was used by staff for patients known to have or suspected of having dementia or cognitive impairment. Staff provided patients and carers with the document so they could complete information about what the patient preferred to be called, as well as their likes and dislikes.

While some wards had been decorated to help orientate dementia patients, other wards had yet to introduce this, including wards that had significant care of the elderly admissions. We did not see wards using stickers in patients records or signs on patient doors to remind staff of where there were vulnerable patients. Staff stated that that following the refurbishment of some wards they hoped to improve ward environments in accordance with national dementia guidance and for patients with complex needs.

Medical wards had designated a ‘dementia champion’ on each ward to support the care of patients with dementia, however some of the staff did not display a sufficient understanding of what this role entailed. Some staff who had been designated as dementia champions were not clinical, which meant that they may need additional training to effectively identify concerns for dementia patients on their wards.

Staff we spoke stated they had regular support from the palliative care team to ensure specialist support was available for palliative patients. Staff stated members of the palliative care team facilitated quick support to end of life medications, rapid transfers to appropriate wards or back to their preferred place of death, and supported training for frontline staff. We saw posters across wards advertising how to reach the palliative care team.

Patients admitted to the hospital with a learning disability were flagged on the patient records system. Hospital passports were used with patients with learning disabilities to provide quicker access to patient information and preferences of treatment. The trust also had a learning disabilities nurse covering all hospital sites to provide advice and support to staff, and be involved in the care of very complex patients.

Patients with mental health needs could be referred to the psychiatric liaison service for assessments and support, which was provided by a neighbouring mental health trust. Staff we spoke with stated patients with mental health needs would be provided with specialist support from a mental health nurse for 1:1 observation.

The stroke unit did not have specialist neuropsychology input available to provide assessments and support care planning. Staff stated they could access the psychiatric liaison service for crisis
mental health support, however lack of neuropsychology meant there was a gap for assessment and rehabilitation for potentially cognitively-impaired patients.

**Access and flow**

Plashet ward:  
From April 2017 to March 2018, 63% of individuals did not move wards during their admission, and 37% moved once or more.

Silvertown ward:  
From April 2017 to March 2018, 61% of individuals did not move wards during their admission, and 39% moved once or more.

Stratford ward:  
From April 2017 to March 2018, 63% of individuals did not move wards during their admission, and 37% moved once or more.

Thistle ward:  
From April 2017 to March 2018, 63% of individuals did not move wards during their admission, and 37% moved once or more.

(Source: RPIR Universal – ward moves tab)

From April 2017 to March 2018, there were 5,626 patients moving wards at night across nine wards within medicine. During the reporting period June, July and August 2017 showed the highest number of ward moves at night. (June: 624, July: 667, August: 588)

The top three wards with the highest moves at night were:

- Silvertown ward: 946 moves at night  
- Plashet ward: 807 moves at night  
- Thistle ward: 771 moves at night

(Source: RPIR Universal – moves at night tab)

Medical wards at Newham had a significant number of patients moving wards at night. Following inspection, senior staff stated that there were significant inaccuracies in the data submitted relating to night moves due to inaccurate recording of time of admission and changes to the electronic patient record that was used at Newham in September 2017. Data initially suggested over 5000 patients moved wards at night between April 2017 and March 2018. The trust business intelligence unit revaluated the total number of ward moves at night to be 2500, however the trust stated that this still may not accurately reflect the number of overnight bed moves.

Patients seen in the emergency department and deemed to require admission were referred to the on-take Medical Registrar and then transferred to the 21-bed Observations Unit (or Medical Assessment Unit). The unit was split into four bays for patients requiring level one care, however there were limited side room space for patients requiring enhanced or isolated care. Staff stated that these patients would be prioritised for an available side room on another ward.
According to the trust admission policy, the observations unit aimed to transfer patients to other specialist wards (such as gastroenterology, respiratory, or cardiology), or discharge them home, within 24 hours. However, staff told us that patients on observations unit were often on the ward for significantly longer than this, some for up to a week, due to difficulties in finding a bed on a medical ward. The ward had an escalation process for patients that were on the ward for long periods of time to speed up their move to the correct specialty ward.

In November 2017 an Emergency Care Improvement Programme (ECIP) team, which included involvement from NHS Improvement and NHS England, were invited to review current practice in acute medicine and offer suggestions for improvement. The team visited the observations unit, clinical decisions unit, ambulatory care unit, and took time to meet with staff. The report stated that the model for the observations unit is complex but it works for the site, however capacity within the Observation Ward was a challenge for the size of the medical take. The report was also positive about the ward rounds system and medical staffing.

The observation ward had access to a nearby room which was being utilised both by the emergency department and the acute medical division as a clinical decisions unit (CDU). This space had a treatment room, was monitored by a nurse, and allowed management of patients that were awaiting the results of diagnostic or required a minor intervention. Depending on results of diagnostics patients could be discharged, provided with an appointment for ambulatory care, or admitted to the observation unit. The ECIP report stated that there was a potential for overlap between the ambulatory care unit and CDU, and recommended that the criteria for each area be clarified to optimise flow.

Ambulatory patients could be sent to the Ambulatory Care Unit following triage in the emergency department or referred by GP within working hours. The Ambulatory Care Unit was a rapid access clinic which helped avoid admissions to medical wards or see patients who could be discharged from medical wards but may need some further observations or tests. GP referrals to the Ambulatory Care Unit were triaged by consultant.

The ECIP report stated that the ambulatory care model was in its infancy, staffing was variable and that the service ran extremely limited hours with a strict exclusion criteria. We observed that the consultant presence on the Ambulatory Care Unit was extremely stretched between seeing patients and triaging referrals from GPs. The ECIP report stated that this could be improved by reviewing the staffing needs of this unit, and considering any mobile and stable patients presenting at the emergency department for transfer to the Ambulatory Care Unit. The report also stated that the location of the Ambulatory Care Unit made referral more difficult and that improved signage could help, with an eventual goal of locating the Ambulatory Care Unit closer to the emergency department.

Discharges were discussed daily in board rounds and were consultant led, and needs of patients (e.g. social care needs, further tests required) were discussed as part of this process. We attended these meetings and reviewed patient records, and observed discharge planning to be multi-disciplinary and well managed.

The hospital had a discharge team which supported and advised medical wards on complex discharges. Discharge coordinators provided specialist advice and support for the MDT, attended board rounds (as well as care planning meetings and weekly discharge meetings), and acted as point of contact between the hospital wards and external providers involved in the patients care (primary care, social services, specialist palliative care).

The discharge lounge for Newham Hospital was open from Monday to Friday, 10am to 6pm. Patients that were stable and mobile were transferred to the discharge lounge to await transport or
to take away (TTA) medications. Patients that were stable but may have needed additional monitoring could be provided with an appointment to attend the ambulatory care unit, however this was not routinely embedded in practice, as identified in the ECIP report.

Medical wards outliers included patients on the observation ward waiting on admission to a medical ward, those on medical wards different to the speciality of their treatment, or patients on a non-medical ward. Senior staff we spoke with stated medical outliers on other wards were not as likely due to the few number of surgery beds available at Newham. In line with trust policy, clinical ward staff aimed to prioritise outlying patients for admission to the correct speciality wards and daily oversight. Any outliers would be discussed as part of the admitted wards board rounds, and the medical teams for that ward would then update the speciality ward with key information relating to their patients. Staff informed us that that nursing staff monitoring outliers had access to contact bleep numbers for speciality input if needed.

Learning from complaints and concerns

From April 2017 to March 2018, there were 65 complaints about medical services at Newham University Hospital. The service took an average of 48 days to investigate and close complaints, in line with their complaints policy, which states complaints should be completed between 10-60 days.

The top three wards with the most complaints were:

- Plashet ward: 13 complaints
- Thistle ward: eight complaints
- Silvertown ward: seven complaints

Thirty-nine complaints related to diagnosis/treatment. The general themes from the complaints related to inadequate care provided to patients, negligence and poor attitude/communication, with the largest number relating to nursing staff.

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

There was a hospital governance team that oversaw the local management of complaints. The governance team or complaints lead would nominate a lead investigator from the staff, who then investigated the complaint. The investigator was also responsible for drafting the initial response to the complainant which would then be signed off and sent by the Chief Executive for the hospital.

We saw posters and leaflets advertising the Patient Advice and Liaison Service (PALS) throughout the wards. Staff we spoke with stated they were aware of how to direct patients or visitors to the PALS team. They stated that PALS could provide advice and support to the ward on managing complaints. Staff also stated they would try to informally resolve any complaints if possible, but if not would direct the complainant to PALS.

Staff we spoke with stated that concerns or learning from complaints would be discussed in ward team meetings, safety huddles, and in monthly divisional quality and safety meetings. However, there was variability in how team meetings and safety huddles were recorded across wards, with some wards not taking minutes or sharing minutes from divisional meetings. This meant that some staff unable to attend meetings would miss the learning and discussions.
Is the service well-led?

Leadership

Medical wards at Newham University Hospital were generally part of the Medicines Division which was led by the triumvirate of the divisional clinical director, the divisional general manager and the divisional head of nursing. Speciality leads managed clinical pathways across the division, with ward level leadership from consultants, ward managers, and clinical site managers.

Different medical specialties across the trust were gathered into 30 clinical networks, which allowed multidisciplinary clinicians across the trust to work more closely and collaboratively within their speciality (e.g. acute medicine, elderly care, stroke etc). The clinical networks allowed the medical wards to address variation in standards of practice across the trust, and to manage patients across sites. Each clinical network was led by a clinical network director and performance within networks was reviewed regularly at clinical boards.

Staff we spoke with were positive about the divisional leadership, stating they were visible on the wards, approachable, and generally accessible if needed. Most staff we spoke to were aware of the site executive team, while staff were less certain of who the trust-wide leadership triumvirate was. However, staff were aware of opportunities for frontline staff to meet with the executive team, and some had done so through the staff conversation meetings.

Medical staff we spoke with, including junior doctors, were generally positive about medical leadership within the division on-site, and felt the consultant body worked well together. Staff stated that there was a sense of community amongst the medical staff on medical wards, and many consultants had worked here as junior doctors in the past. Consultants also stated they felt supported.

The trust had a clear leadership development strategy for recruiting, promoting, and supporting managerial or leadership staff. Recruited staff received a specific induction programme for managers and for new consultants, while there was also a six-month leadership transitions programme for internally appointed senior managers and consultants. The trust also had a career development programme to support BME staff and women into senior leadership roles. Staff we spoke to in leadership roles (both recruited and promoted internally) stated they felt well supported in their roles.

Vision and strategy

In 2017, the trust published the clinical and organisational strategy for the next four years, which included goals related to medical wards at Newham Hospital. The main priorities identified for the division were increasing bed capacity, developing frailty units for care of the elderly, investing in oncology services and specialist staff for cancer services, and refurbishing some ward environments.

Although the trust had an overall strategy for Newham hospital, some of which related to medical wards, there was no overall clinical strategy for the Medicines Division. As some of the ward spaces were being refurbished, this meant there was no strategy for how these wards would be used when the refurbishment was finished. Senior leaders we spoke with stated there were fragmented plans as to how the wards would be utilised when the refurbishment was completed, however this was not set out strategically.

Staff we spoke with across medical wards were unsure of the future development plans of the medical wards at Newham Hospital. Staff stated they were not sure what the plans were for the wards once the refurbishment of other wards had been complete, or how medical specialities may
be moved around. Staff we stated they were not sure if a consultation would take place regarding any future development plans.

The trust launched the trust values (WeCare) in 2017, and staff that we spoke with were generally aware of these values and what they meant for their work. Staff received training on the values as part of corporate induction, and we observed posters on wards reminding staff of the values.

**Culture**

Staff were generally positive about working for the trust and felt valued. Staff stated there was a strong multi-disciplinary team working culture within the organisation, and that managers were supportive and accessible. Morale amongst staff we spoke to was generally positive.

Staff we spoke with stated there was an emphasis on learning within the trust, which encouraged a “No blame” culture. Staff felt that senior clinicians and managers supported staff to report incidents and raise concerns, as it raised opportunities to improve the delivery of care.

Medical staff we spoke with felt there was a positive relationship between consultants and junior doctors, and that there were good opportunities for learning for junior doctors. Many of the medical staff we spoke to felt they were good working relationships by colleagues, and that they felt supported to suggest changes that may improve the delivery of service.

The trust recognised the contribution of staff excellence annually through the Bart’s Health Hero award, with the most recent ceremony being held in February 2018. Nominees were voted for by patients, staff and members of the public each year, and receive a certificate as well as a prize. The Older People’s and Stroke Service, Silvertown Ward, and CCU were all nominated for Barts Health Heroes awards in 2018. Wards also ran monthly “Star of the Month” schemes, where ward staff nominate colleagues to be celebrated for their contributions.

In 2017-18, the Medicine Division took part in a pilot to improve staff wellbeing through a range of interventions including supporting ward managers to give praise, deliver positive 1:1 sessions with staff, and run effective team meetings.

**Governance**

There was a clear governance structure within the division and staff at all levels were clear about their roles and what they were accountable for. The divisional structures were managed by the triumvirate and communication from divisional leadership down to ward level was clear.

The divisional leadership had oversight of clinical governance through the monthly divisional governance board and operational governance through the monthly divisional performance meetings. Governance meetings included review of divisional risks, strategies, actions plans, and performance. Divisional leadership then reported from these governance meetings to the trust board on a quarterly basis.

Ward managers and service leads were responsible for disseminating the outcomes of governance meetings throughout their teams. This was done at team meetings, monthly divisional quality and safety meetings, and daily safety huddles.

Medical specialities across the division and the trust sites met regularly to review operational governance and clinical performance within their areas, which informed the divisional performance and quality meetings. This was supported by the clinical strategies for each speciality, which was led by the relevant clinical networks and clinical boards.
All staff members we spoke with felt there was a robust governance structure within the division. Staff stated they were well informed about quality and safety issues through meeting minutes, team meetings and safety huddles, and stated they were encouraged to report incidents or issues.

### Management of risk, issues and performance

Medical wards had systems in place for monitoring and reporting on risk and performance at ward and divisional level. Medical speciality meetings took place monthly, which feed into the monthly Divisional Board meeting. Clinical speciality leads took turns chairing the (which was chaired by a different speciality lead each time) where complaints, patient outcomes, safety, and incidents were reviewed. There was also a divisional quality and safety meeting which took place monthly and could be attended by nursing and medical staff. Each of these meetings was minuted and disseminated to the ward staff.

Senior staff we spoke with stated that a divisional risk register was maintained and reviewed monthly at divisional performance meetings. Staff stated that the divisional risk register identified the risks for medical wards, however some of the risks we identified on inspection were not reflected on this risk register. This included inconsistent completion of patient risk assessments, inconsistent completion of mental capacity act assessments and deprivation of liberty safeguards, and medical wards not meeting targets for mandatory training.

As some of the concerns we identified were not identified on the risk register, medical wards did not have actions plans in place to minimise the impact of these risks. This limited the oversight that divisional leadership had over risk on medical wards.

There was a process for review all deaths that occurred on medical wards at Newham Hospital. Morbidity and Mortality meetings took place monthly and they feed up into the local governance structure through the divisional board meetings. The meetings included any learning from other sites within the trust, as well as a review of discharge summaries. The meeting was also minuted so any learning or actions could be disseminated to ward staff.

### Information management

Performance on safety measures and Key Performance Indicators (KPIs) were monitored and reported at monthly divisional performance review meetings. Data was collected by allocated leads and this informed divisional level reports. Ward managers had access to quality and safety ward dashboards through an app which could be access on phones or computers.

Quality and safety information for each ward was clearly displayed on notice boards, which allowed patients and visitors to see how well the wards were performing. This included information staffing, the safety thermometer, incidents, falls, and any complaints or compliments.

The trust information governance policies stated that all patient records must be stored securely and kept strictly confidential, in line with legislation. Policies we viewed reflected most recent guidance on information governance, and were up to date. However, we found several instances of patient records unattended on wards, which presented a significant risk to patient confidentiality.

Staff could access policies and procedures through the trust intranet. This was accessible to all staff, and contained information on mandatory training, professional development, and staff support. The trust also used the intranet to provide reminders of patient safety initiatives (such as sepsis awareness and management), and how to access specialist support from the hospital.

### Engagement

Staff we spoke with on medical wards stated there were general opportunities for engagement at Newham Hospital, and there were opportunities to speak to the executive team at the trust. Staff
from medical wards stated that the staff conversation events gave an opportunity for staff to provide feedback, and there were specific meetings with leadership for some disciplines (e.g. clinical nurse specialists) in the last year. Some staff however were unsure of if there would be consultation on the use of wards once refurbishment work had been completed.

There were three Staff Diversity Networks within the trust: one for lesbian, gay, bisexual and trans (LGBT) staff, one for Black and Minority Ethnic (BME) staff, and one for staff with a disability. Each forum provided staff on the wards with an opportunity to represent their interests. Input from each of these groups informed the trust Equality and Diversity Committee, and an annual report and action plan were produced on performance. In July 2018, the trust also launched the diversity and inclusion positive action charter.

The trust offered many volunteering roles to involve members of the local community on medical wards, which were advertised through the trust website. Volunteers were provided with a local induction on the wards when they first started including shadowing a more experienced volunteer where available, and were provided with mandatory training modules (more specialist roles included further training). Volunteer roles included dementia buddies, supporting end of life care, and meal time assistants.

The hospital ran a patient forum monthly, which included membership from the hospital patient experience group. Patients and family member representatives were also on clinical boards for most medical specialities.

Learning, continuous improvement and innovation

In October 2017, the trust was selected to be part of a £3.5 million improvement programme (offered by an independent organisation) to share expand the availability of online patient appointments across the trust. This work is due to be build upon the work of the diabetes team at Newham Hospital, which has won awards for increasing patient attendance rates and preventing inpatient admissions. The aim of the work is to expand the availability to other hospital sites, and work with partners and commissioners to develop standards of care in this area.

The medical wards transitional diabetes service was used as a case study for the “How to Improve Transition for Young People into adult services” guide published by Diabetes UK in 2017.

Maternity

Facts and data about this service

Newham University Hospital provides maternity services to women in the London Boroughs of Newham and Barking and Dagenham. In 2017/18 Newham Hospital had 6,204 births. Most maternity services are located together in one purpose built section of the hospital, where antenatal, intrapartum and postnatal care is provided. The booking and antenatal clinics take place at the other end of the hospital where there are 6 ultrasound rooms.
All expectant women attended the hospital for their first appointment. Community midwifery services deliver antenatal and postnatal care in local areas. Specialist clinics are run at the hospital for women with additional conditions such as diabetes or mental health issues. Fetal and maternal medicine is available for women with specific needs.

A consultant led delivery suite on the first floor has 15 delivery rooms and a midwifery-led birthing unit has 10 rooms. A four bedded recovery/observation unit caters for women who require close monitoring. This area is staffed by nurses and midwives with specialised training.

There is one permanent theatre, and under a temporary arrangement a second theatre is available in the day time. At night the main theatre team must be called to open the second obstetric theatre. Women also have the choice of birth at home or in a standalone birthing unit. Barking birth centre was not inspected as part of this inspection.

Larch ward, on the ground floor, has two sections, an 11 bed antenatal ward and a postnatal ward with 33 beds. There are two bays for transitional care. There is a further bay that staff can open if the ward is very busy. Six single rooms can be used by women with a medical need, or as amenity rooms for which a fee is paid.

A maternity day assessment unit, to which women can walk in during opening hours is open between 8am and 8pm to assess women over 18 weeks of pregnancy, and triage is open 24 hours a day. An early pregnancy unit is open 9am to 5pm on weekdays and 9-2pm at weekends for women with complications of early pregnancy. A maternity helpline is available from 10am to 8pm.

On average 40% of women were assessed as “low risk” at booking, and 24% of women delivered in birthing units under midwifery led care in 2017/18.

The obstetric unit is the recommended place of birth for women with complicated pregnancies, those who go into labour early and for women requesting epidural analgesia in labour.

The service is supported by a local neonatal unit that cares for babies born from 27 weeks’ gestation who need breathing or feeding support or short term intensive care, sometimes before being transferred to neonatal intensive care unit which provides the highest level of care to babies.

We carried out a comprehensive inspection of the maternity service in November 2016. We undertook a focused inspection of maternity services in July 2017 to follow up concerns about the maternity services identified at inspection in November 2016. The service was assessed as requiring improvement overall.

We carried out an announced inspection of the maternity service between 11 and 13 September 2018. We also carried out an unannounced inspection at night on 19 September 2018. During our inspection, we visited all clinical areas in the service including delivery suite, theatres, clinics and antenatal and postnatal wards, the maternity assessment unit (MAU) and early pregnancy assessment unit (EPAU), and one community midwifery centre. We spoke with 10 women and their relatives and over 45 members of staff, including midwives, consultants, anaesthetists, senior managers, student midwives, pharmacist, housekeepers, receptionist, matrons and support staff. We observed care and treatment and reviewed a random sample of 20 medical care records and 10 prescription charts. We observed an incident review meeting, a midwife handover and one midwife and one medical handovers. We received comments from people who told us about their experiences and we reviewed performance information about the Newham’s maternity service.

From April 2017 to March 2018 there were 15,700 (14970 deliveries) births across the three hospitals in the trust. There were 6,204 deliveries at Newham Hospital.
A comparison from the number of deliveries at the trust and the national totals during this period is shown below: (Barts is at the far right side)

A profile of all deliveries and gestation periods from January 2017 to December 2017 can be seen in the tables below.

<table>
<thead>
<tr>
<th>Profile of all deliveries (January 2017 to December 2017)</th>
<th>BARTS HEALTH NHS TRUST</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>---------------------------------------------------------</td>
<td>-----------------</td>
<td>----------------</td>
</tr>
<tr>
<td><strong>Single or multiple births</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>14,972</td>
<td>98.8%</td>
</tr>
<tr>
<td>Multiple</td>
<td>188</td>
<td>1.2%</td>
</tr>
<tr>
<td><strong>Mother’s age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 20</td>
<td>294</td>
<td>1.9%</td>
</tr>
<tr>
<td>20-34</td>
<td>11,327</td>
<td>74.7%</td>
</tr>
<tr>
<td>35-39</td>
<td>2,858</td>
<td>18.9%</td>
</tr>
<tr>
<td>40+</td>
<td>561</td>
<td>4.5%</td>
</tr>
<tr>
<td><strong>Total number of deliveries</strong></td>
<td>15,160</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Hospital Episode Statistics: January 2017 to December 2017

Notes: A single birth includes any delivery where there is no indication of a multiple birth. This table does not include deliveries where delivery method is "other" or "unrecorded."

(Source: Hospital Episodes Statistics (HES) – Provided by CQC Outliers team)

The number of deliveries at the trust by quarter for the last two years can be seen in the graph below.

Number of deliveries at Barts Health NHS Trust by quarter:
Is the service safe?

Mandatory training

At our last inspection we found that mandatory training targets for midwives were not being met. At this inspection the compliance rate had improved and was mainly over 90% which was above the 85% target agreed with the clinical commissioning group. Training was provided via e-learning and some face-to-face sessions in a five day block. Sessions were run monthly and dates were announced well in advance so staff could book their training at a convenient time.

Training was provided via e-learning and some face-to-face sessions in a five day block. Sessions were run monthly and dates were announced well in advance so staff could book their training at a convenient time. However, despite improved mandatory training rates this was not reflected in performance which did not consistently meet professional standards.

In the April 2018 performance report mandatory training compliance had been lowest on Larch ward and the delivery suite. Focused work had been undertaken to improve this.

A breakdown of compliance for mandatory courses as of the 4 June 2018 for nursing staff is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia Awareness</td>
<td>244</td>
<td>251</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fraud Awareness</td>
<td>242</td>
<td>251</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Module</td>
<td>Trust 1</td>
<td>Trust 2</td>
<td>Completion</td>
<td>Target</td>
<td>Status</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>---------</td>
<td>---------</td>
<td>------------</td>
<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td>Working at Barts Health</td>
<td>240</td>
<td>251</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Clinical Documentation</td>
<td>240</td>
<td>251</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>240</td>
<td>251</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Security</td>
<td>239</td>
<td>251</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>238</td>
<td>251</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling - Patient Handling Low Risk</td>
<td>16</td>
<td>17</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Harms - VTE</td>
<td>236</td>
<td>251</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety</td>
<td>236</td>
<td>251</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Nutritional Care</td>
<td>235</td>
<td>251</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Harms - Pressure Ulcer Prevention</td>
<td>235</td>
<td>251</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Early Warning Systems</td>
<td>234</td>
<td>251</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Harms - Slips, Trips and Falls (Patients)</td>
<td>234</td>
<td>251</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Harms - Catheter Acquired Infections</td>
<td>234</td>
<td>251</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Privacy and Dignity</td>
<td>233</td>
<td>251</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Complaints</td>
<td>232</td>
<td>251</td>
<td>92%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>231</td>
<td>251</td>
<td>92%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Emergency Planning</td>
<td>231</td>
<td>251</td>
<td>92%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation - Basic Life Support</td>
<td>229</td>
<td>250</td>
<td>92%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>209</td>
<td>233</td>
<td>90%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling - Patient Handling Practical</td>
<td>206</td>
<td>234</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Investigation of Incidents</td>
<td>51</td>
<td>58</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>212</td>
<td>251</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention and Control - Clinical</td>
<td>211</td>
<td>251</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Risk Assessment for Managers</td>
<td>48</td>
<td>58</td>
<td>83%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Medical Gas Safety</td>
<td>202</td>
<td>249</td>
<td>81%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>201</td>
<td>251</td>
<td>80%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing and midwifery staff exceeded the trusts 85% completion target for 23 out of 28 mandatory training modules. However, across Newham hospital in August 2018 the delivery suite, Larch ward and maternity admin staff had the areas with the highest numbers of non-compliant employees with mandatory and statutory training. A decision was made in September to have weekly
oversight of training compliance and to allocate time to staff to catch up on the training. *(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)*

Staff confirmed that fire safety drills had been held in summer 2018.

We were told that mandatory training had new elements added in response to concerns about practice, but it was not clear what the impact was. Although the compliance with training had improved, there did not seem to be a commensurate improvement in standards of care and record keeping. There was no formal audit of the impact of mandatory training.

Multidisciplinary annual “skills and drills” training to rehearse the response to obstetric emergencies was also mandatory and included classroom sessions and simulations of events. Training compliance was 95%. Maternity care assistants also took part in these. Unannounced simulation drills were regularly held on the delivery suite; however staff on the postnatal ward could not remember when the last drill took place. We saw that live drills in the ward had been recommended in follow up to an SI in the previous year but staff were not sure this had taken place. Some care assistants said they had never been involved in an unannounced drill. Other mandatory, maternity-specific training was cardiotocography (CTG) training and bereavement training.

**Safeguarding**

The systems to keep vulnerable women and unborn babies safe were good when vulnerability was identified and took account of current best practice. However, in discussion with the safeguarding team it appeared that the formal arrangements to identify social vulnerability needed strengthening. We were concerned that cases could be missed. In the hospital’s catchment area it was likely that at least 20% of mothers would be socially vulnerable, but because of language issues, late booking and the transience of some of the population, it was possible some cases were not being identified. The post of named midwife for safeguarding was vacant at the time of the inspection.

As at the last inspection we found staff were aware of safeguarding policies and procedures and understood their responsibilities. All midwives and doctors we spoke with knew how to raise safeguarding concerns, and understood the role of the well-established Acorn midwifery team in supporting vulnerable women. The Acorn Team midwives provided enhanced maternity care to women with additional vulnerabilities who were booked at NUH. These included women with a range of vulnerabilities, such as significant mental health issues, domestic abuse, learning disabilities, young mothers and women with complex safeguarding concerns. The safeguarding team saw women both in the hospital and at home, and appointments were more frequent than those for women without additional concerns. The Acorn midwives provided postnatal care to women at home after birth, until the baby was up to 42 days old. When vulnerabilities had been identified appropriate arrangements were in place to respond to identified risks and to safeguard the unborn child.

There were processes to flag safeguarding concerns. Alerts were entered onto the electronic patient record. The flag immediately alerted midwives and delivery suite staff accessing the case record about a vulnerable unborn child, or mother, prompting them to interrogate the record for a detailed birth plan/child protection plan. However we did not see information displayed in the delivery suite alerting staff to women who were near term, to help them prepare for the arrival of such women in labour.

It is good practice for women to be seen on their own at some stage of the care pathway, for at least part of the consultation. The service could not confirm that every woman was seen alone
during pregnancy. Nor was there a fully comprehensive risk assessment at booking, including consideration of domestic abuse. It is well-evidenced that domestic violence and abuse can begin or escalate in pregnancy and the opportunity to identify and support women who are at risk, may be missed without robust protocols. There was no formal opportunity for midwives to continue to review social risk throughout the pregnancy. We were told that midwives did not routinely consider the partner’s social history in terms of previous children, social care involvement, etc. so we could not be assured all expectant women had a robust risk assessment throughout their pregnancy. There was an overreliance on professional curiosity.

We saw no evidence of any risk assessment tools used to explore child sexual exploitation when mothers were under 18 years old. The trust board papers for July 2018 recorded that 2017 Internal Audit reviews showed reasonable assurance of good safeguarding practice at Newham.

Policies contained information about child sexual exploitation and female genital mutilation (FGM). Maternity and gynaecology guidelines about FGM were in place. FGM had been included in mandatory training since April 2018. We saw evidence that cases of FGM had been reported correctly following the FGM guidelines. Safeguarding concerns were raised and shared with police or social services if required. About 90 women a year attended an FGM clinic.

We saw information on display for women about a Newham one-stop-shop for domestic abuse, but only in English.

A breakdown of compliance for safeguarding courses at 4 June 2018 for nursing and midwifery staff in maternity is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Level 1</td>
<td>250</td>
<td>251</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>242</td>
<td>251</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>238</td>
<td>251</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>226</td>
<td>251</td>
<td>90%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 3</td>
<td>202</td>
<td>237</td>
<td>85%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

At the last inspection training on safeguarding adults training had been below the trust target of 90% in every maternity area. At this inspection training in safeguarding children was compliant with the intercollegiate guidance within maternity. The September 2018 figures showed 81% compliance with training in level 3 safeguarding children for midwives and doctors, which was below the trust target of 85%.

Group safeguarding supervision, normally facilitated by the named midwife for safeguarding, was offered monthly to all band 5, 6 and 7 midwives and nurses on the delivery suite. Midwives were encouraged to select cases they had encountered, which were discussed and reviewed using the Signs of Safety model. The discussions of cases discussed in supervision were documented in the women’s records. 79% of relevant staff were up to date with safeguarding supervision in maternity. One to one supervision was offered on an ad hoc basis.
There were arrangements for the Named Midwife and the specialist midwives in the ‘Acorn Team’ to have quarterly supervision with the designated nurse for safeguarding in the clinical commissioning group (CCG).

There was good attendance by midwives at child protection meetings for unborn babies. Reports submitted, minutes and plans were uploaded onto the electronic patient record and copies filed in the hospital’s confidential copy of women’s maternity notes.

Perinatal mental health was a priority in the local area and the CCGs in north east London were funded by the NHS England community services development fund to deliver specialist community perinatal mental health service. A perinatal mental health community team was based at Newham University Hospital, and included a mental health midwife and IAPT (improved access to psychological therapy) service for women from pre-conception up to 1 year post birth that had moderate to severe mental health illnesses. Three consultant perinatal psychiatrists, two link obstetricians and a mental health midwife ran a clinic once a month in the hospital. The team held outpatient clinics in a number of locations around the borough, and provided a liaison service to the maternity wards. There were peer courses offering support to mothers who had perinatal mental health issues after birth.

Another local service, Newham Change, Grow, Live (CGL) provided support to people who were abusing substances and alcohol. There was a joint fortnightly clinic for pregnant women between CGL and Newham maternity services.

We were told there was good information sharing between GPs through whom most bookings came. A booking referrals template was used to highlight concern around medical or social vulnerability. When women self-referred the maternity service requested information from GPs about any medical conditions and social/family history concerns. This was evidenced in a small sample of six case notes reviewed. However not all women were registered with GPs.

There was a robust policy for following up women who missed appointments. We saw from incident reports that a significant number failed to attend three or more appointments and some could not be contacted. The community midwives said this process was very time consuming because so many women moved accommodation, and some went abroad or elsewhere in the UK for part of their pregnancy. However there was no evidence women who missed appointment being audited, although we were informed a comprehensive audit programme on safeguarding issues was planned for 2018/19, but it was too early to see the impact of this work.

**Cleanliness, infection control and hygiene**

We inspected all areas of the maternity unit including the delivery suite, obstetric theatres, wards and midwife led birthing unit, and visited one community midwife centre. Most accommodation in the maternity service was clean and tidy. The August 2018 patient led assessment of the care environment survey showed a score of 99.55 which was better than the acute hospital average of 98.5%.

However, our observation was that clinical equipment was not consistently clean and some staff did not regularly wash their hands or use hand sanitiser when moving between patients and clinical areas.

We were not assured controls were effectively in place to prevent the spread of infection. Although some hand hygiene audits were carried out these appeared not to assess hand hygiene in all areas, particularly entrances to clinical areas. Within the women’s directorate as a whole, infection control training compliance was 78% in September 2018. In June 2018 the hand hygiene audits were seen not to be submitted weekly by all units. Hand sanitiser dispensers, for staff, patients
and visitors to use, were not available at all entrances and exits to clinical areas. In some areas notices reminded people to use hand sanitiser, but there were no dispensers visible. For example there was a sign on the exit from the antenatal clinic, but no sanitiser beyond this sign.

Staff walked in and out of delivery rooms and the HDU area on the labour ward without using hand sanitiser. Some rooms, such as that used for handover on the delivery suite, did not contain any hand sanitiser. Within a 20 minute period we saw that three doctors, three midwives, a porter and two maternity care assistants moving between clinical areas without using sanitiser. On the next day, in a similar time period we counted 15 staff not using sanitiser. Immediately after the inspection, the managers produced an action plan for hand hygiene improvement, including ensuring that dispensers were better placed.

On the unannounced inspection a staff member encouraged staff to challenge one another to clean their hands. A poster had been put up saying ‘I cleaned my hands. Did you?’ The on the same evening we saw four night staff entering the postnatal ward at the start of their shift without using the hand sanitiser at the door. Reception staff encouraged visiting family members to use hand sanitiser when visiting the clinic, and receptionists on the post-natal ward also reminded visitors. There was a hand hygiene champion in the antenatal clinic before the inspection.

Cleaning schedules were displayed on all units. We found boxes on the floor in some clinical rooms in the booking clinic which restricted cleaning in those areas. We noted mouse traps and saw mention of mice on the risk register relating to this area.

Some clinical equipment was not clean. We saw dust on a drug trolley and on six resuscitaires which were also grimey at the ends where the tubular spirit levels sat.

At least four cots were not wiped clean beneath the mattress. In a bay on the post-natal ward, that was apparently ready for the next patient, the wall mounted suction unit, including the (disconnected) suction tube was dusty, and the indentations in the suction canister lid were grey with thick dust. As we found this at night, and the ward was full, we were unable to check other suction units on the ward.

At March 2018, 85% of midwifery staff had completed infection prevention and control (IPC) training. The trust did not provide IPC training rates for medical staff.

Staff used ‘I am clean’ stickers with the day’s date to indicate a clinical item was clean and ready for use. On the unannounced inspection at least six items on the postnatal ward had stickers with the previous day’s date. An empty resuscitaire had a sticker dated four days previously.

The maternity service provided staff with personal protective equipment (PPE), to protect people from a healthcare-associated infection. There was a supply of PPE, which included sterile gloves and aprons, in most areas. On our unannounced inspection very few dispensers on Larch ward had a full set of equipment, missing either one size of glove or aprons. Two wall mounted containers for disinfectant wipes were empty.

We observed most clinical staff adhered to the trust’s policy that staff should have their arms bare below the elbow to enable effective hand washing and reduce the risk of spreading infection. However, some staff did not adhere to infection control related aspects of uniform policy. We saw midwives on the ward with painted fingernails, some wearing jewellry, and some with hair below the shoulder. Staff did not all store their home clothes in the changing rooms. We found shoes under the computer desk in two bays on Larch ward.

From discussion with staff and records reviewed, we saw that women were offered screening for infectious diseases, such as hepatitis B and syphilis.
Sepsis management was included in obstetric emergency training. Sepsis is one of the biggest causes of death in pregnancy. All midwives told us they had received training in sepsis awareness and management based on the trust policy on antibiotics to manage obstetric infection. There was an obstetric sepsis trolley on the delivery suite and on Larch ward. We saw information on management of sepsis and escalation using the 2222 (internal emergency) service in the maternity areas.

The service monitored postnatal readmission infection. The trust reported 7 maternal readmissions within 42 days delivery for infection for the period April 2018 to July 2018 No data was available for the previous year. The dashboard did not record instances of maternal or puerperal sepsis. Wound audits were not carried out. The most recent audit of 3rd and 4th degree tears was 2015-6. The postnatal ward had some single rooms which could be used if a woman had an infection.

In the twelve months to July 2018, there were no cases of hospital acquired MRSA (antibiotic resistant bacteria) and \textit{Clostridium difficile}.

Domestic staff were seen cleaning the wards both day and night. They had the right equipment and understood their roles. Women and relatives we spoke with said the maternity department appeared clean, although one mother on the postnatal ward mentioned they did not see staff sanitise their hands.

\textbf{Environment and equipment}

The maternity department consisted of antenatal clinic rooms, a day assessment unit, maternal and fetal medicine, delivery suite, maternity theatres, obstetric antenatal/postnatal ward, and birthing unit. The premises and equipment were adequate. However, the design of the main maternity department, with several entry points, meant there were potential weak points in security, despite the tightened security from baby tagging. Equipment was maintained and tested for electrical safety to ensure it was safe for patient use.

At the previous inspection in November 2016, the security of babies was identified as a risk in the delivery suite and postnatal ward. Baby tagging was introduced in 2017 but at the inspection in July 2017, there were insufficient staff to monitor access to the unit day and night. At this inspection, entry and exit to the delivery suite, antenatal wards and maternity assessment unit was by means of swipe card for staff, and through an intercom buzzer system for visitors. A receptionist at each of the main doors from the main hospital corridor controlled access to and exit from the postnatal ward and triage 24 hours a day. Staff told us where there were safeguarding issues in relation to a woman or baby, or if certain visitors were not allowed unsupervised into the postnatal ward, security staff were informed, and would attend. The receptionist said security staff were called about once a week to this ward during visiting hours, usually because too many visitors were trying to visit a mother and baby. The visitor limit was two for a mother and baby. We noted that the receptionists were temporary bank staff so this may not have been a permanent arrangement.

Although doors between the areas within the maternity unit required swipe card access, some doors did not close properly. On the unannounced inspection we were able to walk without a swipe card from the triage area onto the antenatal ward and from there to the postnatal ward. However, entrances from the main hospital corridor were entered via secure locked doors with intercom communication.

Larch ward had a section for antenatal women (11 beds) and a postnatal area of 33 beds. A further bay could be opened if the ward was very busy. On the unannounced inspection we saw
two delivery beds in a corridor next to signs saying that beds should not be left in that area. Staff did not know who should be responsible for moving these back to the delivery suite.

There were six bays for triage, and four bays in the maternity assessment unit. The assessment could include observations and monitoring the baby’s heart rate. One room (room 57) on the ground floor was available for use by women from triage or from the antenatal ward, in the event of precipitate delivery. Two toilets were out of order in the maternity assessment and triage area on the main inspection, and were still not repaired on our unannounced inspection a week later. Triage had a room where a midwife carried out a clinical assessment and rated women on the basis of clinical need.

The temperatures in some parts of the unit were uncomfortably warm, and smaller rooms were too warm to maintain a safe fridge temperature. Doors in clinical rooms were found wide open in several areas. An example was the point of care test room on the delivery suite which, even with the door open was 26.4°C. We noted the fridge temperature was above the recommended range on three occasions in September 2018. The milk kitchen was a non-clinical example; the milk fridge was 5°C. Baby milk should be stored below 4°C. Records showed the fridge temperature had exceeded the recommended level on several days in September 2018. No action had been taken, nor did the documentation advise what to do if the temperature was too high. There was no room thermometer. Likewise there was no room thermometer in the ward kitchen. Although the fridge in that kitchen was within the correct temperature range, it had broken door seals which meant the door did not close effectively and allowed warm moist air to enter the fridge.

The theatres and neonatal unit were close to the delivery suite which allowed timely transfer when required. A dedicated bay for women needing close observation within the delivery suite was staffed by nurses and midwives trained in high dependency unit (HDU) care. The nursing team comprised 17 HDU trained nurses and eight midwives were trained in HDU care. The rota was drawn from these staff.

Until shortly before the inspection there had been one obstetric theatre with dedicated staffing. Incident reports indicated in July and August showed that it had been difficult to staff a second theatre when needed. A unit this size would normally have two dedicated theatres. The lack of a second theatre had been a concern at both the previous CQC inspections and had been high on the hospital risk register for since 2013. This was implemented a couple of weeks before the inspection without wide consultation.

The delivery suite and birthing unit met the Department of Health recommendation that all birthing rooms should include en suite facilities (Department of Health Children, young people and maternity services. Health Building Note 09-02: Maternity care facilities, 2013). One delivery room on the delivery suite (Room 12) was used for equipment storage.

Some birthing rooms in the birthing unit had adaptable beds that could be used as a hoist in the event of a maternal collapse in the birthing pool. Net slings were also available to help women out of the water. Each room in the birthing unit had a fully equipped birthing box which maternity care assistants (MCAs) restocked after use. There were two resuscitaires available in case of need.

There was appropriate emergency equipment on the delivery suite, kept in designated spaces when not in use, including resuscitation equipment, and equipment for specific emergencies such as sepsis, cardiac arrest, postpartum haemorrhage (and a grab box in the fridge for medicines requiring refrigeration). Hypo-boxes contained a range of glucose products for use in cases of low blood sugar.

Although the policy was to check emergency equipment daily, compliance was inconsistent.
All resuscitation trolley drawers were secured with a tamper evident tag. At the previous inspection we had been told it was not the hospital policy to tag resuscitation trolley drawers, but this had now changed. The resuscitation trolley log recorded regular checks of equipment and the drawers were locked and tagged with the tag number recorded. The check had been missed on one day in August 2018 (delivery suite). The neonatal team staff checked the neonatal resuscitation trolley on the delivery suite daily, and drugs near expiry date were highlighted so staff could use them first.

Resuscitation trolley checks on the ward were less good. Some staff told us that safety checks were often filled in retrospectively if they had been missed for a few days, so that the record appeared complete and alleged that standards of checking were weak. This was evidenced by a spot check of resus equipment on 31 August 2018 (reported as an incident) which had revealed the defibrillator had not been checked for 9 days as there was no paper to run the check and there had been a piece of equipment (laryngoscope) missing from the resuscitation trolley for 31 days. None of the staff checking the trolley during this period had identified this. An audit on 8 September 2018 of the resus trolley on the antenatal unit had noted that the drawers were not shut and there was expired stock in need of replacing. Although on the days of our announced inspection daily checks had been recorded, they had not been recorded on this ward on day of our unannounced inspection. Records showed checking processes had been a longstanding problem on Larch ward.

None of the postpartum haemorrhage (PPH) trolleys had tamper evident storage. Open trolleys presented a risk that items could be removed and would not be present in an emergency. The PPH trolley on Larch ward had no recorded check on seven days during August. On the announced inspection this trolley contained eight bags of different intra-venous (IV) fluids on the bottom shelf IV fluids. These were not in tamper evident boxes. We drew attention to this and the fluids were immediately removed with a note placed on the trolley saying where fluids were now stored. The information on where fluids were stored was not visible on the trolley on the unannounced inspection.

The sepsis trolley on the ward had locked and tagged drawers with a clear sign on the wall explaining the management of sepsis. It had not been recorded as checked on four days in August and one in September.

Cardiotocography (CTG) machines were available in the delivery suite for women who required continuous electronic fetal heart rate monitoring and to record uterine contractions during pregnancy and labour, which allowed early detection of fetal distress. Equipment had been safety tested.

On the first day of inspection found in a fridge an unlabelled syringe drawn up with a drug. In the point of care testing room we found three syringes drawn up with umbilical cord blood for haematology examination. One syringe was on a tray with other clinical equipment including syringes; the other two were stuck to separate trays with adhesive tape. They were not labelled so there was a risk that samples could be mixed up. It was not clear how long they had been there, but samples should be refrigerated if not tested immediately. On the unannounced visit, we saw two syringes left in the blood gas analyser machine with patient identifiable print outs. The door was wide open on both occasions.

We checked a range of consumable items from the resuscitaires, including syringes and airways and all were in-date.

Arrangements for disposal of waste and clinical specimens were poor. Maternity staff did not segregate waste using the correct colour-coded sharps bins. The purple lidded bins for cytotoxic and cytostatic waste were for hormonal products used to induce labour and no other products.
After we drew attention to the fact waste was not properly segregated, staff put temporary labels on these bins to remind staff which bin to use for which waste product. However, inconsistent usage of the bins was still evident on our unannounced inspection. The matron confirmed that compliance had been a concern for some time and staff were seeking to address this through training. Four sharps bins were full in the delivery suite on the morning of the first day’s inspection, and we drew this to the attention of staff. By the afternoon one of these bins was overflowing. On our unannounced inspection one sharps bin was overfull on the postnatal ward (Bay 5). Staff did not close the small portable sharps bins after use so if knocked over the contents could spill, risking the transmission of blood-borne viruses. On the unannounced inspection, the sharps boxes in the sluice by MAU and triage were full and closed, but no new bins had been assembled ready for use which meant staff would not be able to dispose of sharp items quickly and safely.

We found a small number of expired blood tubes on Larch ward. We also saw other blood tubes due to expire during the month of inspection. Maternity staff did not highlight expiry dates when checking equipment to encourage staff to use the oldest items first.

The antenatal clinic lacked natural light which made the crowded waiting area unwelcoming. The booking clinic had natural light and appeared more spacious. The booking clinic manager had access to an office around the corner from the booking clinic to use for confidential work rather than being based within the clinic itself. The location of the office meant they could not have clinical oversight of the booking clinic waiting room. We were told there had been two instances of maternal collapse in the waiting area in the past four months but no change had been made to the office of the booking centre midwife to improve the safety of women in this area, despite a request from the postholder.

Community midwives had access to appropriate equipment such as baby weighing scales, sonicaid devices, PPE, mobile phone, stethoscope and emergency grab bags. Baby scales and other equipment in the maternity units had been calibrated and tested for electrical safety. Calibration was six monthly. Bags for home birth were securely stored at the centre. Community midwives did not carry bilimeters which are devices available to measure the bilirubin level non-invasively (without needing to do a blood test). If a baby appeared to have jaundice and might need phototherapy (light treatment) women were asked to take their baby to the hospital for assessment.

Community midwives were not provided with personal safety devices when they were working alone. They relied for their safety on an electronic diary showing midwives’ schedules so administrative staff knew their whereabouts. A community midwife said they would carry out a visit with another midwife where there were known safeguarding risks.

**Assessing and responding to patient risk**

There were processes in place to assess and manage risk. These included the use of team safety briefings and assessments of the risk of gestational diabetes and fetal growth measurements from 24 /26 weeks.

Midwives completed risk assessments for women and babies from the antenatal to the postnatal period in line with national guidance. A risk assessment at the initial (booking) appointment covered areas such as women’s medical history, previous birth history and any complications, mental health and social history. They assessed women’s risk of high blood pressure, gestational diabetes and body mass index (BMI). Women who were at high-risk of gestational diabetes were referred for glucose tolerance testing. The findings of these risk assessments were used to help women consider their preferred place of birth and plan future care. This was confirmed in the
patients’ records we reviewed. The criteria for women planning to have their baby at home, in the birthing unit or the delivery suite were in line with national guidance.

Early booking improved the chances of women receiving appropriate care. The service was booking 56.6% of eligible women by 10 weeks and had shown steady improvement in this over the year. The target was 75%. However, between April and July 2018 the hospital had not met their target to ensure that 90% of women were booked before 12 weeks. Some of the population were transient and there a relatively high number of women booked late in pregnancy.

Community midwives referred women who they identified as high risk for any medical reason to consultant-led clinics at the hospital. A fetal medicine unit supported the identification of diagnosis and treatment of complications which may arise in unborn babies. The hospital worked closely with the fetal medicine unit of another hospital in the network service, where they could refer women if a baby required specialist intervention. The unit carried out amniocentesis and chorionic villus biopsies (tests performed during pregnancy to determine if an unborn child was at risk of a congenital defect). We were told that women and their families, for cultural and religious reasons, rarely chose termination for abnormalities.

In line with Better Birth’ guidance midwives asked women about their baby’s movements at each antenatal contact to reduce the risk of still birth. Staff advised women to contact the maternity telephone line, the maternity assessment unit (MAU) or the maternity triage unit if they had any concerns about their baby’s movements. We did not see information in other languages about reduced fetal movements.

The fetal growth assessment protocol (GAP) had been introduced to help identify babies who were not growing as well as expected. An action from a recent SI mentioned the poor adherence to GAP policy needed addressing by the specialty.

We asked for an action plan for reducing still births. This was not an integrated preventative plan. It took the form of actions in response to specific cases such as feedback to staff about a particular event or “governance team to provide refresher training for GAP GROW recording”. There seemed some risk that staff would not understand the wider context.

Midwives completed venous thromboembolism (VTE) risk assessments to determine a patient’s risk of developing a blood clot, in line with national recommendations. From records reviewed we saw that staff completed VTE assessment during pregnancy but the risk did not appear to be consistently assessed after birth. Staff had different views about where this information was recorded. Senior staff told us later postnatal VTE assessments were, since July 2018, meant to be recorded on the CRS electronic system. As ward staff did not seem to know this, there was a risk that a woman’s VTE status would not be spotted. A trust wide audit we received after the inspection confirmed that there was a lack of understanding on how to complete the risk assessment and where to record it.

Women in labour could attend the dedicated maternity triage 24 hours a day, seven days a week. Midwives prioritised women according to clinical need. However, patient notes showed triage assessment tools were not always fully completed.

The trust continued to ensure that risks for women undergoing obstetric surgery were reduced as staff followed the five steps of the World Health Organisation (WHO) surgical safety checklist for women having a C-section or other obstetric surgical procedure, such as instrumental delivery, to prevent or avoid serious patient harm in the operating theatre. This was in line with national recommendations (NPSA Patient Safety Alert: WHO Surgical Safety Checklist). We found these checklists in most, but not all, patient notes after caesarean section. The results of the WHO
surgical safety checklist audits for June 2018 to August 2018 showed 100% compliance, with only the team brief falling below 100%.

Women were accepted for birth in the birth centre following outpatient induction and some women were accepted if they were diabetic. This was risk assessed for the individual. Women in labour in the birthing unit were transferred to the delivery suite if higher risks emerged in labour. For example, if midwives had concerns about fetal heart rate, failure for labour to progress and meconium in the waters. Meconium is baby’s first stool and its presence in the waters can sometimes be an indicator of foetal distress during labour. The transfer was quick and straightforward.

At the November 2016 inspection, we had concerns about the lack of use of modified early obstetric warning score (MEOWS). These are designed to allow early recognition and deterioration in pregnant and postnatal women by monitoring physical parameters, such as blood pressure, heart rate and temperature. The team had audited performance between December 2016 and January 2017 and found 77% of MEOWS charts contained inaccurate documentation. They re-audited this after training in June and July 2017 and the audit showed some improvement in performance. However the audit recommended teaching sessions should continue to sustain improvement and that there should be training for maternity care assistants. Training had not been provided. Women’s health records showed that staff did not follow the trust’s post-operative protocol on frequency of observations for women which suggested four hourly observations for all high risk patients on transfer to the postnatal ward. There was no standard frequency of observations in the records we reviewed. Midwives did the first set of observations and subsequent observations were done by maternity care assistants (MCAs) who were expected to report any concern about the results to midwives. Maternity care assistants sometimes recorded observations retrospectively. This was not safe practice, and we noted that there was action from a 2017 SI to ensure observations were recorded at the correct frequency. Progress was to be audited but no action had been taken and the audit was not on the audit schedule.

The service used a buddy system for checking the CTG recording of a baby’s heart rate (fresh eyes). Fresh eyes involves a second midwife checking the CTG trace to ensure it has been interpreted correctly, to allow timely and effective intervention when indicated. This was in line with national recommendations (NHS England Saving Babies’ Lives: A care bundle for reducing stillbirth). An audit had indicated that this did not always take place every two hours. The "Fresh eyes" approach was also being introduced in triage and the maternity assessment unit (MAU) where women also had CTGs. In the birthing unit, the service was using ‘fresh ears’ for intermittent auscultation, where midwives use a sonicaid to listen to the fetal heart in between contractions to determine the baseline, and monitor fetal wellbeing. With fresh ears, a second midwife would confirm the fetal heart rate pattern every hour, which can help reduce interpretation errors. However, we did not find written confirmation of fresh ears on a birth record that said fresh ears had been used.

Staff had access to emergency trolleys in the event of an obstetric emergency. These were easily accessible in corridors. The delivery suite and birthing unit had a blood fridge on the unit which ensured women received bloods immediately when needed during an emergency.

The only emergency phone number on display on the delivery suite was for the neonatal team. A manager we spoke with on the delivery suite was unclear when to use the 2222 service to escalate concerns, and when to use the switchboard. In the delivery suite, in the birthing unit and the postnatal ward staff could summon delivery suite support by pressing a buzzer. If the buzzer was used in the birthing unit, a member of staff would bring the resuscitation trolley from the delivery suite. We saw staff respond quickly to an emergency call.
We attended three handovers on the delivery suite which included a safety briefing to help mitigate risk. A long safety briefing reiterated the topics in the fortnightly delivery suite safety brief. A midwife reminded staff to count swabs and dressings so the women could hear that all were accounted for, the importance of fresh eyes/CTG buddying every hour, and told staff that CTG documentation was to be done from the following Monday on a new form. She emphasised the need to complete documentation fully on both electronic and hand held notes, stating the type of epidural, which was important for funding, and ensuring babies had electronic tags before transfer to the ward. The briefing also included issues identified by the CQC on inspection the previous week: using correct sharps bins for waste disposal and closing them when they were three quarters full, and the importance of hand hygiene. There was also a reminder about training for MCAs about waste disposal, and a training course on blood sugar.

The outgoing delivery suite coordinator used the situation, background, assessment, and recommendation (SBAR) tool to transfer information concisely at the handover between shifts. This approach seemed well embedded. All women were discussed, highlighting particular issues, although there was no discussion of the plan for women about to deliver. No midwives asked questions. At the end of the handover the team reviewed women waiting on the antenatal ward after induction, so staff were aware of women who would later come up to the delivery suite. The coordinator remarked that “Someone had added a grade 3 caesarean section to the board for women due for admission”. The coordinator had no information about this information so could not discuss this woman’s needs, indicating a communication issue in the delivery suite. This handover was followed by a doctors’ handover. A number of trainee doctors made significant contributions during this handover.

The NHS new born blood spot (NBS) screening programme helps identify several rare but serious diseases with a small blood sample, also called a heel prick test. There was a weekly failsafe system to check results and ensure no baby missed the screening.

Women and babies wore wrist bands for patient identification. Babies had two identity bands on both ankles and an electronic tag on one ankle. If a tag was tampered with an alert sounded at a panel by the nurses’ station which indicated the relevant baby. An active tag taken towards the exit, locked doors automatically and an alarm sounded in the security guards’ station. Midwives said tags were meant to be checked and recorded three times daily. We saw gaps in the checking which senior staff did not appear to monitor. Abduction drills were held to test the security of the system.

**Nurse staffing**

Newham Hospital reported the following nurse staffing numbers for maternity services in March and April 2018. The trusts fill rate increased by around 5% from March to April 2018.

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<tr>
<td>Maternity</td>
<td>262.0</td>
<td>294.3</td>
<td>89.1%</td>
<td>257.2</td>
<td>272.4</td>
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(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)
Staffing levels were below the planned rate. Midwives mentioned the impact of maternity leave, absenteeism, short and long term sickness and annual leave on staffing levels on the fill rate. Between April and 1 September 2018 256.6 shifts were filled by bank or agency staff. Most but not all vacant shifts were covered. Doctors considered midwives on the delivery unit which had a high proportion of complex cases, were overstretched. Shifts were not fully filled on our inspection. In the year April 2017 to March 2018 there were 50 incident reports relating to staff shortage.

From May 2017 to April 2018, Newham Hospital reported a vacancy rate of 8.1% for nursing staff in maternity services, this was higher than the trust target of 6.3%.

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

From May 2017 to April 2018, Newham Hospital reported a turnover rate of 15.5% for nursing staff in maternity services, this was higher than the trusts target of 13%.

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

From May 2017 to April 2018, Newham Hospital reported a sickness rate of 4.1% for nursing and midwifery staff in maternity services, this was higher than the trusts target of 3%.

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

However the hospital’s maternity dashboard for the same period showed a higher rate, 6.5%. For the year from April to July 2018 the dashboard showed an average sickness rate of 4.3%, but this would not be accurate as no data was reported for June. The rate for July was 7.2% which was high. There was evidence that sickness absence was a hospital wide problem, particularly in school and bank holidays.

Planned and actual staffing was displayed in each area, using different colours if the team was one member short or more than one staff member short. On the delivery suite on the unannounced inspection there was one midwife down but four maternity care assistants instead of three. The staff numbers displayed on the postnatal ward on the unannounced inspection showed that during the first 19 days of September, the ward was one member short of planned numbers on four days, and more than one short on three other days. Incident reports showed a number of occasions in July and August where staff had to be moved to cover shortfalls.

Five band 7s (team leader level midwives), shared the leadership of the midwifery led birthing unit. The MAU was staffed by 2 or 3 midwives and an MCA in the daytime. Triage was staffed by two midwives and an MCA at night.

At both of the last inspections we observed midwives on the delivery suite in particular were overstretched, and this was the case on this inspection too. At the last inspection midwives had said they did not always take breaks and often worked beyond the end of their shift. On this inspection we saw midwives were stretched due to capacity and staffing issues, and midwives often did not have their breaks. On the second day of inspection three midwives had not had lunch by about 3pm. On the unannounced inspection we saw at least two midwives working more than an hour beyond the end of their shift.

The Birthrate Plus is a tool used to determine the number of midwifery staff required to care for women based on a minimum standard of providing one-to-one care throughout established labour. A Birthrate Plus assessment had been completed prior to our inspection in 2014 which had suggested that a ratio of 1:26 was appropriate for the levels of acuity. The funded establishment was 1:28, the same as the national ratio and this rate was reported on the maternity dashboard, rather than the actual rate which would vary monthly. We requested the actual midwife to birth
ratio (excluding managers and midwives on sick leave or maternity leave. The data below was supplied for the year to date, and showed a lower (more favourable) ratio than shown on the maternity dashboard. We did not see how this ratio could have been achieved with a 5% vacancy rate and 6% sickness rate.

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<th>18 Midwife to birth ratio</th>
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The midwife vacancies were expected to be filled by incoming student midwives, but staff confirmed there was a shortage of experienced midwives which affected the amount of supervision they were able to give to less experienced staff.

A new birthrate plus assessment carried out by the trust was sent to us after the inspection, in draft form, which showed a shortfall of 3.23 WTE midwives and RMNs and 12.9 support workers in postnatal services – a total of 15.92 WTE.

From January 2017 to December 2017, the trust had a ratio of one midwife to every 25.88 births. This was similar to the England average of one midwife to every 25.19 births.

(Source: Electronic Staff Records – EST Data Warehouse)

Hospital bank staff were used to cover shifts. These were mainly permanent midwifery staff already working in the hospital or in the community, working additional hours. Agency staff were discouraged because of the cost. From May 2017 to April 2018, Newham Hospital had a total of 9,329 nursing staff shifts. A breakdown of locum and agency usage and unfilled shifts is shown below:

<table>
<thead>
<tr>
<th>Bank/ agency</th>
<th>Total</th>
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<tbody>
<tr>
<td>Bank</td>
<td>8,313 (89.1%)</td>
</tr>
<tr>
<td>Agency</td>
<td>484 (5.1%)</td>
</tr>
<tr>
<td>Not filled</td>
<td>248 (2.7%)</td>
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(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

The highest proportion of bank and agency staff worked on the post-natal ward.

Best practice is to have an experienced supernumerary delivery suite coordinator to oversee safety on the delivery suites, to support clinical staff and manage workload and activity. At the last inspection we said delivery suite coordinators should have supernumerary status with sufficient allocated time and resources to carry out their oversight and support role. On this inspection, coordinators told us they were usually supernumerary for most of the shift, but that there had been recent occasions when short staffed where they had to look after women during active labour.

National recommendations are for all women to receive one-to-one care in established labour (RCOG Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour, 2007). For the period of April 2018 to July 2018, the dashboard showed 97.2% of women received one to one care during active labour; however, discussion at a management meeting referred to levels of 91% and 92% which was low.
A dedicated team covered the main obstetric theatre. Cover for the second theatre had been a long running concern and had been raised at previous CQC inspections. Although funding had been identified temporarily to staff a second theatre in the daytime, a nurse from the HDU had to scrub for theatre emergencies which could impact on the care of women in HDU. One operating department practitioner (ODP) had been identified to support the second theatre.

A bereavement midwife covered maternity as well as early pregnancy and gynaecology. With 200 patient contacts a year and running training too, this seemed a heavily loaded post. A clinical practice facilitator and two practice development midwife managed training and support for preceptor midwives.

The head of midwifery had introduced a maternity rotation for staff at Bands 6, 2 and 7 in summer 2018 so that midwives would experience work in different areas of maternity and thereby broaden their skills across the full range of midwifery work. The first staff rotation had started on 6 August 2018. Staff would complete competency booklets in their new area. There had been some resistance to this programme, and midwives said managers did not listen to their concerns. Managers told us that sickness management and staff lateness had been problems but were being tackled through an emphasis on sticking to the HR rules consistently throughout the service. The action plan was dated 8 October 2018. We observed several midwives arriving late for shifts on our unannounced inspection.

The clinical commissioning group was running a maternity staff recruitment and retention campaign across east London targeting people looking for a career in maternity services, and those already working in maternity, to help retain them.

There were four community midwife teams as well as a small group practice and the Acorn team for vulnerable women.

In one community midwife centre we inspected staff told us there were two vacancies and two staff off sick which increased pressure particularly on home visits. Bank and agency midwives were not generally used in the community, when there were shift gaps.

The division as a whole had a high proportion of temporary staff – about 16%. We did not get a breakdown for maternity.

**Medical staffing**

Consultant cover had been a concern at the previous inspection. There was 98 hours cover a week on the delivery suite and an extra consultant had been recruited since the previous inspection. The Royal College of Obstetricians and Gynaecologists (RCOG recommendation was for 98 hours for a unit delivering 5000 babies and the delivery rate at Newham was higher than this. However, doctors thought the medical cover was safe. In the daytime a consultant was present in the unit from 8am to 9pm, often later. The hospital had agreement from the trust to recruit another senior house officer SHO but the post was still vacant. During the day there was an SHO in each clinical area but consultants recognised that junior doctors were sometimes stretched out of hours as they were also responsible for other areas of the maternity service, so were not always present on the delivery suite.

At night one consultant covered both obstetrics and gynaecology on call from home. Consultants were expected to be present in the unit for a difficult birth where a trial of instrumental vaginal birth was to be conducted in theatre with preparations made for proceeding to caesarean, or caesarean section when the woman was fully dilated, where there could be a higher risk to the woman or the baby. At the weekend a consultant was present on site from 8am to 3.30pm. A consultant anaesthetist and registrar were present on the delivery suite between 7am and 7pm. Out of hours there was a duty anaesthetist with a consultant on call.
Overnight there was a dedicated registrar anaesthetist and access to the emergency theatre anaesthetist if needed (60 hours a week anaesthetic consultant cover). Senior staff told us that out of hours an anaesthetist was not always available to respond to a woman in labour wanting an epidural due to other demands and some women had to wait longer than 45 minutes for an epidural anaesthetic.

Newham Hospital reported the following medical staffing numbers for maternity services in March and April 2018. The trusts fill rate was over establishment at that time, but at the time of inspection there were 43 medical staff in obstetrics.

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<tbody>
<tr>
<td>Maternity</td>
<td>49.4</td>
<td>47.0</td>
<td>105.1%</td>
<td>48.5</td>
<td>48.0</td>
<td>101.0%</td>
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(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)

From May 2017 to April 2018, Newham Hospital reported a vacancy rate of 0.1% for medical staff in maternity services, this was lower than the trust target of 6.3%.

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

The turnover of doctors in maternity services was 2.7%.

The trust did not provide any sickness data for medical staff in maternity services.

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

From January to December 2017, Newham Hospital did not report any shifts filled by locum and agency staff.

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

We were told that locums were being used to cover the vacant SHO post.

In March 2018, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was higher.
Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2
(Source: NHS Digital Workforce Statistics)

Records

At the two previous inspections serious incident reviews and incident reports had highlighted record keeping as being below accepted standards. CQC had commented on the absence of action plans in place to regularly audit or monitor progress to improve the quality of documentation. On this inspection, we saw some instances of good record keeping, however standards remained inconsistent and there was no process for ensuring the standard and quality of record keeping was maintained. We observed in a serious incident review meeting that staff found it hard to locate all information in records and observed gaps in recording and retrospectively completed information without timings. Junior midwives did not seem to fully understand the national standards for record-keeping (NMC The Code: Professional standards and behaviour for nurses and midwives, 2015) and appeared to need more support from managers. There was a tolerance of record keeping that was less than complete (and therefore below professional standards) and an acceptance of retrospective entries. We were told that an audit midwife had been auditing case notes since January 2018 to give staff real time individual feedback to midwives. We would have expected more improvement from this process than we observed.

The maternity service currently used a mixture of paper and electronic records to document patient’s notes. Women carried their own handheld pregnancy records, which staff updated and advised women to bring to each antenatal appointment in line with the National Institute for Health and Care Excellence (NICE) Antenatal care for uncomplicated pregnancies guideline. Electronic records were available only to authorised staff which did not include bank and agency staff. Computers and computer systems used by hospital staff were password protected.

The trust’s electronic Care Records System (CRS) was used for some obstetric information, for example VTE assessments. Another system contained ultrasound scan and blood results. Although staff received training on using electronic records several staff seemed unclear about where information was recorded and were not able to help us find key aspects of the woman’s health status in the notes. Although the trust objective was to reduce the use of paper and ultimately to go paperless, senior staff told us the information technology infrastructure would require strengthening if this vision was to be realised. We noted that at least two computers on the
delivery suite were not working (rooms 12 and 13) and not all rooms had a computer which made it difficult for staff to enter contemporaneous information.

We reviewed a sample of 19 health records for women on the postnatal ward. These were not easy to navigate and two staff members we asked were unable to help us where we could not locate information, such as postnatal VTE assessments, a complete list of antenatal test results, swab, needle and instrument counts or in one case no operative notes from a caesarean section. Only one record stated the named midwife or consultant.

Gaps in recording had come up in incident reports, including in the case of a serious incident at the incident review meeting we attended. Sections of records were not always fully completed or signed, for example we saw a safety alert sticker for a pack in a wound but no indication of who recorded this. Incomplete records meant that staff taking over care might not have complete patient information to make informed decisions on the next stage of care or management.

Audits had shown weaknesses in relation to MEOWS chart completion and records of vaginal examination. Other weaknesses we identified were that the patient’s hospital number was not on every page; there were loose sheets containing patient information which could easily become separated from the main record; MEOWS charts were not consistently completed and observations were not at the correct frequency. This was confirmed by a hospital audit we received after the inspection which showed that despite an improvement since 2017 the frequency of observations was still weak with 50% women at risk having a gap of over 8 hours and 24% over 10 hours. We did not see evidence of regular checks of women’s emotional and mental health. However we saw clear records of breastfeeding and completed stickers on baby wellbeing.

At the previous inspection there had been a concern about compliance with correct procedures for filing cardiotocography (CTG) records. CTG is used during pregnancy to monitor both the fetal heart and contractions of the uterus and to monitor fetal well-being. On this inspection, almost all files reviewed contained CTG traces correctly filed in brown sealable envelopes. This matched the findings of a storage audit in February 2018. However, midwives did not routinely sign and note the CTG end time, the date, time and mode of birth on the CTG trace in line with the policy. The end time of the CTG was generally marked on the envelope, but not on the primary record itself. It was not clear whether the February 2018 audit that recorded 96% compliance with labelling looked at the labelling of the traces themselves. The audit of CTG records undertaken in response to the last inspection, was overdue, however the sample records undertaken after the inspection revealed a need to improve CTG documentation.

We were told there was a plan to have a champion for patient notes to promote improvement but no date was given. The practice development team were aware that there were gaps in documentation of women’s health records and said they had increased training on record keeping, and run ‘focus weeks’ on patient documentation, but these appeared to had insufficient impact on standards.

Confidentiality was also an issue. There were instances where patients’ personal information was easily accessible and could potentially be viewed or removed by unauthorised people. Paper records on the ward were stored in unlocked rooms in containers that were not lockable. On our unannounced inspection we found five sets of notes on an unattended and unsecured, but locked, drug trolley in the entrance to the postnatal ward during visiting hours. In a transitional care bay records were left unattended on a desk. We also saw the numbers on baby tags could be seen at the midwives station that was not always manned. Blood cord samples were left in the point of care testing machine with the print out containing results and patient identifiable information with the room door wide open. Not all patient notes had a file cover, for instance the notes for a woman
transferred in for delivery, and another person’s record without a file cover, had prominent safeguarding notes on the front. We saw from an incident report in July 2017 that 46 individual antenatal notes of vulnerable women from 2015 to 2017 were found on Larch ward which should have been filed at the time of discharge. Within the women’s directorate as a whole compliance with information governance training in August 2018 was 79.7%. This was within the bottom five training compliance scores at the hospital.

In a community midwives centre, we were told that not all computers could print. Community midwives were shortly to be given laptops to enable them to complete records remotely, although these had not yet been distributed. On the unannounced inspection the computers were not working.

**Medicines**

Medicines were supplied by the onsite trust pharmacy. A technician topped up supplies once a week and a pharmacist visited the maternity unit once a week, or as required. In most cases staff ordered and dispensed medicines safely and securely. There were arrangements to obtain medicines supplies out of hours (after 5pm). In the main, medicines were safely managed, accurately recorded, in-date and most were stored in locked clinical treatment rooms or locked fridges.

Medicines that needed to be kept below a certain temperature were stored in locked fridges. Staff monitored the fridge temperature daily. There were few gaps in the records but no temperatures above the recommended range were recorded. Room temperatures to measure the ambient temperatures in drug storage and preparation rooms had recently been installed. Staff measured and recorded the temperatures but these were often measured late in the day which might not accurately reflect maximum temperatures. There were some gaps in recording, for example on the first two days of inspection the ambient temperature was not recorded in the delivery suite clinical room. Most medicines fridges were clean and locked. However in the clean utility room in the antenatal clinic an empty fridge was labelled as being for research samples. The fridge door seals were stained. This appeared to be a domestic fridge as it did not have an external temperature display.

Controlled drugs (CD) were stored and managed appropriately. CDs were checked and reconciled twice daily by two nurses. There were only two occasions in August 2018 where checks on the delivery suite were missed.

We found some errors in medicine storage. Prostaglandin pessaries on the antenatal ward were stored in an unlocked room in an unlocked freezer. Staff could not explain why the freezer was unlocked. When stocks had been replenished on 19 September 2018 the logbook was signed as unlocked, although it had been signed as locked the previous day. There was no record of the restocking at all. The log said stocks of pessaries had run out. We also saw antibiotics on a drug trolley not stored in original boxes but cut into strips which meant the expiry date was not identifiable.

Prescription charts recorded allergies in most cases but on at least four records reviewed the allergy section was not completed. There were about 96 incidents a month reported in the maternity service, most in the intrapartum period but with quite high numbers in both antenatal and postnatal care within the hospital.

Medical gas cylinders in the maternity unit were stored appropriately in a locked room, in line with national guidance. Oxygen cylinders were mainly full, appropriately secured and within date.
However, two empty cylinders were seen unsecured in the delivery suite and postnatal ward in corridors.

There was a book on the postnatal ward for staff to record medicines for women to take home. Some women left before receiving these and staff were advised to contact women three times to arrange collection, but there was no indication of the frequency of follow up calls.

Newham hospital had a lead pharmacist for antibiotics and another lead for sepsis.

**Incidents**

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

From August 2017 to July 2018, the trust reported no incidents classified as never events for maternity services at Newham General Hospital.

(Source: NHS Improvement - STEIS)

On inspection we found that in August 2018 an incident initially classified as a never event had been downgraded by the CCG to an internal serious incident (SI). A dressing used to apply pressure during suturing had been left inside a woman. In response to the incident senior staff had made it a requirement that staff must count all dressing pads, swabs and needles after delivery, and in suturing, and that two staff should be involved in suturing. Previously only swabs used in delivery were counted. A laminated swab count board had been prominently placed in all delivery suite rooms, along with copies of the Local Safety Standards for Invasive Procedures (LocSSIPs). This showed a quick response and a sharing of learning to prevent recurrence. All staff were aware of this incident.

In accordance with the Serious Incident Framework 2015, the trust reported eight serious incidents (SIs) in maternity services which met the reporting criteria set by NHS England from August 2017 to July 2018.

The types of incident reported were:

- Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant): five incidents
- Maternity/Obstetric incident meeting SI criteria: mother only: three incidents

(Source: NHS Improvement - STEIS)

Data provided by the trust before the inspection showed 15 serious incidents at Newham between April 2017 and 31 March 2018, although the maternity dashboard showed 14 incidents. Data later provided by the hospital showed 18 incidents had been escalated as potential SIs and 16 had been confirmed. The trust governance lead told us there were nine serious incident investigations in progress of which four were overdue from the previous financial year, six months before the inspection, but was not able to explain why the delays were occurring. Learning from Never events was shared across the whole trust. There was a vacancy for the maternity governance lead at the hospital.

The hospital used an electronic system for reporting incidents. The service reported about 100 maternity incidents a month, which was low for a maternity service. All but 14 of those reported in
July and August were classified as no harm. In the extract of incidents for July and August none were reported by doctors. The top areas reporting incidents were the delivery suite and the postnatal ward. The largest category of incidents was post partum haemorrhage. Incidents were being closed more quickly than in 2017. There were 66 incidents open in May 2017 and 62 in June that year, but there were 27 open incidents in May 2018 and this performance was rated as red. Medicine incidents were recorded separately.

At the last inspection we had a number of concerns about incident reporting. There had been a backlog of incidents, inconsistent classification and lack of shared learning from incidents to improve services. We imposed a requirement to improve the timeliness of incident investigations. At this inspection the backlog of incidents had reduced but completing investigations and actions to prevent recurrence were slow and performance over the year was inconsistent. A governance board displayed the number of serious incidents (SIs), about one a month during 2018, the number overdue and the number of actions overdue, but the lack of reference to these in the minutes suggests that staff were not focused on achieving a first draft by day 30 in line with trust policy. Three SIs were overdue in July and four in August 2018. In July 2018, 23 serious incident actions were overdue, but effort had been put into reducing the number to 11 overdue actions in August. Overdue SI reports were rated amber on the governance dashboard. There were 17 concise investigations overdue in May 2018 (rated red and therefore needing urgent action). Concise investigations are suited to less complex incidents which can be managed by individuals or a small group of individuals at a local level.

We reviewed the two most recently completed SI investigations. One incident from 11 December 2017 was completed on 8 August 2018, the other was an incident from 29 January 2018 was completed on 27 July 2018. Both these investigations had taken significantly longer than trust and national policy which was to close incidents in a maximum of 60 working days. None of the follow up actions were signed off in the reports as sent to CQC in October 2018, nor in the monthly governance dashboards. Actions to prevent the likelihood of similar incidents happening again were essential but not usually started ahead of the completion of the report. From these two reports alone there were 14 actions, which did not tally with the hospital’s data saying there were only 11 actions overdue in August 2018. Some of the actions involved re-training all staff so they would involve significant resource and time.

We were told managers reviewed incidents reported on the electronic reporting system every day at the safety huddle, although this did not happen at the huddle we attended. At that huddle staff instead where staff focused on new form in response to a recent serious incident regarding full completion of records. There appeared to be emphasis on paper communication such as sending a memo to staff rather than ensuring staff understood what needed to improve and why. Learning from incidents appeared to be covered more fully by medical staff than by midwives.

Incidents considered for escalation were discussed at the weekly Women’s incident review (WIR) meeting and then brought to the attention of the site serious incident review panel, outlining the decision and the rationale for escalation in line with the National Serious Incident Framework. We observed the weekly maternity serious incident review meeting during inspection. This was a multi-disciplinary meeting to review new incidents and progress on others under investigation. Sub-optimal practice was identified in the cases discussed, including retrospective recording without clear timings and in another case, a decision-time sticker introduced in response to a previous serious incident, had not been used and a long delay in suturing had occurred. The meeting also noted good practice in the cases reviewed, to be conveyed to staff. Areas of concern would be shared through presentations at staff meetings and forums, as well as discussions at risk meetings and team meetings. Information was also communicated on noticeboards and in
newsletters such as the fortnightly *Hot topics* which contained information on current themes such as induction protocols and the use of fresh eyes by midwives in triage and MAU. It was not clear that midwives involved in incidents were asked to reflect on and improve their practice.

Decisions in the maternity service were traditionally made at the top and then communicated to staff. Junior staff awareness of governance was limited and staff did not feel communications were two-way to engage them with the governance agenda for quality improvement. Managerial communications did not energise staff and staff at ward level did not seem to see that their personal efforts in the ward or clinic could improve patient safety, patient experience and quality of service.

The service had weekly perinatal mortality meetings. These meetings were an opportunity to review all perinatal deaths at the hospital to explore key themes and identify any trends or themes. This meant that any deaths in the service were reviewed by a multidisciplinary team. Morbidity was discussed at risk management meetings.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify and families of certain ‘notifiable’ safety incidents and provides reasonable support to that person, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staff apologised and gave patients information and support when things went wrong. Staff understood the principle of duty of candour and importance of being open and honest with women and those close to them in the event of an adverse incident. We saw records of duty of candour being carried out.

Bank staff said they had no access to the results of investigations. They were not involved in debriefing from incidents and had little feedback.

**Safety thermometer**

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

Data from the national patient safety thermometer showed that the trust reported no new pressure ulcers or falls with harm. However, the trust reported three new urinary tract infections in patients with a catheter from September 2017 to May 2018 for the maternity services. Safety information was displayed on Larch ward using the safety cross so safety performance information was available to women and their families. A safety cross is a visual data collection used to identify areas for improvement and shows the number of days since the last incident. Staff told us that after a pressure ulcer in maternity they had implemented body mapping and a five step approach to identifying, preventing and treating pressure ulcers and there had been none since April 2018.

The maternity unit did not display the maternity safety thermometer which reports on maternity specific issues including the proportion of women that had a maternal infection, proportion of women with a 3rd or 4th degree tear, proportion of women having a postpartum haemorrhage of over 1000 mls and proportion of babies with a score of less than seven at five minutes (a measure of the physical condition of a new-born infant) and women’s experience of having concerns not taken seriously. However, the trust submitted data to NHS improvement on this. Newham hospital prepared a safety thermometer return in response to our request for data, but this was not based on a 100% sample of postnatal women so it was hard to make valid comparisons with national data.
Is the service effective?

Evidence-based care and treatment

The maternity service had effective systems in place to ensure policies, protocols and clinical pathways were reviewed regularly and reflected national guidance and legislation.

A trust-wide maternity guidelines group oversaw the updating of the maternity guidelines. Guidelines were updated regularly and reflected guidance from the Royal College of Obstetricians and Gynaecologists (RCOG) and National Institute for Health and Care Excellence (NICE) guidance. They were on the trust intranet. The Trust policy for Perinatal Mental Health was in draft form. In the absence of a finalised policy, the hospital referred to the Pan-London Perinatal Mental Health: Guidance for Newborn Assessment and the NICE guidelines on Antenatal and Postnatal Mental Health: Clinical Management and Service Guidance.

There were some local guidelines in a file share folder at Newham. We did not see any mention of new guidelines on display. We were told any revised guidelines would be reported to staff at the safety briefings.

The hospital offered screening in line with the National Screening Committee (NSC) recommendations. Two antenatal and new born screening coordinators were responsible for antenatal and new born screening and reported data to NHS England on screening assessments. Women were screened for Hepatitis B and syphilis. If a woman had risk factors, or knew they had the hepatitis C virus they could be referred to a doctor. Women with HIV or Hepatitis B were seen by a doctor to make a plan to protect their new born baby. The service dashboard did not show whether the service was meeting the standard of achieving sickle cell and thalassaemia screening by 10 weeks of pregnancy. The screening return showed this was 54.8% which was above the threshold; however the service was below the threshold for full completion of laboratory request forms and had started from June 2018 to check forms before sending to improve compliance.

Relevant women (156 between April and June 2018) were offered the quad test, a non-invasive test that screens for conditions such as Downs syndrome and trisomy 18 (chromosomal abnormalities), as well as for neural tube defects, such as spina bifida. An ultrasound, called a nuchal translucency screening which measured the amount of fluid behind the baby’s neck, and which could be an indicator of the risk of Down’s syndrome was offered to women at risk of a problem with the baby's chromosomes. A small number of these were outside the time frame for all elements of the tests, such as both blood test and ultrasound. The screening team were auditing the reasons for this to prevent recurrence.

Where abnormalities were suspected women were referred to the fetal medicine service. There were daily clinics for amniocentesis (a process in which a small amount of amniotic fluid, which contains fetal tissues, is sampled from the amniotic sac) and chorionic villus sampling (a process where small sample of chorionic villus (placental) tissue is removed for testing). Newham hospital worked closely with another hospital in the trust in screening and management of specific genetic conditions. Rapid referrals, within 72 hours were possible.

The hospital measured key performance indicators required by commissioners, such as screening and safeguarding. They contributed data to the National Neonatal Audit Programme (NNAP) and to the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries in the UK (MBRRACE-UK). MBRRACE is a national programme of work involving the surveillance and investigation of maternal deaths, stillbirths and infant deaths. The hospital employed a
bereavement/ MBRRACE midwife who was involved in the investigation of all still births and neonatal deaths.

**Nutrition and hydration**

Women’s nutrition and hydration needs were met. We spoke with three women on the postnatal ward who said the food was adequate and that the service could cater for special diets. Women were offered light refreshments such as hot or cold drinks during labour, and food was available after delivery. They reported that the menu had enough choice.

Women had access to dietary information for themselves during pregnancy and for their babies in the first months of life. Babies with tongue tie which affected their feeding could be referred to a clinic at another hospital within the trust.

Staff supported and advised women on infant feeding, including positioning and attachment for those who were breastfeeding. There were daily breast feeding sessions on the postnatal ward and volunteers had been recruited to support women in the hospital and in the community with breastfeeding. We saw leaflets by a charity advertising a breast feeding drop in sessions as well as information about other support services such as those women who were feeling low or anxious and other support services.

The dashboard showed 78.9% of women were exclusively breast feeding on discharge in 2017/18 and 5.2% were partially breast feeding. The overall rate of breastfeeding had dropped slightly in the period April 2018 to July 2018, 78.7% exclusively breastfeeding and 2.6% partially breastfeeding. The breastfeeding initiation rate was not displayed on the maternity wards but we were told after the inspection that it was the current breastfeeding initiation rate was 85.5%. The rate in 2017 had been 89.6%. The hospital had level one accreditation and was working towards the United Nations Children’s Fund (UNICEF) baby friendly initiative level 2. Not all staff on the postnatal ward knew about initiatives to increase breastfeeding.

Women and babies at risk of hypoglycaemia were regularly monitored following delivery to ensure they were well and maintained blood glucose levels within the normal range. We observed hypoglycaemia box on the maternity wards which contained glucose juice and biscuits which were given to patients during diabetic emergencies. Women with pre-existing or gestational diabetes were referred to the dietitian with advice given on diet to help control blood sugar levels and weight, in line with national guidance (NICE *Diabetes in pregnancy: management from preconception to the postnatal period*).

Women were given advice on fasting before their elective caesarean section in line with national guidance (OAA/AAGBI *Guidelines for Obstetric Anaesthetic Services*).

The service used a gestational related optimal weight (GROW) assessment to plot babies’ weight. The weight centile result informed the care plan of the baby. We saw from an SI in January 2018 on the death of a small for date’s baby that the poor adherence to GAP policy needed addressing by the specialty. The target date for completing this was December 2018. The length of time before action was taken created a risk that small for dates babies could be missed in the interim.

A midwife said they would escalate weight loss in a new born baby on the postnatal ward to the neonatal team for a feeding plan. When there was significant weight loss (over 8%) in a baby at home the community midwife told us staff would monitor this for a day, and would then suggest the mother and baby attend hospital.
Pain relief

During women’s hospital stay we saw that staff assessed and managed pain levels regularly. The birthing unit had birthing pools for pain relief and water birth. Women were encouraged to mobilise in labour. A ready-to-use medical gas (a mix of gas and air) that provides short term pain relief was available in all the birth rooms, and a morphine-like opioid and paracetamol were available. On the obstetric unit opioids (such as oral morphine) and epidural anaesthesia were available for women, in addition to gas and air. Women were also prescribed non-steroidal anti-inflammatory drugs (NSAIDs) post-operatively to manage their pain.

At the November 2016 and July 2017 inspection we found that women did not have timely epidurals out of hours due to anaesthetists being busy elsewhere and not able to attend when requested. Staff told us there were still delays out of hours. The 2013 Obstetric Anaesthetists’ Association and Association of Anaesthetists of Great Britain and Ireland OAA/AAGBI guidance for standards of obstetric anaesthetic practice included a recommendation that all patients requesting epidurals for labour analgesia should be seen by an anaesthetist within 30 minutes or 60 min in exceptional circumstances. There was only one dedicated anaesthetist on the delivery suite out of hours, and when they were busy in theatre this impacted on the time midwives told us women waited for epidurals for pain management. We were told the time waiting for an epidural was calculated from the time the anaesthetist was ready rather than from when a woman requested an epidural. An audit in February 2018 showed 85.7% of epidurals were set up within 30 minutes of request and 93.2% within an hour. This was an improvement from the June 2017 audit but that still meant over 14% of women had to wait longer than recommended. The 2017/18 quality report said the hospital would soon be recruiting additional anaesthetists and theatre staff to ensure that they were able to provide timely epidural anaesthesia to women. Midwives were aware the hospital was seeking to recruit another anaesthetist for emergency theatre, which would help reduce delay but this person was not yet in post.

Patients we spoke with told us they had generally received good pain relief, although one woman mentioned inadequate pain relief during suturing.

Patient outcomes

Staff collected information about the outcomes of patient’s care and treatment and monitored this using a maternity dashboard, a clinical governance tool for monitoring a range of clinical indicators to enable quality and safety assurance monitoring, as recommended by the RCOG Maternity Dashboard: Clinical Performance and Governance Score Card (Good Practice No.7). The data reviewed at the divisional management meeting in September related to July so was not wholly up to date. The information was shared externally with stakeholders and within clinical networks, and internally for the service and the Trust Board. Performance was monitored for a range of outcomes such as deliveries, instrumental deliveries, caesarean section deliveries, still birth rate, neonatal death rate and the number of third and fourth degree perineal tears. However, for a number of items there was no goal, percentage of inductions, maternal readmissions, low and very low birth rate. These items were not displayed with a RAG rating which made it difficult to judge the figures reported by comparison with other units.

We reviewed the Newham maternity dashboard from April 2018 to July 2018. This tracked monthly performance against London and national goals, where available. A traffic light system was used to flag performance against agreed thresholds. We did not see evidence of the maternity dashboard used to focus on improving performance and where data was outside trust thresholds month after month we saw no evidence of effective action being taken.
There were 53 indicators of which two were new since April 2017: maternal readmission within 42 days of delivery and the rate of staff sickness. The hospital was amber on one indicator and red for two indicators against their local goals. The hospital was not meeting their local goals for the emergency caesarean rate which was 27.9%. The trust was an outlier for emergency caesarean sections. There was an action plan to reduce unnecessary caesarean sections, however it was not comprehensive. The monthly presentations on caesarean sections did not always appear to review whether the procedure was appropriate in every case. There was no reference to actively reducing elective caesarean sections that did not have a medical justification, but only mentioned maximising the use of the elective list.

Information on the dashboard showed that:

- There were fewer planned caesarean sections than the London average, 8.4% in 2017/18 rising to 9% in the period April 2018 to July 2018. The national average was 11.3%.
- The percentage of emergency caesareans had been 20.5% in 2017/18 and was 18.9% in the period April 2018 to July 2018. This was affected by having only one obstetric theatre. It was expected that the use of a second obstetric theatre could reduce the emergency caesarean section rate for the site.
- One to one care in established labour had averaged 98.4% compared to the NICE standard of 100% in 2017/18. In the period April 2018 to July 2018 this had fallen slightly to 97.2%.
- 491 babies were born with low birthweight between 1.5 and 2.5 kg, and 76 with birth-rates under 1.5kg in 2017/18.
- 10.3% of babies were delivered with a gestation of less than 37 weeks with about 0.3% less than 27 weeks.
- Third or fourth degree tears had been low in 2017/18 at 1.4% but had risen to 1.9% in the period April 2018 to July 2018.
- The percentage of inductions of labour was 22.2% in 2017/18, lower than the England average of 26.8%. But this had risen to 32.7% in the period April 2018 to July 2018 which was higher than average.
- The postpartum haemorrhage rate was low with 2.6% of women experiencing blood loss over 1500ml. The service did not breakdown obstetric haemorrhage for blood loss of more than 500mls, 1000mls and 1500mls. The only metric was over 1500mls.
- 50.5% of births were normal unassisted births which was better than the London average of 40%.
- The percentage of vaginal deliveries was 59.7% which was below the service target of 55.9%, although the RCOG recommendation was 70%.
- 24 % of women delivered in midwife led care. This was better than the national average of 14%.
- The home birth rate was low at 0.9% in 2017/18 and 0.8% in the current year to July 2018. The national average was 2.3%.
- There had been 218 unexpected term admissions to NICU in 2017/18, about 4%. The main indication for admission was respiratory distress. No neonatal re-admission rates for the period of April 2018 to July 2018 were recorded.
• For the period April 2018 to July 2018, the trust reported an average unexpected term readmission rate of 3.7%, which was lower (better) than the national average of 5%.

• The trust was amber on the still birth rate indicator (6.3%) per 1000 births. There had been three neonatal deaths in period of April 2018 to July 2018. In 2017/18 there had been 26 antepartum still births (after 24 weeks gestation) and 4 infant deaths during birth. The overall rate was 4.19 still births per 1000 births, but the rate had increased in the period from April 2018 to July 2018 to 6.36 still births per 1000.

• The proportion of birth out of obstetric unit births was significantly higher than in neighbouring hospitals at 24% 2018 in 2017/8 although this had fallen slightly in the period April to July 2018m to 22.5%. Homebirths were rising slowly but only 0.9% of births,

Although the dashboard showed some workforce data, staff sickness and vacancies, there was no information on the use of agency staff and the midwife to birth ratio was quoted as the funded establishment. This figure would be expected to vary with vacancies, turnover and sickness.

The rate of vaginal birth after caesarean section (VBAC was last audited in 2016 and was 62%. We were told this was normally audited every two years, yet it was not on either of the audit plans shown to us after the inspection. Similarly, documentation on the completion of epidural forms was due for audit following two separate SIs from 2017, but was not on either copy of the audit plans. That audit was on the list of overdue SI actions in May 2018 (the latest date for which we saw the overdue SI action tracker).

The trust provided data showed the percentage of low birth weight babies was higher than the London and England mean. In 2014, this figure was 4.4% compared to 3.2% in London and 2.9% in England. We did not see data for Newham hospital.

At the last inspection, we did not see effective systems to monitor the outcomes of local audits. On this inspection we did not see any audit results on display. There was an audit folder on the birthing unit but it contained no audit reports. Staff told us the service audited the transfer of women from the midwife led birthing unit to the delivery suite. In the period from April 2018 to June 2018 35% of women were transferred, mostly first-time mothers. This was higher than the average for transfer from alongside birth units which is about 26%. 36% of all transfers were for unknown reasons and for 46% of women the position for birth was documented as unknown, indicating a need to improve documentation.

We received from the trust after the inspection different undated versions of an audit plan for the year. The first we saw had 19 clinical audits, only one of which was complete. At least three had not started and four had missed their due date. Another plan we saw had many more audits but no status. There appeared to be a problem with version control.

In the 2017 National Neonatal Audit Newham University Hospital, performance in the two measures relevant to maternity services was as follows:

• Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids?

There were 157 eligible cases identified for inclusion, 93.8% of mothers were given a complete or incomplete course of antenatal steroids.

This was better than expected when compared to the national aggregate where 86.1% of mothers were given at least one dose of antenatal steroids.
The hospital met the audit's recommended standard of 85% for this measure.

- Are mothers who deliver babies below 30 weeks gestation given magnesium sulphate in the 24 hours prior to delivery?

There were 19 eligible cases identified for inclusion, 52.6% of mothers were given magnesium sulphate in the 24 hours prior to delivery.

This was higher than the national aggregate of 43.5%, and put the hospital in the middle 50% of all units.

(Source: National Neonatal Audit Programme, Royal College of Paediatrics and Child Health)

Trust wide maternity data in relation to modes of delivery is shown below.

From January 2017 to December 2018, the total number of caesarean sections across the three maternity units in the trust was similar to expected. The standardised caesarean section rates for elective sections were lower than expected and rates for emergency sections were similar to expected. However more recent data showed the trust was an outlier for emergency caesarean section.

<table>
<thead>
<tr>
<th>Standardised caesarean section rate (January 2017 to December 2017)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type of caesarean</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>-----------------------</td>
</tr>
<tr>
<td>Elective caesareans</td>
</tr>
<tr>
<td>Emergency caesareans</td>
</tr>
<tr>
<td>Total caesareans</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics January 2017 to December 2017)

Notes: Standardisation is carried out to adjust for the age profile of women delivering at the trust and for the proportion of privately funded deliveries.

Delivery methods are derived from the primary procedure code within a delivery episode.

In relation to other modes of delivery from January 2017 to December 2017 the table below shows the proportions of deliveries recorded by method in comparison to the England average:

<table>
<thead>
<tr>
<th>Proportions of deliveries by recorded delivery method (January 2017 to December 2017)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Delivery method</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>----------------------</td>
</tr>
<tr>
<td>Total caesarean sections¹</td>
</tr>
<tr>
<td>Instrumental deliveries²</td>
</tr>
<tr>
<td>Non-interventional deliveries³</td>
</tr>
<tr>
<td>Total deliveries</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics January 2017 to December 2017)

Notes: This table does not include deliveries where delivery method is ‘other’ or ‘unrecorded’.

¹ Includes elective and emergency caesareans
² Includes forceps and ventouse/vacuum deliveries
³ Includes breech and normal/non-assisted deliveries
From January 2017 to December 2018, the total number of instrumental deliveries and non-interventional deliveries were similar to the England average. (Source: Hospital Episodes Statistics (HES) – provided by CQC Outliers team)

The service took part most national audits, such as the RCOG project Each Baby Counts, bringing together investigations into stillbirths, neonatal deaths and brain injuries occurring due to incidents in labour.

Newham hospital took part in the 2018 audit and their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 total births) was 5.5. There is currently no national aspirational standard for this audit. The hospital was working with the Each Baby Counts quality improvement initiative and the CCG on how to address the risk factors caused by the co-morbidities of local women including obesity, smoking and diabetes in pregnancy. The rate of stillbirth was showing as amber on the maternity dashboard in the period April to July 2018.

We asked for an action plan for reducing still births. This was not an integrated preventative plan. It took the form of actions in response to specific cases such as feedback to staff about a particular event or “governance team to provide refresher training for GAP GROW recording”. There was a risk that staff would not understand the wider context.

The hospital had not taken part in the national pregnancy in diabetes audit in the past but was planning to do so.

We were told there was an ongoing epidural audit but were not shown this. A retrospective epidural audit sent to us after the inspection (covering 1 December 2017 to 28 February 2018) showed overall improvement to meet national standards in epidural waiting times of 30 minutes or less, from 52% in 2017 to 85.7% in early 2018. We noted that the doctor carrying out this audit found and reported high rates of missing data, missing notes and poor documentation in notes, so the findings may not have been wholly accurate. Notes reviewed at the weekly maternity multi-professional incident review (4 September 2018) we attended showed one woman had waited over four hours and one two hours in the previous week.

**Competent staff**

Newly qualified midwives had a two-week orientation and followed a nine month competency-based preceptorship programme to develop their skills. They were rotated throughout the maternity department including community midwifery, to develop skills in all areas of maternity. New midwives were given a supernumerary period and rotated through different maternity clinical areas.

A clinical practice facilitator and two clinical educators supported the education of midwives and preceptors.

Midwifery care assistants undertook a competency-based programme to support their development.

Although there were courses to support experienced midwives to develop their professional skills, some expressed frustration that few opportunities were available to attend external courses. There was some internal training available. The Alan Naftalin Newham Academic Faculty for women's Health (ANNA faculty) on site ran courses such as combined online and practical perineal suturing (COPPS) training, and a breech study day. Some midwives had been released to attend these courses.

The hospital had recently changed the CTG training package because staff had found the former training package daunting. There were arrangements to support staff with more training in
response to concerns about their interpretation competency in practice. The overall CTG training compliance for midwives was 97.75% and for doctors it was 93%. In October 2018 the trust told us that all who had not received training were signed up to a course at the end of September 2018. However we noted that CCG training was only available to 223 midwives whereas the total number of midwives was 256. This meant that some midwives were not competent to work on the delivery suite. There had been some changes to training following concerns about CTG interpretation (which was on the risk register until October 2018), and the results of a CTG audit earlier in the year. It was mandatory for all staff to attend a CTG Masterclass and the content was now part of mandatory training. Staff were encouraged to attend weekly CTG meetings and there was direct 1:1 feedback when missing data was found in individual midwives’ notes. A sticker had been developed for the start of CTG monitoring to prompt consideration of the need to escalate concerns. We did not see a review of the impact of the revised training on performance in CTG interpretation.

Following some poor outcomes in midwifery led units in 2017 a training package on intelligent structured intermittent auscultation (a systematic method of listening to fetal heart tones with an acoustical device to monitor heart rate) had been introduced to support midwives working in the birthing unit or facilitation home births. There had been no incidents since all staff had been trained.

There were 17 midwives trained on the NHS new born and infant physical examination (NIPE) checks, a thorough physical examination of a baby within 72 hours of giving birth, to see whether a baby had any problems with their eyes, heart, or hips. Staff said more NIPE trained midwives were needed as it was difficult to get paediatricians to review babies after 5pm which delayed discharge for some mothers and their babies. We were told a further six would be trained by March 2019/ Midwives used the NIPE Screening Management and Reporting Tool which provided a robust failsafe system as well as a consistent means of capturing data from the new born physical examinations.

Bereavement courses were run monthly for medical, nursing and midwifery staff in both obstetrics and gynaecology. Women with early miscarriage were managed on the gynaecology ward.

Midwives received support through the professional midwifery advocate (PMAs) which replaced the supervisors of midwives. There were four sessional PMAs. They were not on call, nor were they part of the education team, although they worked with the practice development midwife and their team to develop supervision.

Community midwives received the same training as other midwives, plus training focused on emergencies in the community. Bank midwives also received training. Another hospital in the trust arranged train the trainer courses in topics such as Practical Obstetric Multi-Professional Training (PROMPT).

Doctors in training reported having a full induction. They said they had daily training on wards and the delivery suite, and regular teaching and learning opportunities. They attended weekly risk management meetings and safety huddles where learning was shared. They said consultants were approachable and always willing to give advice. The doctors reported they also took part regularly in skills and drills for obstetric emergencies. Trainee doctors told us they felt supported by consultants and reported good access to supervision and advice.

Midwifery and medical staff within the maternity service said they were up-to-date with their professional revalidation.

91% of permanent medical staff and 100% of doctors in training had appraisals. However performance management and staff development appeared a lower priority for midwives. Rates of
appraisal among midwives were lower. 98% of midwives on the delivery suite had appraisals and 63% of community midwives and birthing centre staff, but only 6% of midwifery and other staff across the antenatal clinic, fetal medicine, screening and postnatal areas had appraisals. We were told after the inspection that the remainder were due to be completed by December 2018. From 1 April 2019 line managers were required to ensure appraisals were complete for any increments to their own salaries.

**Multidisciplinary working**

Obstetricians said they worked well with obstetric anaesthetists and other theatre staff as a multidisciplinary team. They also reported good communication with and support from specialists elsewhere in the hospital for women who had medical conditions that affected their pregnancy, for example diabetes or epilepsy. Multidisciplinary clinics were run for women with a BMI (body mass index) between 35 and 40 as they were at higher risk clinically during pregnancy.

Midwives handed over separately from doctors, and in the instance where we attended the two handovers consecutively there was some inconsistency between the two handovers, and evidence that communication between doctors and midwives was not always effective. Doctors also took a more active part in their handover than midwives. The teams had daily handovers on the delivery suite between changes in shifts (twice daily).

We saw evidence of multi professional engagement in the maternity weekly safeguarding meetings that supported identification and response to safeguarding concerns through reflective review. The team held weekly referral meetings where they discussed individual women. The team was linked with the East London perinatal mental health service to meet the needs of pregnant and postnatal women with moderate to severe mental health needs; however we noted that this team was not represented at two meetings in August where women with mental health needs were discussed.

Midwives and obstetricians had a close working relationship with the neonatal department. There was an HDU nursing team on the delivery suite, and regular contact with pharmacists.

A safety huddle each morning involved managerial midwives and doctors with representatives from antenatal, postnatal and the community. They discussed activity that day, staffing for the next three days, any safeguarding issues and potential discharges. The ward level equivalent was the shift handover.

Community midwives reported good communication with their hospital colleagues and being able to contact doctors for advice. They had little face to face contact with health visitors and told us the safeguarding team midwives would have more contact with health visitors, as well as with the local authority safeguarding team, family nurse partnership and social services. Patient records confirmed hospital staff communicated with GPs and the community maternity team on discharge.

**Seven-day services**

Triage, the birthing unit, delivery suite and antenatal and postnatal wards were open seven days a week, 24 hours a day.
Access to medical support was available seven days a week. Dedicated consultant cover was from 8am to 9pm during weekdays, and until 3.30pm at weekends on the deliver suite. On-call arrangements were in place out-of-hours.

There was 24-hour access to the dedicated obstetric theatre. Under a temporary funding arrangement, started two weeks before the inspection. We understood this was part funding of theatre team for the second theatre in the daytime between 8am and 8pm seven days a week. However, the escalation process provided after the inspection referred to this as 24/7 funding for emergencies. We found staff varied in their understanding of the new arrangement. However, there was not yet agreement at trust level to fund a second theatre in the long term, so staff had not been recruited. We were told after the inspection that between 19 September 2018 and 18 October 2018 the second obstetric theatre was opened for emergency obstetric cases on 11 occasions, for three forceps deliveries, five emergency caesarean sections, a third degree tear, a perineal suturing and an emergency cervical cerclage. This will have reduced delays for these women.

We were told the Maternity Quality and Safety Meeting would look at a thematic review of all datix at relating to the theatre to identify trends, and concerns would be escalated through the site Quality and Safety Committee.

Anaesthetic cover was available for emergencies on the delivery suite 24 hours a day, seven days a week in line with national recommendations. The early pregnancy unit was open every day from 9am to 5pm, and at weekends between 9am to 2pm.

A maternity telephone line was open for women to call for advice and support daily between 10am and 8pm. The MAU was open between 8am and 8pm on weekdays, by appointment, but triage was open 24 hours a day.

The hospital pharmacy provided a dispensary, distribution and ward service seven days a week, with a reduced service at the weekends and in the evenings. Normal working hours were 9am to 5pm on weekdays. There was an on-call pharmacist from 5pm to 8pm. Out of hours pharmacy cover was provided by one of the trust’s nearby acute hospitals which remained open 24 hours a day, seven days a week and urgent calls were directed through to them.

**Health promotion**

Little general health promotion material was displayed in the antenatal clinics or booking clinic areas, or on the wards to encourage women to live healthier lives and manage their own health and wellbeing.

Staff gave health promotion advice to women about conditions related to pregnancy such as gestational diabetes, breastfeeding, high body mass index and fatal movement monitoring in line with the local maternity priorities of maternal health, low birthweight among new-borns and the high prevalence of diabetes during pregnancy. Antenatal classes were run as five-week evening classes or an intensive two day course on the postnatal ward as well as breast feeding workshops. Staff also ran water birth workshops, a Dadi antenatal class for fathers and Relax for birth sessions.

The hospital did not offer influenza (flu) and pertussis (whooping cough) vaccination to women in pregnancy, in line with NICE *Antenatal care guidance*. Instead midwives encouraged women to obtain these from their GP. We saw posters and leaflets about these vaccinations on display in the antenatal clinic. It was surprising the hospital did not offer the vaccines when it was known that a number of women were not registered with a GP.
No records we reviewed contained information on smoking status, even though smoking cessation was one of the key local area objectives.

Breast feeding leaflets for breastfeeding support in the community from hospital staff and volunteers were seen displayed in the maternity unit. We saw leaflets on display in the post-natal ward for parents whose babies were having neonatal care and information about a charity supporting women with multiple births.

BCG (Bacillus Calmette-Guérin vaccine) was offered to all babies to protect them against tuberculosis. One room on the postnatal ward was designated for BCG vaccination, and this and hearing screening tests were completed before the mother and baby were discharged home. Women were given advice on after-care of the BCG vaccination site and a leaflet.

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

Staff understood their responsibility to seek consent from women for caesarean section and other procedures, including screening, the administration of medicines and blood samples. Women told us staff explained treatment and sought consent before proceeding.

The notes we reviewed included signed consent forms by women before procedures, and consent forms relating to the risks and benefits of caesarean section were clear. However, consent for epidural was less clear from the notes. We were told women were given a leaflet to read, and then the epidural observation forms were annotated by hand to say ‘consent ✓’. This was the only record of epidural consent in patient’s notes. Best practice suggests there should be a discussion of the risks and benefits of epidural analgesia, including information on late complications that may occur after discharge from hospital, with a summary of this discussion documented in the patient’s notes. We were not assured that all women were given adequate information to make informed decisions. We saw from incidents that there had been serious complications from epidural top ups for two women in July and August 2018.

We did not see written consent for photographs. In one case photographs had been taken of a woman’s perineal abscess, and the file contained a note that the woman had been shown the photograph afterwards, but no reference to her giving prior consent. We also found evidence in case notes that some consent was taken (for example for chorionic villus sampling) on the basis of translation by friends or family. On the delivery suite we saw staff waiting for a woman’s partner to arrive to explain the drugs that had been prescribed so that she could consent to taking them.

A midwife told us some women decided they did not want any screening or scans and their choice was respected.

At the last inspection we had found that staff were unsure about the law on mental capacity. However on this inspection we saw that staff addressed this through annual mandatory training on the mental capacity act and deprivation of liberty safeguards. However, a few staff we spoke with confused the mental capacity act, and deprivation of liberty with safeguarding. Staff were not aware of any DoLs applications.

Staff said that if there were concerns about a woman’s mental health they would refer the woman to the perinatal mental health team for further assessment as required.
Compassionate care

Women were cared for with compassion, respect and dignity. Feedback from women and their relatives was generally positive. We saw staff speaking with women and families in an appropriate and caring way, and introducing themselves.

We saw many positive comments on thank you cards displayed. This included, “Excellent care” and “Calm reassurance”.

We saw that curtains were used in all the bays in the maternity service. Women told us that staff always maintained their privacy and dignity. We observed most patients had the curtains pulled round their beds on the ward. Staff told us it was the women’s choice to pull curtains round for privacy.

We spoke to 10 women and their relatives during the inspection. These women and relatives were content with their antenatal and intrapartum care. Women we spoke to in the antenatal clinic told us they found the care to be kind, although "Waiting times can be long”.

Two women on the post-natal ward said all staff had introduced themselves when coming to visit patients, but another mother in the transitional care unit said some staff had not done so. One mother commented she had not seen midwives or doctors washing their hands before touching patient or baby. She thought they might have done this outside the bay.

Staff told us they sought feedback from women in a variety of ways: ‘I want great care’, NHS choices, through complaints and through “Maternity voices” volunteers who visited the maternity unit and gave feedback. We were told this feedback was shared with staff during team meetings and informed mandatory training. The midwifery group practice had recently set up a social media page to collect women’s views. The post-natal ward had less positive feedback from women than other parts of the service. We saw two different photocopied forms displayed in clinics to collect feedback, one A4 sheet headed FFT survey and another headed Patient satisfaction survey. They had different questions, which would make it difficult to collate results. We saw that an attempt to collect data using text messaging had not yet produced useful data. The trust hoped the new provider for FFT would ensure more responses were completed.

Friends and family test results were not displayed in all areas, and where displayed did not show the percentage response rate to indicate the validity of responses. The hospital provided more information after the inspection which showed response rates to the test had declined since the previous year. In December 2017 there were 166 responses about antenatal care and a 27.7% response rate to the survey on birth experience but in July 2018 there were 24 responses about antenatal care and a 5.2% response rate on birthing the period April to August 2018. Only 50% of women on the post-natal ward would recommend it. Not all staff were aware of the Friends and Family survey or where the information was recorded. We spoke with three mothers in the birthing unit who were happy with their birth experience and the support of staff.
The results below are trust wide:

From June 2017 to January 2018 the trust's maternity Friends and Family Test (antenatal) performance (% recommended) was generally worse or similar to the England average:

From June 2017 to June 2018, the trust's maternity Friends and Family Test (birth) performance (% recommended) was generally similar to the England average. However in the latest month June 2018 the trust performance for birth was 78% compared to the England average of 97%.

From June 2017 to June 2018 the trust's maternity Friends and Family Test (postnatal ward) performance (% recommended) was generally worse the England average.
From June 2017 to June 2018, the trust’s maternity Friends and Family Test (postnatal community) performance (% recommended) was generally similar to the England average.

Note: scores of 0% are due to data being suppressed because of low numbers of responses. (Source: NHS England Friends and Family Test)

The trust performed worse than other trusts for 14 out of 16 questions in the CQC ‘Women’s experiences of maternity services 2017’ survey which surveyed women who gave birth in February 2017.

<table>
<thead>
<tr>
<th>Area</th>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour and birth</td>
<td>At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?</td>
<td>8.03</td>
<td>Worst performing trusts</td>
</tr>
<tr>
<td></td>
<td>During your labour, were you able to move around and choose the position that made you most comfortable?</td>
<td>7.23</td>
<td>Worst performing trusts</td>
</tr>
<tr>
<td></td>
<td>If your ✓ or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?</td>
<td>9.21</td>
<td>Worst performing trusts</td>
</tr>
<tr>
<td></td>
<td>Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?</td>
<td>8.37</td>
<td>Worst performing trusts</td>
</tr>
<tr>
<td>Staff during labour and birth</td>
<td>Did the staff treating and examining you introduce themselves?</td>
<td>8.80</td>
<td>Worst performing trusts</td>
</tr>
<tr>
<td></td>
<td>Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?</td>
<td>6.83</td>
<td>Worst performing trusts</td>
</tr>
<tr>
<td></td>
<td>If you raised a concern during labour and birth, did you feel that it was taken seriously?</td>
<td>7.00</td>
<td>Worst performing trusts</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you spoken to in a way you could understand?</td>
<td>8.99</td>
<td>Worst performing trusts</td>
</tr>
<tr>
<td></td>
<td>If you used the call button how long did it usually take before you got the help you needed?</td>
<td>7.98</td>
<td>Worst performing trusts</td>
</tr>
</tbody>
</table>
Thinking about your care during labour and birth, were you involved enough in decisions about your care? 8.12 Worst performing trusts
Thinking about your care during labour and birth, were you treated with respect and dignity? 8.57 Worst performing trusts
Did you have confidence and trust in the staff caring for you during your labour and birth? 8.05 Worst performing trusts

<table>
<thead>
<tr>
<th>Care in hospital after the birth</th>
<th>Thinking back, do you feel that the length of your stay in hospital after the birth was appropriate? 6.19 Worst performing trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed? 7.53 About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your stay in hospital, how clean was the hospital room or ward you were in? 8.38 About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding? 8.17 About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your stay in hospital, how clean were the toilets and bathrooms you used? 8.38 About the same</td>
</tr>
</tbody>
</table>

(Source: CQC Survey of Women’s Experiences of Maternity Services 2017)

Staff reported improvements at Newham in so far as more women said they had been given birth options and more women felt they were part of the care decision. However more women than previously (17% compared to 6%) the previous year felt telephone contact was difficult.

Staff told us that the maternity survey results for Newham had shown that women had been critical of postnatal care at the hospital. Women in the survey said they were left alone when they felt they needed support and said it took a long time to get help when they pressed the call bell. One mother we spoke with on the postnatal ward said she had to repeatedly explain her situation to different staff, but another said the care on the postnatal ward was “Better than it was five years ago”.

**Emotional support**

Women we spoke with described mainly good emotional support.

Women who had suffered foetal loss or stillbirth were offered support from the specialist bereavement midwife who supported bereaved families in the event of a neonatal death or pregnancy loss at any stage of pregnancy after 14 weeks. The midwife was present in the hospital four days a week but was available by telephone at other times. There was no deputy to cover periods of leave or absence. She provided training for midwives and doctors and supported women and their loved ones from their initial loss, throughout their time in hospital and their return home. She also supported staff and staff told us they had timely access to the bereavement midwife when necessary. She also ensured women had support and advice up until the next pregnancy. The bereavement midwife ran regular bereavement clinics to support women.

There was a dedicated room for bereaved families where people could spend the night if they wished. A separate room in the scanning department could be used to break bad news.
The hospital had introduced a birth reflections clinic (debriefing service) run by senior midwives and a consultant obstetrician. Women could be referred to this about six weeks after a difficult birth, which gave women and their partners the opportunity to discuss and better understand concerns about their pregnancy or birth. We did not see this advertised, although staff said it was offered to relevant women.

Counselling was offered to women whose initial screening results meant they needed to make a further decision about diagnostic testing. For example, when screening indicated that the baby may have Down’s syndrome. Midwives could signpost women to national and local advisory groups such as the Down’s syndrome Association, Tiny Tickers (a charity relating babies with congenital heart conditions) and Sands (stillbirth and neonatal death charity), to offer both practical advice and emotional support to women and their families.

The multi-faith hospital chaplaincy service provided spiritual care and support for patients, partners and relatives as needed. Staff told us there was chaplaincy support for the religions that reflected their population, and there were good relations with the local imam.

Two mothers said they found staff in triage “A bit dismissive” of the concerns of first time mothers and less understanding than they had hoped. One person complained of the wait for a caesarean section and lack of clarity about the expected timing. Women thought the postnatal ward felt short-staffed, and women thought they did not have enough support.

The information on women’s’ perception of safety in the Maternity Safety thermometer indicated that the proportion of women who were left alone at a time that worried them and with concerns about safety during labour and birth that were not taken seriously were higher, even on the limited data sample, than national standards.

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

Women we spoke with said they had been involved in decisions about their choice of birth location and the benefits and risks of each. They felt staff supported their decisions.

Women said they had been given clear information in clinics and were encouraged to ask questions. Women mentioned that antenatal clinic noticeboards were a source of information for those who could read English but did not meet the needs of all women attending.

Women said they had good support around the choice of place of birth, including home birth, although the home birth rate was low (0.9%). Minutes of the Maternity Voices partnership meetings indicated low awareness of the Barking Birth Centre. No women we spoke with were aware of the option to give birth at a different hospital across geographical boundaries. However staff said they had leaflets that informed women of all four choices of birth place (Home, Barking birth centre, Newham midwifery led birthing unit and the delivery suite). These were given out and discussed with women at booking and during their birth planning meeting between 34 and 36 weeks.
**Is the service responsive?**

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

Staff were very aware of the diversity of the local population and the diversity was reflected in the staff. 76.7% of women who give birth in Newham are born outside the UK, compared to a London average of 58.1%, and over 130 languages are spoken in the area. The borough has the UK's lowest proportion of white British people (16.7%), the second largest Bangladeshi population, and fourth largest Black African population. Newham hosts the second highest proportion of Muslims and the seventh highest Hindu population. 40% of the population had affiliations with Christianity. Staff emphasised the demands on the service in terms of the need for interpreting services, different cultural norms, sometimes complex health needs and a range of different expectations of health service provision.

All woman we spoke with said they were given a choice of birth location, and records confirmed discussions were held. Women we spoke with on the postnatal ward and in the hospital antenatal clinic reported seeing many different doctors and midwives, and several said they did not have a named midwife. However managers assured us this would improve as they now aimed to provide women with a named midwife by 16 weeks. Staff aimed for all women on the low risk pathway to have a named midwife and see no more than three midwives throughout the antenatal and postnatal period.

Staff accepted there was less continuity for women with more complex needs who were seen in consultant clinics. The intention was that all such women would have a named midwife who they would see for three key appointments. This would give women the opportunity to develop a personalised birth plan. There was not yet an audit to assess how the new continuity policy was working.

Specialist midwives were available for women in vulnerable circumstances and for women with HIV and other infectious diseases. A maternity helpline offered easy access to advice for women that were pregnant. We were given examples of the service being able to reassure women or signpost them to other services so that they did not come to hospital unnecessarily. Although Barts Health produced a range of leaflets in English, few were on display. There was very little information about maternity services at Newham on the hospital website.

Women were given an information pack when they were booked for maternity services. Tours of the maternity unit were run weekly for women to see the facilities, and to ask any questions. A helpful cartoon style video about pregnancy and birth was playing in the booking clinic. There were baby changing facilities and women only toilets, as well as toilets for visitors. Drinking water was available.

The booking clinics were all held in the hospital and booking was done by hospital midwives. There was no option for women to have their booking appointment nearer home. Women’s medical history, scan and blood tests were done at one appointment, so reducing the need for many women to come to the hospital more than once. There were no play facilities in either the booking clinic or the antenatal clinic and women were discouraged from bringing children. There were more male than female sonographers, which did not meet the cultural needs of women and families. Although some midwives were interested in training as sonographers funding limitations had prevented training more female sonographers.

For anxious women who presented more than three times for triage, there was an early labour suite in the birthing unit.
The delivery suite and birthing unit had large well-equipped birth rooms. The birthing unit environment was spacious with colourful chairs which gave a relaxed feel. Rooms had bean bags, and other equipment they could use to sit in different positions and birth pools to promote the comfort of women in labour. Women could play music during labour. Lighting was dimmable.

On Larch ward partners could stay overnight in a chair if they agreed to accept certain rules, such as remaining in the unit after 10pm and not disturbing other people on the ward. Staff said that behaviour had been a problem before the contract was introduced a couple of months before the inspection. Compliance was now good and there had been no recent need to summon security. In the day time there was a quiet period between 12pm and 2pm when women could rest. A number of the single rooms on Larch ward could be used as amenity rooms where women could pay for the use of a single room.

From October 2016 to September 2017, the trust’s bed occupancy levels for maternity were generally higher than the England average, but from October 2017 to March 2018, the trust’s bed occupancy for maternity was lower than the England average. At Newham the postnatal ward was full during the inspection.

The chart below shows the occupancy levels compared to the England average over the period.

(Source: NHS England)

Data since April 2018 showed most women were discharged between 5pm & 8pm with only small numbers, 13 or 14 women, discharged before 12pm. Staff told us they aimed to discharge women before 7pm but this was not being achieved. In addition, 145 mothers in that six-month period were discharged at varying times between 9pm and 8am which would have been disruptive for other inpatients. The service did not audit discharge times to seek improvement. We saw that discharge summaries were sent to health visitors and GPs, including information about the woman’s pregnancy, labour and postnatal care, any medications they had been prescribed, and any ongoing risks and/or follow-up care needed.
The red book was given to mothers on discharge. The red book is a national standard health and development record and is used to monitor growth and development of the child, up to the first four years of life. Staff completed these to pass on information to the health visitor.

Women had a choice of meals as inpatients, and some choices were available outside of set meal times for women who had recently given birth. In the August 2018 patient led assessment care environment (PLACE) survey, the ward scores for food at Newham were 98.7%. This was above the average for acute hospitals (90.55).

There was a waiting area for visitors outside the postnatal ward, where people could wait if the woman already had the maximum of two visitors.

**Meeting people’s individual needs**

The early pregnancy assessment unit (EPAU) offered a one-stop service with a full range of medical and surgical treatment options to manage miscarriage and ectopic pregnancy. It was open every day to support women experiencing complications in early pregnancy (less than 18 week’s gestation), such as miscarriage or ectopic pregnancy. There was a quiet room for counselling. The unit was located at the opposite end of the hospital from the maternity ward and had its own scanning facilities which ensured that women did not need to go to the antenatal area. Women were advised to attend the emergency department out of hours. Women were referred by their GP or from the emergency department, and could refer themselves if they had had two previous miscarriages, or a previous ectopic or molar pregnancy. Women in early pregnancy who needed admission were seen on Becton gynaecology ward. Staff said sometimes there was a wait for a bed and despite efforts to agree a standard pathway for women who met the requirements for admission, when there was no bed on the gynaecology ward, no resolution had been found at the time of inspection. This meant clinic staff sometimes had to stay late on the unit to care for women until a bed became available.

Women who had suffered an intrauterine death in late pregnancy were seen on the delivery suite. Women were given options about the disposal of pregnancy remains in line with the guidance from the Human Tissue Authority.

There was wheelchair access to the wards and antenatal clinic, and accessible toilets and showers which were suitable for people with reduced mobility. There was designated parking for patients with disabilities.

Healthwatch Newham’s 2017 report into Newham Hospital Maternity Services identified a number of areas of patient concern, including breast-feeding, communication and staff attitude and care and concerns about problems experienced by women with sensory impairments. The hospital had responded to this with increased staff training a specific action plan to support deaf patients, but we noted that in May 2018 staff had not known how to obtain a sign language interpreter. We noticed a deaf awareness poster on Larch ward.

The maternity service had adequate arrangements to support women with learning disabilities and with mental health and with medical conditions such as diabetes, HIV, blood disorders, and high BMI. Teenagers were supported by the family nurse partnership. Support for women who misused substances were provided in conjunction with local substance misuse advice services. Midwives could refer women who did not have a suitable support network, to Maternity Mates, a community health charity that provided practical and emotional support to women from trained volunteers.

There were joint clinics for women with cardiac problems, and for haematology and rheumatology, and fetal medicine clinics. Some women with specialist needs were referred to another hospital in the trust.
Newham ranks 3rd in the UK in terms of those for whom English is not their first language and who cannot speak English at all. Staff could arrange interpreters, with notice, and bilingual health advocates were available to give face to face interpreting and cultural support for many women for whom English was not their first language. Health advocates were available Monday to Friday. Out of hours staff could use a telephone translation service. However, we found evidence of friends and family members being used for translation which was not good practice. Community midwives tried to offer flexibility in appointments and to offer longer appointments where telephone translation was needed, to ensure they had time to gather all relevant information.

Although there was a small welcome sign in many languages in the antenatal clinic, all other written information was in English. The back of all trust and hospital leaflets gave information about alternative formats and translation. However, we saw no signs in other languages to tell women about this. There was a local plan to improve dissemination of information to expectant women, specifically in relation to safety, through translation into more languages. Midwives at Newham were not aware of this. We saw staff in the delivery suite mentioning a woman’s limited English at handover, but there was no suggestion of using language line. Staff were waiting for the woman’s partner to arrive so he could explain. The bereavement midwife told us she used online translation service to provide translations into over 90 languages when an advocate was not available.

There were more male than female sonographers. Some women had a strong preference for female clinicians when gynaecological examinations were necessary due to ethnic, religious or cultural background. Where time allowed this preference was respected.

Two transitional care bays (each with 6 beds) were available for women whose babies needed additional nursing care and monitoring so the baby could stay with their mother rather than being in the special care baby unit. This was under the joint care of the neonatal and maternity team. In 2017/18, 1008 babies had transitional care but the figures were growing and in the four month period April 2018 to July 2018 there had been 947 transitional care admissions.

The service had a small bereavement room with a double bed where a woman and her partner could spend time before going home. A cold cot was available to cool the baby so the bereaved parents could spend time after losing their baby during pregnancy or soon after birth. This was known as the butterfly room and was away from the main ward, with a shower and toilet next door which a couple could use, but the room was not ensuite. There was no emergency bell in this room so it was not suitable for postnatal women about whom there was a medical concern. Midwives said some women preferred to stay on the delivery suite.

Memory boxes were provided to women who had suffered a loss. This could include photographs and hand and foot prints in line with national recommendations (Sands Stillbirth: how professionals can make a difference, 2015). A charity sponsored a professional photographer to take picture of the baby if the family wished. The trusts bereavement policy took account of different faiths and cultures in how to deal with death. Arrangements were in place to ensure documentation needed to help with the registration of death was handled swiftly to ensure burial could take place quickly for people who required funerals for cultural and religious reasons. The hospital’s multi-faith chaplaincy service offered support to parents who faced the loss of a baby. Representatives of various denominations were available.

The service was offering minimally invasive autopsy by magnetic resonance imaging (MRI) instead of a conventional post-mortem when a baby died. This was more acceptable to families in some cultures and religions as a way of finding out, if possible, why their baby died and still
allowing a swift burial. This information can be important in trying to prevent further bereavements occurring, if the parents have another baby. Staff told us that feedback received from women having bereavement care within the last two years indicated their appreciation of the service.

Two quiet multi-faith rooms were open 24 hours a day for people to pray or reflect.

**Access and flow**

Flow through the unit had been identified as a problem at the inspection in November 2016 with many reports of women waiting for beds in the postnatal ward after delivery, other women waiting in the antenatal ward for admission to the delivery suite and procedures including caesarean sections were delayed by the fact there was only one theatre. Staff said the flow through the delivery suite would improve with the increased capacity from a second theatre, however there was no indication that staff had considered the impact on the postnatal ward. Staff told us women often had to wait on the delivery suite for beds on the postnatal ward. On the unannounced inspection the postnatal ward was full, although the ‘extended beds’ — extra beds in a normally closed bay were not in use. There did not appear to be sufficient staffing to open the “extended beds”.

Women accessed the maternity services via their GP. Patients could also self-refer to the service by collecting and completing a booking form at the hospital, but there was no option online referral option. About 40% of women self-referred. The service then contacted the GP, if the person was registered with a GP, for the medical history. Women from outside the area were seen at the antenatal clinics in the maternity unit.

Staff had sought to encourage GPs, through meetings and written communication, to refer women earlier to the hospital so they could have time-critical screening tests recommended in NICE guidelines. This had led to an increase in women seen below 12 weeks.

After their booking appointment in the hospital, women were allocated to a named midwife in one of the four community midwifery teams in the area where they lived. Depending on clinical need women were streamed into low risk (midwife-led care) or high risk (consultant led) pathways. Community midwives undertook all antenatal care of low risk women. Midwives emphasised to women the importance of regular attendance at antenatal appointments and followed the safeguarding team’s protocol on women at risk who missed two or more appointments. This included midwives making home visits. All women who missed appointed were contacted to rearrange their appointments, although staff were aware of instances where contact was not successful.

There was no dashboard data about the proportion of women who cancelled appointments, or when they were cancelled by the hospital, yet we saw that both these events occurred. No work had been undertaken to understand why women cancelled or to offer appointments at times that might suit them better. There were no hospital clinics at weekends or in the evenings.

Continuity of care required improvement and the unit had recognised this. Plans were not yet having an impact for many women. A midwifery group practice operated primarily in the E20 postcode area, although staff currently saw women in the hospital because no base for them had been found in E20 which meant women had to travel out of their area. The women could expect to see their named midwife for the majority of their antenatal, intrapartum and postnatal care. This would benefit about 2% of women increasing to 10% by 2020. For other women continuity of care began after the booking appointment, and did not include intrapartum care.

Midwives in the Maternity Assessment Unit (MAU), open 8am to 8pm, saw women over 18 weeks of pregnancy with concerns such as rupture of the membranes, bleeding, reduced fetal
movements or high blood pressure. The MAU service was appointment based, and had four bays. A doctor from the delivery suite covered MAU and triage.

A variety of specialised clinics were run in the hospital for whose pregnancies were higher risk. Birth would be on the consultant led delivery suite. Women attending antenatal clinics did not receive text reminders, only a letter. We were told that an extra diabetic clinic was to be added because the current Friday clinic was too crowded and women had long waits, up to two hours. We were sent, after the inspection, a retrospective audit of time spent in different clinics between June and August 2018. Waiting times were longest for the diabetic clinic. The audit did not show the percentage of women seen on time, only total time in the clinic. The audit showed that for some clinics up to 20% of women failed to attend appointments, although another return the hospital provided after the inspection said the percentage rate of DNAs to clinics for 2017 -2018 was 10.3%.

Triage was open 24 hours. The target was for midwives to give an initial assessment within 15 minutes, and then prioritise women for full assessment according to a RAG rating. Only about a third of women were seen with 15 minutes in September 2018. Women in labour were admitted to the delivery suite through the maternity triage, unless they arrived in ambulance. They were assessed by a midwife and transferred to the delivery suite if needed. Low risk women in labour might be triaged in the birthing unit. If a woman was not thought to be in labour they were invited to return for an appointment within two days. There was an audit of waiting times in MAU and triage underway but no results were yet available.

Elective caesarean sections and delivery suite inductions of labour were undertaken on Monday, Wednesday and Thursday afternoons and on Tuesday mornings. There was no specific elective caesarean team so there could be delays if staff were involved in emergency caesarean sections. The maternity assessment unit (MAU) was open from 8am to 8pm on weekdays for assessing women referred by GPs and triaged for monitoring. On our inspection in 2016 women who came for induction of labour were sometimes asked to return home or had to wait until a bed was available on the antenatal ward. A recent audit showed 50% of women still had to wait for a bed.

Staff told us they had births for women admitted in advanced labour when it was unsafe to transfer to the delivery suite, and sometimes women who had a quick labour after induction. There was a room on Larch ward that could be used. This was used once in July and August 2018, and nine times in year 2017-2018.

Staff told us flow through the maternity unit sometimes caused problems because there were not enough postnatal beds and woman had to wait longer in the delivery suite. This could impact on their care because midwives in the delivery suite necessarily focused primarily on women in labour.

Discharge arrangements on the postnatal ward had been a concern at the previous inspection as shortage of administrative staff had meant women were regularly discharged without discharge paperwork. This process had improved. We saw from the performance review for March 2018 that 97.3% of women had completed discharge summaries. There were sometimes delays because patients had to wait for pharmacy to prepare their medication. There was no area where women could wait in before they went home, which would enable them to vacate postnatal beds earlier.

Some women had complained that no community midwife visited them after they were discharged home. Staff were aware that some discharges were not being reported to midwives in the correct area, so those women missed their post-natal check from midwives. Staff said this was recorded as an incident when discovered and escalated to the band 7. There had only been one incident.
since system changes had been made in March 2018. We saw information displayed informing women to expect a visit within 24 hours and, if they were not visited, to call the maternity helpline. The maternity unit had closed seven times in 2017/18 and twice in the period April 2018 to July 2018.

Women were helped to develop birth plans according to their level of risk; these ensured that they were cared for in the most appropriate area during labour. Women who were low risk followed the midwifery led pathway and could go home after six hours from the birthing unit if staff felt they were ready.

**Learning from complaints and concerns**

Information about how to report concerns was available to women and families. We saw leaflets from the patient advice and liaison services service (PALS) around the hospital, although not specifically in the maternity unit. We asked four women and a woman’s partner whether they knew the procedures for raising complaints and concerns. All were aware of the processes and the availability of the (PALS), and none had any significant complaints.

Staff told us they always tried to resolve concerns locally. If a woman or their family had a concern, women were encouraged to speak to midwives directly in the clinic or the ward.

From April 2017 to March 2018 there were 44 written complaints about maternity services at Newham University Hospital. The trust took an average of 61 days to investigate and close complaints. This was not in line with their complaints policy, which states complaints should be completed between 10-60 days. Complaints were overseen by the site governance team, but there were not sufficient resources to keep on top of complaints. The number of complaints was recorded in the maternity dashboard although informal complaints were not represented here.

The top three maternity areas with the most complaints were:

- Larch ward (postnatal): 24 complaints
- Antenatal clinic: five complaints
- Maternity assessment unit: five complaints

Diagnosis and treatment was the leading cause of formal complaints. Other themes were inadequate care to women and babies on the postnatal ward and lack of information prior to giving birth and afterwards, particularly when there were complications surrounding birth. Staff expected that the birth reflections clinic would ensure effective debriefing of women when things did not go as planned, and reduce complaints about this.

We saw that women complained about waiting times in antenatal clinics and that the area needed renovation. Delays in care were a cause of complaint. There had been some complaints about staff being abrupt with women both face to face and on the telephone. In the antenatal ward we saw that one of the things for staff to work on was ‘Being kind’. We also saw that telephones were labelled with advice on answering the phone politely giving name, designation and asking ‘how may I help you’ to improve the impression staff made when answering calls.

PALS also recorded informal complaints and reported these to the maternity service monthly at the delivery suite forum. Staff told us communication and staff attitude were causes of complaint, as well as appointments and clinics. Other examples of complaints related to facilities such as a blocked sink.
From April 2017 to March 2018, there were 39 compliments given to Bart’s Health NHS Trust. No site or core service breakdown is available. On the birthing unit and delivery suite at Newham Hospital we saw numerous thank you cards on display. In May 2018 there were 156 complaints and 2 compliments.

**Is the service well-led?**

**Leadership**

Organisationally the trust was responsible for overall strategy, planning and oversight of services across the hospitals in the trust. A cross-site clinical network for women and new born health brought together multidisciplinary clinicians, and reported to the clinical board for women and new born health. A director of midwifery worked across the sites and provided oversight of all maternity. The chief nurse was the designated board member for maternity services. The head of midwifery at this site did not have direct access to the trust board.

The maternity services were part of the Women’s and Children’s services, which included gynaecology and paediatrics. A general manager for women’s and children’s services, a clinical director and the head of midwifery ran the service at Newham Hospital.

The head of midwifery was supported by two consultant midwives, two matrons, as well as by specialist midwives. Governance and safeguarding lead posts were vacant. Below the head of midwifery were several layers of management. Each day there was a designated ‘manager of the day’ in addition to the delivery suite manager, midwife managers for low risk women, and for high risk women. In addition, there was a manager on call. Some staff were unaware of the manager of the day.

Senior leaders demonstrated knowledge of the service’s challenges and performance at a high level, but showed insufficient awareness of weaknesses in some basic processes. These weaknesses were evident from incident reports including serious incidents and from direct observation. Variation during the year in response times to complaints and serious incident investigations, indicated there was still not a sustainable solution to managing performance in these areas. Although the backlog of serious incident investigations had reduced, the two most recently completed investigations had taken eight and six months to complete and actions to embed learning had not been completed.

Following the inspection, the trust told us of a planned multi-disciplinary improvement programme, based on a model successfully used elsewhere in the hospital. The plan would be owned by the leadership team for the Women’s and Children’s Division with leaders across the Maternity service taking responsibility for different aspects of it. This would include learning and development for leaders.

At previous inspections there had been concern about the visibility of senior staff, we heard on this inspection that senior managers were visible within the unit, although they did not work clinically. Staff said the management structure was hierarchical and cut off from the everyday experience of midwives.

The head of midwifery held monthly open meetings. From the minutes these seemed to be predominantly training sessions but also gave staff a chance to say what was working well and what was working less well. Some staff told us managers were not very receptive to staff raising concerns. At ward level, leadership was not effective in setting and maintaining high standards.
Due to persisting concerns we found in the governance and safety of the maternity service that had not been addressed since previous inspections, we issued the trust with a Section 29a Warning Notice (Health and Social Care Act 2008) following this inspection. The trust developed an action plan in response to our Warning Notice outlining immediate steps they were taking to address the concerns. The trust also made changes to the leadership structure, that included the trust director of midwifery directly moving to Newham to drive improvement. In addition, the trust were receiving support externally from NHS Improvement and the Newham Clinical Commissioning Group.

A follow up inspection of maternity services at Newham University Hospital on 14 and 15 January 2019 assessed progress in response to the Section 29a Warning Notice we issued to the trust. We found that appropriate steps to address these concerns had been taken and there was evidence of improvement to the safety and governance of the service, albeit that these areas would require a sustained focus.

Medical leadership appeared strong and effective. Doctors in training said consultants were supportive and accessible, and they were encouraged to ask questions. Obstetricians and anaesthetists worked well as a team.

**Vision and strategy**

The trust vision was to be a high performing group of hospitals renowned for excellence and innovation, providing safe and compassionate care to our patients in East London and beyond. There was not a well understood vision for Newham maternity services. We were told after the inspection that engagement events were planned, involving as many staff as possible to develop a vision for the service and share improvement ideas.

There was a clearly defined overarching strategy for the trust’s maternity service in the context of the local maternity system for North East London (LMS), set up by NHS England to bring together providers and commissioners of the programme to improve care aligned with the national clinical strategy in “Better Births, Improving outcomes of maternity services in England” (February 2016) to improve patient choice and experience. The key priorities for women’s experience were to increase choice, improve continuity of midwife care and to increase the number of patients giving birth in home and midwife-led

The trust was seeking to improve continuity of care and monitoring this through a trustwide group. At Newham, a small a pilot ‘group practice’ had a small team of midwives to provide continuity of care for women through antenatal, intrapartum and postnatal care for women.

**Culture**

Most staff we spoke with were reasonably happy working at Newham Hospital, and those in the birth centre and group practice were particularly enthusiastic about their work. Some staff had worked in the unit for a long time and told us the hospital “Feels like a family”. However, the fact that long serving staff had little experience from outside this unit meant there was a strong risk of complacency about working practices and unwillingness to learn and develop. Many staff described good relations with their immediate colleagues but less good relations between staff at different levels and between different parts of the unit. For example, staff said and we saw from incident reports that staff could be reluctant to move between areas at times of staff shortage, and that it was not easy to persuade staff to accept women onto the antenatal ward.

Several staff described a “Last minute” culture, in which managers sought to solve longstanding problems with quick fixes. We observed this. Other staff described an acceptance of
“Retrospective” recording where staff regularly completed records some time after the event. There was not a culture of continuous improvement.

At the last two inspections, we had remarked on staff morale, which was seen to be improving at the inspection on July 2017. We were told the staff survey had shown better engagement of staff with the maternity service than other trust sites, and more staff felt supported by colleagues and line managers and that communication was good. Midwives acknowledged some recent improvements in staff support, for example through the Caring for You campaign. Senior staff reported observable improvements in emotional well-being and reduced incidence of back pain from this campaign. Staff also mentioned mentorship and better mandatory training. The first ever Band 7 away day had been held in 2018, which staff appreciated.

However, we found mixed views among staff who said that management at all levels, and communication still needed improvement. Some made allegations of passive bullying and harassment. They said that having ideas accepted depended on “If your face fits”. Several staff alleged others; including senior midwives had left the hospital because of this behaviour. Staff sickness had recently risen to 7%. Sickness can indicate poor morale. Although staff knew how to raise concerns if they were unhappy with anything in the service, some told us they did not have confidence in these systems, and gave examples of where they had asked for investigation that had not taken place.

A SCORE survey in maternity was undertaken in April 2018. This survey is a recognised way of measuring and understanding culture that exists within organisations and teams. The response rate was only 24% overall so the results may not have been representative. Low response may indicate low engagement. The highest response was from managers and specialist midwives. This may have been reflective of historical cultural issues. There was a Newham-wide ‘Culture and Leadership programme to bring to life the trust values, including the development of values-based recruitment. This involved developing a shared understanding or what constituted bullying and harassment, improving reporting and being seen to take firm action. We were told after the inspection of a renewed effort to define the target organisational culture for maternity and what needs to change to achieve this.

The working relationship between midwifery and medical teams appeared generally positive. Medical trainees we spoke to told us they felt well-supported, valued by colleagues and consultants and enjoyed working in the hospital. They reported a good working atmosphere and a culture of providing mutual support. Staff spoke positively of the leadership by the clinical director for obstetrics and the obstetrics clinical lead.

**Governance**

We were told that a new governance structure of the maternity had been introduced after the last inspection. Midwifery management had been reduced from 11 posts to 10 with the audit midwife no longer part of the team. Six of the staff were new to post.

At the July 2017 inspection, we found there was still a need to improve and strengthen site level governance structure and reporting systems. Good governance requires structures and processes to lead, direct and control the quality of service. This includes identifying and minimising risk, ensuring that the required standards are achieved, investigating and responding to sub-standard performance, driving quality improvement and sharing best practice. The absence of a governance manager may have contributed to a lack of drive to improve governance at the time of the inspection.
Management of the maternity service was reactive in response to adverse events. We observed firefighting rather than strategic planning for improvement, and limited engagement of staff at the front line in devising solutions. For example a new form (a sticker to include in notes) was introduced overnight during the inspection in response to an SI in which incomplete intrapartum documentation was a concern. This was a checklist staff to midwives to ensure all documentation; labour notes, mother and baby postnatal notes, the red book and the transfer list were completed. It was to be used forthwith. However, we did not see this form in use in the records we reviewed at the unannounced inspection. We saw from the incident reports that another new form, a transfer checklist was created in August 2018 to remind staff to check feto-maternal haemorrhage (FMH) in order to gauge the dose of anti-D immunoglobulin (anti-D Ig) required, and to give the anti D injection within 72 hours. These forms were specific to Newham Hospital and had not gone through consultation. There was no version control, and no logo. The service had no clinical records lead to ensure that any forms developed locally met the trust's record keeping standards, were piloted, and approved by a documents group before issue.

Governance processes did not provide sufficient assurance that senior staff had a sustainable plan for all performance issues within the service. Performance rated red on the maternity and governance dashboards was not reflected in local or maternity wide risk registers so that mitigations and performance improvements could be highlighted, and improvement tracked.

The trust did not have effective systems to draw together information held in different places. We saw different undated versions of an audit plan for the year. There did not seem to be any link between audits stemming from SIs and other audit plans drawn up by the service, so audits in response to SIs appeared to be monitored separately from the other audits. The service sent us a number of audits that were completed in September 2018 that were not on the service’s audit plan.

There had been a tradition at the hospital of not sharing overall performance information with staff. We had remarked on this in previous inspections. This was not in line with the governance standards of the RCM (2016) which says information should support midwives and other clinical staff to have access to the relevant data to assess and improve outcomes. The maternity dashboard, governance dashboard and risk register were not displayed in staffrooms, only simplified versions of these. Communication to staff seemed to be about discrete events rather than giving a performance overview. However, governance noticeboards were introduced in June 2018 were a recent attempt to share information, but many staff seemed not to understand the relevance of governance to their day to day work. Managers said a governance newsletter was sent to staff quarterly but there was no current newsletter displayed on the governance boards.

Following the inspection, we issued the trust with a Section 29a Warning Notice (Health and Social Care Act 2008) due to the lack of improvement with governance and safety arrangements in the maternity service. The trust developed an action plan and told us of immediate steps they were taking to address the concerns. To strengthen governance a weekly maternity executive oversight group was introduced to oversee improvement, chaired by the managing director and regularly attended by the chief nursing officer and chief medical officer. Five sub-groups were introduced to specifically look at improvements to data, documentation, governance, rota planning and daily routine.

Management of risk, issues and performance

There was not a complete register of all risks within maternity services. In the November 2016 inspection gaps had been a concern and this was still the case at this inspection. The audit programme was not related to risk and did not ensure that cyclical improvement was established.
This meant governance processes did not provide sufficient assurance that senior staff had a sustainable plan for improving key performance issues.

Access to a second theatre had been at the top of the risk register at both previous inspections and had been on the Newham Hospital risk register since July 2013. CQC had said at the last inspection the hospital should consider funding for staffing a second obstetrics theatre to improve waiting times for caesarean sections and other procedures. Progress had been extremely slow, despite the growing number of caesarean sections at the hospital. The hospital had told the Newham scrutiny group in March 2018 that agreement to the second theatre had been obtained, but it was not until late August 2018, two weeks before this inspection, that the theatre came into use. Senior staff said their expectation was that permanent funding would replace this. Some staff were not clear about how this arrangement was to work, or how long it would last.

We did not see the risk register during this inspection although the four top rated risks (rated 16, the top rating) were on display on an undated poster, but with no information about mitigation. The risk listed were intrapartum CTG interpretation, access to a second theatre team, the storage of anomaly scans, and accommodation used by community midwives for clinics. At the last inspection security of women and babies had been identified as a risk. The 2017 Internal Audit review concluded there was reasonable assurance of maternity security at Newham and the risk had been appropriately downgraded.

After the inspection the hospital provided a risk register for October 2018. This contained only two top-rated risks both relating to foetal medicine: storage of anomaly scans and aging ultrasound machines. The next highest risk was shortage of ultrasound machines and sonographers. The second theatre risk had been reduced to 9. Other risks such as the level of caesarean sections, high sickness absence and delays in SI investigation and follow up actions were not on the risk register.

The divisional performance review provided the monthly opportunity to monitor the quality of service provided to women at a high level. The main governance meeting was the Women’s Health Quality Assurance and Safety Committee. We reviewed minutes of these meetings. The agenda followed a standard template to cover all topics. For each meeting an action tracker covered the current risk register, serious incidents (SIs), overdue, incidents, complaints and compliance with NICE guidance. However, the minutes were brief, with no discussion or actions appearing to stem from the meeting. There was no recorded review of progress on points raised at the previous meeting. No actions were allocated to staff for follow up and there was no evidence of challenge to the information presented.

We found weak arrangements for covering work in staff absence. For example, there had been no caesarean section review in August 2018 because of staff absence. We saw a recent incident reported where cover had not been arranged for an out of hours manager on call who was unwell; and where items on the management meeting agenda did not have a representative present, the topic was not covered.

The service was not meeting professional standards for documentation and record keeping which limited the value of data. As at the last inspection, serious incident reviews and incident reports had highlighted incomplete patient records as an ongoing problem. Several presentations at the weekly risk meetings mentioned quality of patient notes, and from our own reviews of case notes we saw incomplete documentation to be a continuing issue. An audit of a sample of antenatal, intrapartum and postnatal records carried out by the service after the inspection, in September 2018, showed a number of weaknesses similar to those we identified on our inspection. Following this audit, an action plan was drawn up to manage the themes identified. There were plans to
tackle documentation standards through training, including one to one. The audit that mentioned documentation was on the trust risk register, although senior staff did not tell us this during the inspection when we raised concerns about documentation. It would seem appropriate to reflect quality of documentation on the hospital risk register too.

Alongside ward dashboards the hospital used the ‘perfect ward’ app as a digital tool to evidence clinical quality and identify opportunities for improvement. We did not see results on display but the integrated performance report for September 2018 reported on quality and practice around the fundamentals of care. Larch ward made no returns in June, July and August, and scores in May 2018 had been low, for example 72.2% for effective and 76.8 for well led. The inconsistent performance in basic safety processes indicated that expectations were not set high enough and monitoring by senior staff was ineffective.

The CCG held regular meetings with Newham site maternity team to review performance and quality.

**Information management**

We were not confident that accurate information was being effectively processed, challenged and acted on. We found inconsistency between information quoted in different places, for example the caesarean section rate, appraisal rates and different versions of the status of audits. This conflicting information meant we could not be assured of the accuracy of information available. Paper information was not always dated.

There were two IT systems in addition to the primary paper system in use, and the result was cumbersome. Staff had to record information on more than one computer system and in the different sections of the national maternity notes as well as on hospital stickers and proformas. Managers said KPI data was drawn from the IT system. There was a risk this was inaccurate as we found many midwives were uncertain where to record certain information, especially where it needed to be recorded in more than one place. Bank staff said they did not have access to the IT system. On the unannounced inspection the computers were not working so paper notes were the only source of information during that time.

After the inspection the maternity service sent us an action plan to meet the Health Secretary’s call for a paperless care environment by 2020. Paper lite records were scheduled for June 2019, but was a dependent on trust wide support.

Maternity and governance dashboards were used to record activity and management data, as well as clinical indicators, and provided a monthly record. This was not fully utilised to improve performance. As at the last inspection, not all data collected had a target against which to assess performance. We saw no evidence of action in response to red RAG ratings either on the maternity or the governance dashboards. For example, communications were rated red in 11 of the past 14 months (at May 2018), and complaints responses were rated red in nine of the 11 months for which data was recorded.

Staff told us a data quality specialist was to be recruited with the aim of having accurate information by December 2018.

Senior managers were aware that the Better Births strategy outlined that NHS providers should invest in technological solutions. This would require a significant investment at Newham. We were told the oldest PCs at the hospital were being replaced as part of the IT strategy.
Engagement

During the previous inspections we had seen that mechanisms for communicating with maternity staff were top down rather than two-way. During this inspection many staff still felt communication was top down, and often through posters and noticeboards rather than through team discussion, involving staff in developing solutions. We noted that attendance at a workshop to improve motivation, engagement and training opportunities following the staff survey had been attended mainly by student and preceptor midwives, and only one band 7 midwife which could be interpreted as lack of engagement.

Staff were aware of the trust values: welcoming, engaging, collaborative, accountable, respectful and equitable. Some staff felt the values were not routinely demonstrated by staff including managers.

The main initiative to learn from women’s experience was through the local maternity voices partnership (MVP) an advisory group made up of professionals and parents, supported by Social Action for Health. This met five times a year. In their 2017/18 outreach work the MVP service had captured 117 birth/pregnancy stories from women in the borough, including stories from vulnerable woman, and shared these with the hospital. Representatives were involved in developing an action plan in response to the recent CQC patient survey.

Staff told us about motivational initiatives undertaken by the trust including nominating staff for the Barts Health Heroes awards that aimed to recognise staff commitment to providing safe and compassionate care to patients and going ‘above and beyond’. The delivery suite team had been nominated for this award in 2018 for multidisciplinary working.

Learning, continuous improvement and innovation

A small pilot ‘group practice’, in which team of midwives provided continuity of care for women through antenatal, intrapartum and postnatal care for women, had potential as a new model of care. They carried a caseload of a group of women with and without risk factors. The women could expect to see their named midwife for the majority of their antenatal, intrapartum and postnatal care. This would benefit about 2% of women increasing to 10% by 2020.

This was part of the Better Births vision of offering midwives new options to take charge of the maternity services they offer.

As part of the Maternal and Neonatal Health Safety Collaborative the unit was involved in a three-year programme, launched in February 2017, to support maternal and neonatal care services to provide a safe, reliable and quality healthcare experience. A team had made a presentation about planned quality improvement in induction of labour at the March 2018 meeting, about having a dedicated midwife and dedicated induction bays on the antenatal ward. We did not see an audit in place in relation to this improvement work.

Work was taking place to develop a community pathway for diabetes antenatal care.
The critical care service at Newham University Hospital consisted of an eight bed critical care unit providing care at level two (high dependency) and level three (intensive care), to adults who required a higher level of care than could be provided on the wards. The critical care service also included a critical care outreach team (CCOT) to support acutely ill patients in other areas of the hospital. The CCOT was led by three specialist nurses supported by a critical care consultant and the team were available seven days a week between 08:00am and 08:00pm. There were immediate plans in place to increase the CCOT service to a 24-hour, seven day a week service.

The critical care service used a range of enhanced physiological monitoring systems, organ supportive therapies and complex treatments and treated all acute illnesses that necessitated a high staff to patient ratio and a highly skilled, multi-professional team. Level two patients were nursed 1:2 and level three were nursed 1:1.

Critical care was part of the hospital's surgical directorate, led locally by a clinical lead and a matron. The critical care team included five critical care consultants who led the unit for a week at a time, a matron, five teams of nurses each led by a senior nurse (band seven), a practice development nurse, physiotherapists, a dietician and pharmacist. There were also weekly tracheostomy multidisciplinary (MDT) ward rounds for admitted patients within the hospital who had a tracheostomy. The tracheostomy team included a CCOT nurse, speech and language therapist, physiotherapist, critical care consultant and ears nose and throat consultant.

There were a further two level two beds in the coronary care unit within the hospital which sat in the hospital’s medical directorate. As critical care consultants did not lead these patients care we did not inspect this area. This was carried out as part of the medical core service inspection.

Between September 2017 and August 2018, there were 427 admissions to the critical care unit.

At our last inspection in 2015 we identified numerous concerns regarding: staffing numbers, staff training, the premises, there was no practice development nurse in post, staff understanding regarding the Mental Capacity Act, patient flow, high number of cancelled elective operations and governance.

Between 1 October and 3 October 2018, we inspected the whole core service and looked at all five key questions. We spoke with 27 members of staff including clinical leads, doctors, nurses, senior managers, support staff, cleaners, a dietician, pharmacist, a chaplain and physiotherapists. We reviewed the healthcare records of ten patients and spoke with seven patients and relatives.

**Is the service safe?**

**Mandatory training**

At our last inspection in 2015 we found that staff compliance with mandatory training was low, however, at this inspection in 2018 saw that compliance had improved significantly.

The hospital set a target of 85% for completion of mandatory training.
A breakdown of compliance for mandatory courses as of the 4 June 2018 for nursing staff in critical care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Assessment for Managers</td>
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<td>85%</td>
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<tr>
<td>Investigation of Incidents</td>
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<td>85%</td>
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<tr>
<td>Information Governance</td>
<td>37</td>
<td>37</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>36</td>
<td>37</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Working at Barts Health</td>
<td>36</td>
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<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness</td>
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<td>37</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Security</td>
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<td>37</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fraud Awareness</td>
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<td>37</td>
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<td>85%</td>
<td>Yes</td>
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<tr>
<td>Blood Transfusion</td>
<td>20</td>
<td>21</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
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<tr>
<td>Clinical Documentation</td>
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<td>37</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Harms - Catheter Acquired Infections</td>
<td>35</td>
<td>37</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Complaints</td>
<td>35</td>
<td>37</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
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<tr>
<td>Emergency Planning</td>
<td>35</td>
<td>37</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Harms - Slips, Trips and Falls (Patients)</td>
<td>35</td>
<td>37</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Harms - VTE</td>
<td>35</td>
<td>37</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
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<td>85%</td>
<td>Yes</td>
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<tr>
<td>Medicines Management</td>
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<td>85%</td>
<td>Yes</td>
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<tr>
<td>4 Harms - Pressure Ulcer Prevention</td>
<td>35</td>
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<td>95%</td>
<td>85%</td>
<td>Yes</td>
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<tr>
<td>Medical Gas Safety</td>
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<td>95%</td>
<td>85%</td>
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<tr>
<td>Nutritional Care</td>
<td>35</td>
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<tr>
<td>Privacy and Dignity</td>
<td>35</td>
<td>37</td>
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</tr>
<tr>
<td>Health and Safety</td>
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<td>85%</td>
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<tr>
<td>Early Warning Systems</td>
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<td>Yes</td>
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<tr>
<td>Infection Prevention and Control - Clinical</td>
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<td>37</td>
<td>92%</td>
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<tr>
<td>Fire Safety</td>
<td>34</td>
<td>37</td>
<td>92%</td>
<td>85%</td>
<td>Yes</td>
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</table>
Nursing staff compliance exceeded the trust's target of 85% for 26 out of 27 mandatory training modules. Three modules achieved 100% completion and moving and handling had the lowest completion rate with 76%.

Records seen during inspection showed that these figures had improved further as 96% of nursing staff were compliant with mandatory training.

A breakdown of compliance for mandatory courses as of the 4 June 2018 for medical staff in critical care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Privacy and Dignity</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
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<tr>
<td>Fraud Awareness</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Emergency Planning</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Harms - Catheter Acquired Infections</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
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<tr>
<td>Moving and Handling - Patient Handling Low Risk</td>
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<td>3</td>
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<tr>
<td>4 Harms - Pressure Ulcer Prevention</td>
<td>3</td>
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<td>85%</td>
<td>Yes</td>
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<tr>
<td>Working at Barts Health</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Harms - Slips, Trips and Falls (Patients)</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
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<td>3</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
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<tr>
<td>4 Harms - VTE</td>
<td>3</td>
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<td>85%</td>
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<tr>
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<td>3</td>
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<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Early Warning Systems</td>
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<td>3</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
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</table>


<table>
<thead>
<tr>
<th>Information Governance</th>
<th>2</th>
<th>3</th>
<th>67%</th>
<th>85%</th>
<th>No</th>
</tr>
</thead>
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<tr>
<td>Infection Prevention and Control - Clinical</td>
<td>2</td>
<td>3</td>
<td>67%</td>
<td>85%</td>
<td>No</td>
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<tr>
<td>Blood Transfusion</td>
<td>2</td>
<td>3</td>
<td>67%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>2</td>
<td>3</td>
<td>67%</td>
<td>85%</td>
<td>No</td>
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<tr>
<td>Resuscitation - Basic Life Support</td>
<td>1</td>
<td>3</td>
<td>33%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical staff achieved 100% completion rate for 18 out of 23 mandatory training modules. Five modules did not meet the trust target of 85%, and basic life support had the lowest completion rate with 33%.

Records seen during our inspection showed that mandatory training compliance for medical staff had increased to 90%.

Staff told us that they had received training for screening and application of the trust’s sepsis protocol and were aware of the trust’s sepsis policy.

**Safeguarding**

Safeguarding training was incorporated into staff’s mandatory training. Compliance with safeguarding training for nursing and medical staff in critical care exceeded the trust’s target of 85%.

A breakdown of compliance for safeguarding courses as of the 4 June 2018 for nursing staff in critical care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
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<tbody>
<tr>
<td>Safeguarding Children Level 1</td>
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<td>85%</td>
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<tr>
<td>Safeguarding Adults Level 2</td>
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<td>37</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
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</tbody>
</table>

Nursing staff exceeded the trust target of 85% for all four safeguarding modules.

A breakdown of compliance for safeguarding courses as of the 4 June 2018 for medical staff in critical care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults Level 1</td>
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<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 1</td>
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<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
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<td>3</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
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Medical staff achieved 100% completion rate for three out of four safeguarding modules; safeguarding adults level 2 had the lowest completion rate with 67%.

Records we were shown during inspection showed that safeguarding training for medical staff was 90% overall.

Staff told us they had access to the trust’s adult and children’s safeguarding policies and procedures via the staff intranet. One member of staff showed us how they could access these.

Staff throughout the service knew what constituted a safeguarding concern, how to recognise different types of abuse and how to escalate concerns appropriately. They were also able to give examples of how they or another member of staff had acted appropriately to safeguard people who used the service. This included being able to explain trust processes in place to safeguard women and children at risk of female genital mutilation (FGM).

There was a dedicated link nurse for safeguarding within the critical care service. We saw a notice in the staff room reminding staff who this was with contact details available. Staff were aware that there was a safeguarding team for the hospital and knew how to contact them.

Safeguarding assessments were carried out for all patients admitted to the critical care unit during their initial assessment. We checked seven patient healthcare records and found all safeguarding assessments completed.

One patient admitted to the critical care unit during our inspection had a safeguarding concern identified. We found that staff had acted appropriately in line with the trust policy to safeguard this person. This included a referral to the local safeguarding team, with immediate safeguarding practices in place to keep the patient safe, including a password system to ensure that only specific significant others were provided with medical updates for this patient.

There was not a safeguarding alert system in place such as a sticker system to quickly identify patients with a safeguarding concern. Staff we spoke with confirmed this, however, also demonstrated that they were aware of any safeguarding concerns on the critical care unit.

Cleanliness, infection control and hygiene

Infection, prevention and control training was mandatory for all staff. Records showed that 92% of nursing and 90% of medical staff had completed this training.

We saw numerous episodes of care which demonstrated staff followed this trust policy. For example, one patient discharged from the critical care unit had a history of episodes of diarrhoea. We saw that this patient had been cared for in a side room, with staff seen using personal protective equipment (PPE), and following the discharge of the patient this room was thoroughly cleaned (high cleaned) in line with trust policy and procedure.

Throughout the service we saw sufficient hand sanitiser and PPE was available. Staff also were seen to wear their uniform above their elbows.

In August 2018 results showed that there were two weeks where hand hygiene compliance was scored as 60% and 70%. We spoke with a manager who was aware of these concerns and told us that action was being taken to improve this and subsequently audit results had improved since then. They showed us new large floor signs that had been put in place at the entrance doors of the critical care unit reminding people to stop and clean their hand and that the “give moments of hand hygiene” notices were now displayed at all bed spaces. Records we saw demonstrated that hand hygiene audit results for September 2018 had gradually improved. We also saw that there was a
A robust action plan was in place, which was being actioned in a timely way, in relation to hand hygiene concerns.

However during our inspection we saw that staff did not always decontaminate their hands where required. For example, we carried out a twenty minute observation during our visit and counted 11 members of staff that failed to clean their hands when entering the critical care unit despite a notice reminding them and sufficient supply of hand sanitiser. We raised our concerns to senior managers who took immediate action including the introduction of daily hand hygiene audits until results improved.

There were two side rooms within the critical care unit which were designated areas available for the respiratory isolation of patients as required. Both rooms had an appropriate airflow system in place to ensure adequate ventilation.

We observed that linen trolleys were delivered daily and kept closed with a zip to ensure cleanliness.

Equipment we checked and the environment was visibly clean. We also saw that there were daily checklists for equipment cleaning, which included intravenous drip stands, infusion pumps and the electrocardiogram machine. Records we reviewed from 01 September to 02 October 2018 showed that all listed equipment had been cleaned twice daily. However, we did find that the “I am Clean” green stickers were not used consistently to show whether equipment was clean and ready to use. For example, we counted 17 pieces of equipment that did not display a sticker. This was not inline with the trusts “Infection prevention and control policy” issued December 2017 with a review date of January 2020 which stated that following cleaning of equipment staff must, “attach where appropriate ‘I am Clean’ labels”.

Cleaning staff were contracted through an external provider and worked seven days a week within critical care unit. We observed cleaning staff carrying out cleaning duties throughout our visit, however, found there were no records kept to show cleaning schedules and when cleaning happened. We raised our concern to a senior manager who told us that they would contact the third party and send us necessary information to show this did happen, however, this was not provided. This meant we could not be sure what had been cleaned and when.

Data from between October 2017 and September 2018 showed that there had been one Clostridium difficile, four E.coli, one Klebsiella, one Methacilin Resistant Staphalacoccoc Aureus (MSSA) and one Pseudomonas, trust apportioned cases for patients admitted to critical care unit.

**Environment and equipment**

In 2015, we found that the critical care unit environment did not comply with building guidelines for critical care services on a number of levels (Health Building Notes: HBN 04-02 Critical Care Units: Planning and Design). We were told that there were plans in place which would be pursued.

At this inspection in 2018 we saw that no action had been taken. The environment therefore continued not to comply with these building guidelines. This included a lack of storage space, bed space and hand-wash basins. All staff we spoke with during our inspection recognised this as a concern. We also saw this issue was on the risk register for critical care which stated, “The current 8-bedded Critical Care unit at NUH is not fit for purpose as it has outgrown its footprint and has insufficient space for the number of beds - the risk from this lack of space in the unit is that the area has an increased fire risk.”

We observed that these environmental issues posed risk to staff and people who used the service. For example, a lack of hand-wash basins meant that staff frequently moved across the unit with dirty hands which increased the risk of spreading infection. A lack of bed space less than 25
metres squared, as stated by the above building guidelines, meant that it was difficult to move large equipment that maybe used intermittently, such as portable x-ray devices. Lack of storage space meant that staff were frequently moving multiple pieces of equipment throughout the unit to free up patient beds spaces. Bed spaces and side rooms when not used for patients, were used for storing equipment. For example, on 02 October 2018 we observed that bed space five opposite the work station had 27 pieces of equipment behind closed curtains, a ventilator, a bed and mattress and 15 infusion pumps. This equipment occupied so much space that it was full and we saw leads and the bases of some equipment outside the curtain causing a potential trip hazard to people. On 03 October 2018 we saw that this bed space was occupied with a patient and subsequently all the equipment had to be moved by staff to one of the side rooms which was empty. That same day we then saw staff move all that same equipment to a corridor. This frequent moving of equipment increased the risk of infection spreading and tripping.

Senior managers told us that that expansion and re-development plans for the critical care unit had not been agreed and there was no date when building work would commence. This meant we were not assured that action would be taken nor in a timely way.

The service risk register showed that the critical care unit had a high fire risk rating of 20 based mainly on the lack of compartmentation and limitations with the means of escape within the critical care unit. Senior hospital managers explained that fire risk was a hospital wide concern, however, showed us a robust fire risk management plan which was being actioned with clear dates of completion specified.

Managers of the critical care service also showed us robust and up-to-date fire evacuation plans for the critical care unit and told us recent fire evacuation drills of the critical care unit had been completed which were effective. Staff we spoke with confirmed they were familiar with their role in fire evacuation and knew where the evacuation plans were.

The critical care unit was secure. Entry to the unit was via an intercom entry system and staff key card access only. We observed these systems be used consistently.

There were effective systems in place for the safe management and disposal of waste products. Each bed space had a clinical waste and pharmaceutical bin next to it. There was also a functioning sluice within the centre of the critical care unit. Sharps bins throughout the unit were readily available, clearly labelled and not overfilled, and we saw that waste was labelled and handled appropriately.

There was a dedicated stores manager for the critical care service, who worked Monday to Friday 7:30am to 4:00pm, and was responsible for maintenance and supply of equipment.

Staff responsible for equipment maintenance told us that they were not aware of a program in place for the routine replacement of capital equipment. Instead, they told us, any faulty equipment was labelled and reported to the relevant department. The risk register showed that some equipment that was near the end of its working life and needed replacing and this included a transport ventilator and renal dialysis machines. We noted that these issues had been on the service risk register since May 2018, however, there was no completion date to show when this equipment would be replaced. A manager confirmed our finding.

There were two programmes of equipment maintenance, one was completed by the trust’s equipment team and another by an external agency. We checked the servicing records for 20 pieces of equipment used in the critical care unit, including a ventilator, defibrillator and respiratory humidifying equipment, serviced by the trust and found all equipment had an up-to-date service history. However we also found that therewere 32 pieces of equipment which showed theywere not up-to-date with servicing requirements, of which 12 were considered high risk, and 20 medium
risk equipment. We were told that some of this equipment may have been serviced by the external company without the trust being updated. Senior managers told us that they were certain all equipment was safe and up-to-date with servicing requirements. The trust told us that they would take immediate action to ensure that servicing records were updated.

Staff told us they had received appropriate training and were competent and familiar with the use of equipment. For example, one junior nurse we spoke with told us they had completed all their critical new starter competencies and had received necessary equipment training including for infusion devices, observation machines and ventilators. Records we were shown demonstrated that there were additional “new” classroom sessions planned for equipment, including infusion pump training, and all staff would have completed this by the end of 2018.

We reviewed the checking history records for the resuscitation trolley and difficult airways trolley between 01 September to 03 October 2018 and saw that this equipment was checked daily and fully stocked. A red tag was used to secure this equipment which ensured it was tamperproof.

On 01 September 2018 we checked the cupboard inside the entrance of the critical care unit which was labelled “transfer out equipment”. We saw there was a red bag called the “transfer bag” containing equipment used when transferring patients to and from the critical care unit. This bag was sealed and when we checked fully stocked, however, the equipment checklist that accompanied it had not been completed for 17 days between 01 September and 01 October 2018. We saw a further three of these bags in the critical care unit storeroom in the “outreach cupboard” and found that two of three of these bags had not been checked since 2017. Our concerns were heightened as we were also shown three red “transfer bags” stored on the coronary care unit, below the critical care unit, which staff told us were used by the critical care service if needed. We saw that some equipment within these bags were out of date. We showed all of these records to either a member of staff responsible for checking them or a manager, who confirmed our findings. A manager then told us they were taking immediate action to ensure this equipment was safe which we saw happen. We raised our concerns about transfer out bags to senior managers.

We also saw there were no warning notices displayed showing that oxygen was stored in this cupboard labelled “transfer out equipment”. This meant that oxygen was not stored safely and not in line with the trust’s policy for the management of medical gases. We raised this concern to senior managers who told us they would take action.

At the start of each shift on the critical care unit nursing staff were responsible for completing a thorough check of bedside equipment for their allocated patient. One member of staff talked us through this process. We checked the healthcare records of three patients and found that their equipment had been checked each shift for the past two days.

We saw that there was a sufficient amount of equipment available including syringe drivers, a chair for those with a high body mass index (bariatric), ventilators and nasal gastric feeding pumps. Staff we spoke with confirmed this.

The critical care unit was located within close proximity to the emergency department, theatres and radiology.

**Assessing and responding to patient risk**

The critical care service included a critical care outreach team (CCOT) to support acutely ill patients in other areas of the hospital, prior to their transfer to the critical care unit, all patients in the hospital with a tracheostomy, or to follow up on patients discharged from the critical care unit. The CCOT was led by three specialist nurses supported by a consultant intensivist, and the team
were available seven days a week between 08:00am and 08:00pm. We saw that there were plans in place to increase to a 24 hours, seven day a week service imminently. A business plan had been approved to recruit an additional one band seven and three band six CCOT nurses. Records showed that applicants had been shortlisted and interviews were scheduled.

We saw that patients on the critical care unit were reviewed at least twice daily by a consultant, and patients who were cared for by the CCOT were reviewed twice daily by the CCOT.

The trust had a hospital-wide standardised approach for the detection of the deteriorating patient and a clearly documented escalation response. This process was outlined in the trust's policy titled, “Observation and escalation policy – adult patients” issued 05 February 2016 with a three-year review date. We saw that this policy incorporated the National Early Warning Score (NEWS) system. During our inspection, generally we saw that NEWS were utilised and escalated appropriately, for example one patient with a very high NEWS we tracked from another area in the hospital, resulted in admission to the critical care unit subsequently. However, one patient on medical ward who was known to the CCOT, did not have their high NEWS escalated to the CCOT in a timely way by ward staff. We escalated this to the CCOT and the patient was reviewed. The CCOT carried out monthly NEWS audits for deteriorating patients throughout the hospital.

They looked at eight random NEWS charts in each department to see if these were completed, scores added correctly and whether risk was escalated and managed appropriately. Data the hospital provided between August 2017 to May 2018 showed that 85-100% of ward staff escalated and recorded vital signs appropriately, however, that patients consistently did not have a completed physiological monitoring plan in place where needed (i.e. clear instructions to the nursing staff when to call for assistance for further review). We checked more recent audits to see if progress had been made and found the results for August 2018 to be similar. However the CCOT told us that “NEWS 2”, a different type of early warning scoring system, was going to be implemented on 14 January 2019 throughout the trust, and that the team were focusing on providing staff training for this. Training included a combination of face-to-face and e-learning for all relevant hospital staff for this.

We reviewed the trust’s policy titled, “Observation and escalation policy – for adults” issued February 2016 with a three year review date. This policy showed the escalation plans for patients who suddenly required further observation or level three care due to their health deteriorating. We saw two episodes of care where this policy was followed correctly, leading to critical care unit admission on one occasion. Staff we spoke with demonstrated they were familiar with this policy and process.

The service’s performance dashboard did not capture data to show the amount of level of level three admissions to the critical care unit which occurred within four hours of making the decision to admit. A manager confirmed this data was not collated.

A manager told us there was a standing operating procedure (SOP) in place whereby an additional two level three beds could be provided and staffed in the recovery area of theatres. They told us this had not been required in the past 12 months. Records we checked confirmed this contingency plan.

There was a critical care consultant on call twenty four hours a day, seven days a week, and a middle grade doctor within the critical care unit at all times. Between daytime hours the CCOT were also available. This meant that there was appropriate liaison with critical care available to other areas of the hospital in the event a patient requires input from the critical care service. Staff we spoke with in the emergency department and coronary care unit confirmed this.
The CCOT told us that there were sepsis trolleys on each ward within the hospital which they used for patients. We saw a sepsis trolley on the critical care unit also. There were notices in the staff room reminding staff of the link nurse for sepsis for critical care.

We checked the healthcare records of seven patients who used the service and found individual risk assessments were carried out for each. This included but was not limited to safeguarding, skin integrity and mental capacity assessments. Where risk had been identified we also saw evidence that risk management plans were developed in line with national guidance, with risks managed positively. For example, all patients had a daily critical care unit observation record next to their bedside which included a detailed “fluid balance” section where staff recorded patient’s fluid input and output. We saw that all seven patients had their fluid balance observations recorded hourly with correlating up-to-date care plans in place. Staff demonstrated they were competent in assessing patients’ fluid and electrolyte needs, prescribing and administering IV fluids, and monitoring patient response which was in line with relevant evidence based practice (National Institute of Health and Clinical Excellence, Quality Standard 66 Statement 2).

Training records showed that 95% of nursing and 100% of medical staff had received training in major incident planning.

Staff we spoke with were aware of what constituted a “major incident” and knew that there was a policy for this on the staff intranet. They also told us that there were twice weekly mains power testing to check the back-up generator system, including the checking of emergency lighting in the unit. We were also told that all ventilators had additional back-up power.

Senior staff could clearly articulate what action they would take in the event of emergencies and major incidents in line with local procedure. This included fire evacuation plans which were seen to be robust, recently reviewed and available to staff in paper format at the staff desk on critical care unit.

**Nurse staffing**

The hospital reported the following nurse staffing numbers for the critical care service in March and April 2018. The trusts fill rate increased by 12% from March to April 2018.

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<tr>
<td>Critical Care</td>
<td>33.7</td>
<td>40.7</td>
<td>82.8%</td>
<td>38.3</td>
<td>40.7</td>
<td>94%</td>
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Records we were shown during inspection showed staffing establishment was reviewed regularly for the critical care service, the last review was carried out in October 2018.

From May 2017 to April 2018, the hospital reported a vacancy rate of 16.1% for nursing staff in critical care, this was higher than the trust target of 6.3%.

However, during our inspection, we found this vacancy rate had improved significantly. A manager told us that there were 40 registered nurses in post for the critical care unit, with four band five vacancies at the time of our inspection of which two were being interviewed for the week following our inspection and others out toadvert. They told us that when these posts were filled adequate staffing numbers and compliance with nursing staffing standards for critical care were met, with bank staff used until then. Therefore, the vacancy rate had improved significantly.
There were also five health care assistants (band three) in post with one vacancy which we were told was out to advert.

There were three whole time equivalent (WTE) band seven CCOT nurses in post. A business plan had been approved to recruit an additional one band seven and three band six CCOT nurses. Records showed that applicants had been shortlisted and interviews were scheduled.

There was a dedicated practice development nurse (PDN) for the critical care service who was a WTE. This member of staff completed two clinical shifts on the critical care unit per month and had been in post as PDN for one year.

We saw a notice board at the entrance of critical care unit which displayed planned compared to the days actual staffing numbers. Planned critical care unit staffing numbers per shift were seven registered nurses and one healthcare assistant day and night. We saw one day of our inspection where planned staffing levels were not met. This was on 02 October 2018 where there were only six registered nurses for the day and night shift with one HCA per shift. Staff confirmed this and told us that the coordinator was subsequently allocated a patient as the shift could not be filled by bank or agency. We saw that this allowed for 1:1 nursing for level three patients and 1:2 nursing for level two patients.

Staff told us that nursing staffing levels were good for critical care unit, however, that there were times where the nurse coordinator for the critical care unit was not supernumerary due to planned staffing numbers not being met. During our inspection we saw that this happened on 02 October 2018 and that this meant the coordinator had to care for an allocated patient and coordinate the critical care unit which was not safe. We also checked nursing staffing rotas for the past three months prior to our inspection and found that there were numerous occasions where this happened. For example, rotas showed that between 03 September and 30 September 2018 there were nine day shifts and five night shifts where there were six registered nurses on duty opposed to the planned seven.

We observed handover between nurses and found that this was structured and that communication was clear. There was a group handover at the staff of shifts followed by a nurse to nurse handover at bedside.

From May 2017 to April 2018, the trust reported a turnover rate of 12% for nursing staff in critical care, this was lower than the trusts target of 13%. Nursing and support staff throughout the service told us that they had worked for the service for many years. One senior member of staff told us that retention of staff was “very good here”.

From May 2017 to April 2018, the trust reported a sickness rate of 5.8% for nursing staff in critical care, this was higher than the trusts target of 3%.

We were told by staff that agency staffing was rarely used and where shifts were not filled regular bank staff would be used. Staffing records demonstrated that regular bank staff were used and a manager confirmed these members of staff had completed local and trust induction.
Medical staffing

The hospital reported the following medical staffing numbers for critical care in March and April 2018. The trusts fill rate decreased by 4% from March to April 2018.

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<tr>
<td>Critical Care</td>
<td>2.6</td>
<td>12.5</td>
<td>20.8%</td>
<td>2.6</td>
<td>16.0</td>
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From May 2017 to April 2018, the trust reported a vacancy rate of 72.2% for medical staff in critical care, this was much higher than the trust target of 6.3%.

During this same period the trust reported a turnover rate of 0% for medical staff in critical care, this was lower than the trusts target of 13%.

However, on inspection we found that medical staffing numbers were starting to improve. A manager told us that there was one consultant vacancy which was out to advert, and that there was one middle grade doctor employed with the rest of the middle-grade shifts being completed by locums, who were already employed by the trust who worked regularly for the critical care unit. Of these seven middle-grade doctors, three were advanced airway trained (AAT). The manager told us that recruitment for middle-grade doctors to the critical care unit had been difficult, however, that three new middle-grade doctors had been appointed to post who were also AAT and were starting at the end October 2018.

We checked the medical staffing rotas for July, August and September 2018. These showed each dayshift there was a duty critical care consultant on the unit between 8am and 5pm, a middle grade doctor who was trained in advanced airway management, a junior doctor and second middle grade doctor who supported the CCOT with the duty consultant. On Monday, Tuesday and Thursday there was a second critical care consultant working who covered the tracheostomy and CCOT ward rounds.

Out of hours there was a middle grade doctor who was advanced airway trained allocated to the critical care unit. There was also a consultant on-call 24 hours a day, seven days a week, available on the unit in 30 minutes of being called.

Medical staff told us that bank locum staff were used regularly where needed to fill shifts, and that these were doctors who had worked on the critical care unit before, who had completed an induction at the trust and for the critical care unit. Records showed that one locum consultant had been used between September 2017 to September 2018 and that this member of staff was a long-term locum consultant for the service.

From May 2017 to April 2018 the trust reported a sickness rate of 0.1% for medical staff in critical care, this was lower than the trusts target of 3%.

A robust handover document was completed for all patients discharged from the critical care unit, which was completed by the medical team. We observed handover of one patient who was stepped-down to the ward. This handover was concise and contained all necessary information. We also saw that the patient’s handover document followed the patient to the ward.
Records

The service used handwritten patient healthcare records. Each patient had a critical care unit observation record showing hourly information such as vital signs (such as blood pressure and temperature) and fluid balance. They also had two folders one for nursing documentation, including care plans, and another for medical staff and other members of the multidisciplinary (MDT) team.

Patient's critical care unit observation records and folders were kept at their bedside on a trolley. They were not locked away as they were in constant use by staff and monitored closely. We observed that computer screens at the critical care unit desk were locked when not in use.

Staff told us there were plans to introduce an electronic patient healthcare records system for critical care unit however a manager confirmed no date for introduction had been set.

We examined ten patient healthcare records for people either admitted to the critical care unit or using the CCOT service. We found that records were accurate, complete, legible, up-to-date and stored safely. The time and decision to admit to the critical care unit was recorded for those admitted for level three care with formal handover documentation in place.

When patients were discharged from the critical care unit an electronic discharge summary was completed and sent to the relevant healthcare team. We checked three discharge summaries and found all were fully completed, contained all necessary information and were easy to understand.

The service employed an audit nurse for the critical care unit who was responsible for electronic patient data collection, which they regularly input into the services performance dashboard system and into the Intensive Care National Audit Research Centre (ICNARC) database.

Medicines

The critical care unit had a dedicated pharmacist who worked Monday to Saturday. Out of these hours there was an on call pharmacist available. One pharmacist told us that they had completed additional critical care service training to allow them to work in the area. They also told us that they or a colleague were part of the MDT ward round during the week days and on a Saturday.

We observed staff administer medicine, including a controlled drug, in line with the “Nursing Midwifery Council’s (NMC) Standards for Medicines Management”. For example, we saw one nurse administer intravenous medicine safely and in line with these standards.

We reviewed the medicine records for five people who used the service and found that allergies were clearly documented, prescriptions were readable and signed, administration and route of administration were also clearly recorded.

Medicines were stored securely behind locked doors with the lead nurse holding the keys. We checked the controlled drug cupboard and found these medicines were in date, all accounted for and checked daily between 01 September to 02 October 2018. We also randomly checked 20 stock medicines throughout the service and found that packaging was intact, medicines were in date and stored according to the manufacturer’s recommendation.

Records from between 01 September and 02 October 2018 showed that the fridge temperature was checked daily and within set parameters. This fridge was in the clinical room and used to store medicines.

We saw that patient’s own medicine was kept at their bedside on a trolley in a locked draw.
At our inspection in 2015 we raised concern about intravenous (IV) fluid storage. However at this inspection in 2018 we found that appropriate action had been taken because IV fluids were seen to be stored safely in boxes with labels and in a locked, ventilated room.

Records showed 95% of nursing staff had completed their medical gas and medicines management training. This was above the trust’s target of 85%.

Nursing staff we spoke with were aware of trust policies on medicines management including administration of controlled drugs. Staff told us they could access these policies and procedures via the staff intranet or the pharmacy folder at the staff desk.

We checked the pharmacy folder on critical care unit which staff told us they used. We found that three of the six policies, procedures and guidelines we checked had either not been reviewed or had no date of publication. For example, we saw that the, “Prescribing guideline: Continuous Intravenous Infusions” guideline had an issue date of November 2013 and review date of 2016 which had not been actioned. We raised our concern to a pharmacist and senior manager.

Prescribing staff told us that their local microbial protocols they followed for medicines such as antibiotics.

Incidents

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

From August 2017 to September 2018, the hospital reported no incidents classified as never events for the critical care service.

In accordance with the Serious Incident Framework 2015, the hospital reported two serious incidents (SIs) in critical care which met the reporting criteria set by NHS England from August 2017 to September 2018. Both incidents related to medical equipment/devices/disposables.

We reviewed the Root Cause Analysis (RCA) reports for both SIs and found that these were investigated appropriately in accordance with the Serious Incident Framework (NHS England, 2015). All RCA reports had corresponding action plans in place where action needed had been identified.

Records from September 2017 to September 2018 showed there had been 267 incidents reported by the critical care service, with skin trauma, continence management and pressure ulcer being the most frequently reported type.

Records showed 100% of staff who were required to, had completed incident investigation training.

Staff demonstrated they understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses. They knew how to report these appropriately using the hospital’s electronic incident reporting system which they could access. Staff also told us they received feedback from any incidents reported.

Lessons were learnt following incidents, with necessary action taken as a result of investigation when things went wrong. For example, the critical care unit reported one incident where a patient acquired a pressure ulcer on their ear. We saw that learning from this incident had been communicated to all staff on multiple occasions, including via the “ITU Newsletter” dated September 2018. Subsequently all staff we asked were aware of this incident and could demonstrate they knew what changes to practice were expected. That was to ensure that patient’s with oxygen have their ears covered with a dressing to prevent pressure ulcers.
We saw that lessons learnt were shared to make sure action was taken to improve safety, including beyond the critical care service. For example, following one SI which involved a blocked tracheostomy, staff we spoke with were aware of the SI and the emergency algorithm (national AAGBI guidance) for patients with tracheostomy which they had recently been reminded of. We also saw that there was a subsequent tracheostomy simulation training session for staff held in August 2018.

Staff we spoke with demonstrated they understood their role and responsibility in terms of the duty of candour (DoC). The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. We saw evidence of where duty of candour had been applied which related to a pressure ulcer acquired during a patient’s admission to the critical care unit.

We reviewed the last three morbidity and mortality meeting minutes for the service from June to September 2018. We saw that meetings were well attended by consultants but there was minimal junior doctor attendance, however, however there was discussion within one of the minutes that meetings were going to be moved to the afternoon time where junior doctors would be more available and encouraged to present. These meetings had a standing agenda and with multiple patient cases analysed and discussed.

Safety thermometer

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

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

Safety thermometer data from July, August and September 2018 showed harm free care. For example, data captured on 18 August 2018 showed there were six patients admitted to the critical care unit at that time; none had a pressure ulcer, urine infection or fall, and all had a venous thromboembolism assessment and prophylaxis which showed 100% harm free care.

Is the service effective?

Evidence-based care and treatment

Relevant and current evidence-based guidance, standards, best practice and legislation were identified through monthly clinical governance meetings, and were used to develop how care and treatment was delivered. This included from the National Institute of Health and Clinical Excellence (NICE), Intensive Care Society (ICS) standards and other professional bodies.

We reviewed seven patients’ healthcare records who were admitted to the critical care unit during our inspection. We found that patients had their needs assessed and their care planned and delivered in line with evidence based, guidance, standards and best practice. For example, we saw that all patients were assessed for venous thromboembolism (VTE) and provided with VTE
prophylaxis where required and screened on admission for delirium (NICE Quality Standard 3, 2018 and Guidelines for the Provision of Intensive Care Services, 2015).

The service participated in local and national benchmarking. Local benchmarking occurred through participation in the “North East and North Central London Adult Critical Care Network”. The clinical lead for the service was the Newham University Hospital critical care service representative and records we saw showed they attended regular network meetings, contributed to these meetings and shared these with staff at Newham University Hospital critical care unit.

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

The critical care unit used care bundles. A care bundle is a group of evidence-based interventions, when performed together; improve outcomes more than if used individually. We saw that ventilator care and surviving sepsis care bundles were embedded into practice.

We checked 15 policies and procedures relevant to the service and found that seven of these had either not been reviewed as required or were not the most up-to-date version available. This included the CCOT policy and procedure with no issue or review date shown to us by a manager, an adult safeguarding policy found in the “safeguarding folder” which had last been reviewed in March 2015, and a student experience and placement guide dated October 2014 with no review date. Staff confirmed that all policies and procedure we checked were in use.

Staff we spoke with were aware of the Mental Health Act (MHA). We discussed this fully with a service lead who demonstrated they understood the MHA code of practice and that the rights of any patient subject to the MHA would be protected.

Nutrition and hydration

We checked seven patient’s healthcare records and saw that all patients had their nutrition and hydration needs regularly assessed and met. All patients we checked were having their fluid balance and nutrition assessed hourly, they had a recent Malnutrition National Screening Tool (MUST) score with an up-to-date nutrition and hydration care plan in place which was being followed. We also saw that there was regular input from the service’s dietician.

There was a designated dietician assigned to the critical care unit. During our inspection we observed that they were involved in the assessment, implementation and management of appropriate nutrition support. This included for all people admitted to the critical care unit and those using the tracheostomy service. The dietic service was available Monday to Friday during daytime hours. Nursing staff showed us the nutrition assessment they completed for all patients and the protocol doctors and nurses followed OOH to initiate enteral nutrition (tube feeding) as required. Nurses also said they completed a referral to the dietetic team OOH who would action this as a priority the next working day.

We saw that patients who were unable to take food and fluid orally had their nutrition support (enteral or parental) commenced on admission where required, to ensure adequate nutrition to facilitate rehabilitation.

There were regular meals, drinks and snacks provided for patients who could eat and drink. We saw a “nutrition and hydration” notice board that ward host team used to determine what nutrition and hydration needs each patient had. For example, if people were nil by mouth or were requiring a pureed diet. The ward host discussed this daily with the nurse in charge of the critical care unit. We observed that this board was updated and accurately completed each day of our inspection.
95% of nursing staff had completed their training on nutritional care which was mandatory. Nursing staff told us that they had also completed enhanced training and competencies for nutrition and hydration relevant to critical care.

**Pain relief**

Patient’s pain was appropriately assessed and effectively managed. For example, we saw one nurse regularly ask a level two patient who was able to communicate, whether they were in pain or not and subsequently administer pain relief and promptly. Another patient who was ventilated (assisted to breath mechanically) was provided with sedation and their pain, vital signs such as heart rate, and delirium was regularly assessed to ensure they were comfortable.

Staff used a standardised tool to assess patient’s pain. We checked seven patient’s healthcare records and saw that pain assessments were recorded hourly as a minimum. There were individualised pain relief plans in place for people who used the service, that were appropriate to their clinical conditions.

There was a dedicated acute pain service at the hospital. Staff were aware of this and told us they could access this service Monday to Friday with anaesthetic consultant cover OOHs. The critical care unit had a dedicated link nurse for pain management. Their contact details were seen on a notice in the staff room as a reminder for staff.

Staff told us that they had completed patient and controlled analgesia (PCA) and epidural study session. We also found this was part of the induction checklist which new starters had to achieve.

**Patient outcomes**

The service monitored adherence to local best practice guidelines through a local audit programme which included the “perfect ward” audit, which was a smart phone app introduced at the trust to help staff quickly complete a set of questions which monitor quality of care. The audit captures data from whether patients have enough to drink through to more complex indicators such as sepsis management and care bundle compliance. This audit was conducted monthly and five reports were generated titled, “safe, effective, responsive, caring and well-led”. We checked the audit results for the critical care unit’s “perfect ward” audit for July, August and September 2018 which demonstrated that quality of care was improving as month by month. In August 2018 results for each reported showed compliance with the many indicators were between 95.4% to 100% which was an improvement from the previous month.

There were also medical led local audits which included, “Anticoagulation control during continuous haemofiltration in intensive care” and the “2018 Tracheostomy incident review”.

There was evidence that changes to practice had been made after audit. This included a recent audit (2017) titled, “Can nasal high flow support be used in Type 2 respiratory failure”, which was a study led by one of the critical care consultants from the service. It identified that “high flow oxygen therapy (Optiflow) has changed the outcome and quality of life in our patients in the wards”. We saw that these results had been published in the “American Journal of Respiratory and Critical Care Medicine” (2018).

The unit was part of the “North East and North Central London Adult Critical Care Network”, which was the local critical care network, which enabled patient outcome and quality benchmarking against other local critical care units.

The critical care unit contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered and patient mortality could be benchmarked
against similar units nationwide. The service employed a full time equivalent (FTE) audit nurse who was responsible for uploading audit data including to ICNARC.

The last annual ICNARC report for the service from 2016/2017 showed that the risk adjusted hospital mortality ratio was 1.0 in 2016/17. This was within expected range. The figure in the 2015/16 ICNARC annual report was the same (1.0).

<table>
<thead>
<tr>
<th>Number of cases</th>
<th>Metric</th>
<th>2015/16</th>
<th>2016/17</th>
<th>National aggregate</th>
<th>Asp Standard</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>366 admissions</td>
<td>Risk-adjusted hospital mortality ratio (all patients)</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
<td>none</td>
<td>Within expected range</td>
</tr>
</tbody>
</table>

We checked the more recent quarterly ICNARC report for this critical care unit dated April 2017 to March 2018. This report showed that the 11 quality indicators, such as “risk adjusted hospital mortality” and “high-risk sepsis admissions from the ward”, were all within the expected range.

**Competent staff**

Records showed that 100% of nursing staff and junior doctors in training and 89% of consultant staff had received an appraisal between September 2017 to September 2018, against a trust target of 90%. Staff told us that learning needs were identified during appraisals and gave us examples where they were encouraged and given opportunities to develop subsequently.

Staff did not receive one-to-one meetings with their manager however told us that leaders of the service were always available for support. This included supporting revalidation processes.

A manager explained how poor or variable staff performance was identified and managed. They gave us a past example where a drug error occurred, which demonstrated this and how staff were supported to improve in the first instance.

There were seven qualified mentors and one sign-off mentor for student nurses. A senior member of staff told us that there were plans to increase the amount of sign-off mentors. Records showed that there were two student nurses allocated to the critical care unit by local universities commencing November 2018. We saw a student notice board and education folder for students in the staff room which contained relevant resources, such as names and photos of the education team within the critical care service.

A recent audit dated February 2018 which was conducted by a local university, showed positive outcomes. Comments included that the critical care unit allowed for, “proactive management of learning provision”, there were “trained and experienced mentors” and the report concluded that the critical care unit provided a “positive learning experience for pre-registration students”.

At out inspection in 2015 we raised concern that there was no clinical nurse educator in post. However at this inspection in 2018 we saw a practice development nurse (PDN) was in post, who was responsible for coordinating the education, training and continuing professional development (CPD) framework for critical care unit nursing staff and pre-registration student allocation. The PDN was a WTE who worked two clinical shifts on the critical care unit per month. Staff spoke highly of this member of staff and multiple times staff told us this clinical nurse educator had worked hard to make significant improvements to learning and development within the service.
The PDN had developed a training matrix which they told us they regularly reviewed for all nursing staff, which assisted oversite of compliance with training.

There was a comprehensive induction programme for new starters. Staff told us that new starters had a period of approximately four-week supernumerary practice when appointed to critical care unit. This included the allocation of a mentor who worked alongside them, an induction checklist and an extensive set of critical care unit competencies, some of which were required to be completed within six months, others within a year of starting.

There were different sets of nursing core competencies for new starters, to support those completing the post registration intensive care course, on return from a career break and a band six development programme. Staff we spoke with of different grades confirmed they had completed such competencies relevant to their job role.

Staff told us that all bank and agency staff completed the induction checklist and were welcomed to monthly staff meetings for the service.

Records showed that 67% of registered nurses working in the critical care unit had completed their post registration award in critical care nursing, and another was part way through their course. This meant that the service was adhering to national guidelines which stipulate that 50% of registered nurse should have completed this qualification (Guidelines for the Provision of Intensive Care Service, 2015). A senior member of staff told us that four additional nurses were scheduled to complete this training in May 2019.

A manager told us that all of the six critical care consultants in post, one of which was leaving at the end of October 2018, had intensive care accreditation.

Medical and nursing staff we spoke with across all levels told us that additional training opportunities were good. We observed an “education” notice board which listed numerous study days available to nursing and support staff. Training available included “tissue viability learning opportunities” and an “end of life” course, and they were all relevant to the service provision.

**Multidisciplinary working**

There was a good rapport between staff observed, with nurses, doctors, physiotherapists, dieticians and pharmacists working well together throughout the service.

We found that all necessary staff, including those in different teams and services, were involved in assessing, planning and delivering patient’s care and treatment. We saw the daily MDT ward round take place which showed this. Staff also told us about the weekly MDT ward round that happened for all tracheostomy patients in the hospital. This ward round included a CCOT nurse, speech and language therapist, physiotherapy, an intensive care consultant and ears nose and throat (ENT) consultant.

Staff throughout the service repeatedly told us that the critical care unit worked well together including the wider MDT team which we observed. One member of staff told us, “It’s what keeps me here for so long – the team”, and another said, “We are a great team, everyone supports one another and is approachable”.

Monthly critical care unit meetings were held were all members of the MDT were invited. We reviewed the minutes of these minutes from July, August and September 2018 which showed a set agenda and that meetings were well attended.

Staff told us that on admission to the critical care unit all patients have a treatment plan discussed with a critical care consultant. We checked the healthcare records of four level three patients.
which showed this happened and was in line with “Guidelines for the Provision of Intensive Care Services” (2015).

We found that care was well coordinated when different teams and services were involved, and that staff worked well together to assess and plan ongoing care and treatment. For example, we saw that the matron attended regular hospital-wide bed meetings where they informed senior managers about patient’s requiring ward beds, who were assessed as safe to step-down from the critical care unit, in view of planning ongoing care and treatment.

There was a dedicated physiotherapist for the critical care unit who demonstrated they were an experienced physiotherapist. They told us that they were starting to contribute and construct suitable ventilation weaning plan for complex, or long stay patients, in conjunction with the wider MDT.

Staff told us that there was no dedicated occupational therapist available for the critical care unit, however, that support could be gained from trust-wide or community occupational therapy services as required.

During our inspection we checked the healthcare records of three patients who had been transferred and stepped down to wards. We saw that there was a clear discharge and handover protocol in place, followed by medical and nursing staff. This included a robust critical care unit discharge print out which went with the patient, with evidence of an MDT approach to discharge, including ongoing physiotherapy support as necessary.

There was a clear MDT approach to the management of sepsis. The CCOT told us that there were sepsis trolleys on all wards, including the emergency department and critical care unit, that sepsis training had been delivered to all clinical staff in these areas and a sepsis screening tool was embedded in the hospital-wide NEWS chart. The hospital followed the sepsis six bundle, which is a term used for the management of sepsis after admission to hospital involving three treatments and three tests.

Seven-day services

There was a critical care consultant present for the critical care unit during daytime hours seven days a week. Consultant-led ward rounds took place twice daily including for patients in level two beds in the acute coronary unit. Out of hours, usually after 8pm, there was a consultant on call specifically for this service who was able to attend within 30 minutes. Consultants worked on rotation each taking lead for the service on a weekly basis.

There were plans in place that were being actioned to increase the CCOT service from a day time to a 24-hour, seven day a week service.

There was a specialist pharmacist allocated to the service from Monday to Saturday during daytime hours. Outside of these hours an on-site pharmacist or an on-call pharmacist was available 24 hours a day, seven days a week.

A physiotherapy service dedicated to the critical care unit was available daily seven days a week with on-call cover out of these hours. Staff confirmed that physiotherapists reviewed critical care unit patients everyday as required.

Specialist dietetic support was available daily Monday to Friday. Staff told us that outside of these hours an initial dietetic assessment and protocol was completed, and followed, by nurses and doctors to initiate enteral nutrition (tube feeding).
Staff told us that the hospital's mental health liaison service was available 24 hours a day, seven days a week. One doctor gave us an example of how they had accessed this service effectively for a patient recent to our inspection.

A consultant confirmed there was seven-day access to diagnostic services such as x-ray and computerised tomography (CT). Consultant-directed diagnostic tests and completed reporting was also available seven days a week, within one hour for critical care patients.

**Health promotion**

The MDT ensured health promotion was embedded into patient care from admission and beyond discharge from the critical care unit. Health promotion is the process of enabling people to increase control over, and to improve, their health (World Health Organisation, 2018).

Staff told us they encouraged patients to bring their relatives or those close to them to the critical care follow up clinic, as the service focused on the patient and family, and such additional support was seen as fundamental in terms of health improvement.

However we also found that patient’s short risk assessment for rehabilitation records were not always completed. These should be completed during all patient’s critical care stay and as early as possible to determine the patient’s risk of developing physical and non-physical morbidity (National Institute of Health and Clinical Excellence, Clinical Guideline 83: Rehabilitation after critical illness). We checked five patient’s healthcare records and found only two patients had this completed, one within 24 hours of admission and another at admission day ten.

There was no dedicated psychological support service for the critical care unit. The National Institute of Health and Clinical Excellence (NICE) state that depression is approximately two to three times more common in patients with a chronic physical health problem, and treating depression in people with a chronic physical health problem has the potential to increase their quality of life and life expectancy (NICE, Clinical Guideline 91: Depression in adults with a chronical physical health problem). However, staff at the critical care unit follow up clinic told us that they could refer patients to the community mental health team for psychological support as required.

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

We reviewed the healthcare records of seven patients admitted to the critical care unit during our inspection. We found that all of these patients had completed mental capacity assessments in place.

There were trust policies in place for consent, the Mental Capacity Act, DoLS and restraint. We reviewed each of the following policies and found they were up-to-date, where necessary reflective of legislation such as the Mental Capacity Act (2005) and Mental Health Act (1983) and the Mental Health Act Code of Practice.

Doctors told us that they completed mental capacity assessments for patients whose capacity to make decisions was in doubt, and described what action was taken when a patient lack mental capacity. They could demonstrate this was in line with trust policy and procedure, and subsequently the Mental Capacity Act.

Training records showed 100% of nursing staff and 90% of medical staff had completed training on the MCA and consent.

A manager confirmed there was no policy for sedation. We were however shown a “sedation algorithm” dated 2018 which we were told staff followed.
Records showed that 95% of nursing staff and 100% of medical staff had completed conflict resolution training which assisted staff to know how to de-escalate conflict where possible.

Staff told us they used hand control mittens as required to keep people safe when completing clinical tasks such as removing invasive equipment such as feeding tubes. Hand control mittens are a product designed in order to restrict the movement of one or both patient hands.

We requested audit data for consent to treatment however were told by the trust that these audits were not carried out.

Is the service caring?

**Compassionate care**

Patients and those close to them told us that staff were caring. One relative of a patient admitted to the critical care unit during our inspection told us they were, “Very happy with the care” delivered by staff. Another patient told us, “Yes staff are really kind and nice here.”

We consistently observed that staff acted in a kind and sensitive manner towards patients and those close to them.

There were thank you cards to staff from patients and relatives displayed in abundance on a notice board at the entrance of the critical care unit. There were no dates on these cards so it was not clear when they related to however.

Staff understood and respected people’s personal, cultural, social and religious needs and took these into account when planning and delivering care. We saw this in initial assessments where these issues were considered. We saw care was planned accordingly, for example, we observed a chaplain being called for one patient with religious needs and food needs being planned with another patient who had specific cultural and religious requirement.

We saw numerous examples which showed that staff took time to interact with patients and those close to them in a respectful and considerate manner. For example, one patient who was sedated and ventilated was having medicine administered intravenously. We heard the nurse explain the process slowly and in a gentle voice to the patient before this episode of care.

Where possible patient’s privacy and dignity was seen to be respected throughout our inspection. Nurses closed patient curtains, or closed blinds and doors in side rooms, when personal care or clinical review took place. Staff voices were kept low during ward rounds. However due to insufficient bed space being available reasonable auditory privacy was difficult to maintain.

We saw that staff acted in a timely and compassionate way when patients experienced physical pain and discomfort. One sedated patient was indicating they were uncomfortable and the nurse acted immediately to assess and resolve their discomfort.

**Emotional support**

There was a quiet room outside the entrance to the critical care unit which was used to deliver bad news to patients and their relatives.

A hospital chaplaincy service was available 24 hours per day, seven days per week. The team offered spiritual or religious support to patients, relatives and staff. We saw a member of staff from the chaplaincy service visit a patient on the critical care unit who had requested this input. Staff told us that other than chaplaincy support there was no other bereavement support available.
Staff had access to the hospital’s psychiatric liaison team 24 hours a day, seven days a week. This service provided integrated mental health assessment, treatment and management of patient’s with mental health conditions, such as depression, alcohol and drug misuse and schizophrenia. The service was based on the RAID (Rapid Assessment, Interface and Discharge) model of care. Staff told us that this team were responsive and gave examples where they had supported critical care unit patients in the past.

Critical care follow up clinics had recently been introduced to the service. We observed this clinic and found that a thorough and holistic assessment was carried out for the patient, including lifestyle before being unwell and a psychological analysis. The clinic was based on the other side of the hospital to the critical care unit, in case patients felt uncomfortable going near the critical care unit due to their experience. Doctors told us that they can refer patients for psychological support to the local community mental health service as required.

Staff told us that the service did not use patient diaries for level three patients. Patient diaries provide a daily record of each day’s event whilst a patient is in intensive care. Supporting patients with a better understanding of what has happened to them in critical care may help to set realistic goals for recovery and minimise the risk of adverse long-term problems (National Institute of Clinical Excellence (2009) Rehabilitation after Critical Illness).

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

Paper feedback forms called “family and relative experience surveys” were given to patients and those close to them. We asked a manager to see the feedback forms the service had received in the past few months. We were shown only three forms, two gave positive feedback, such as one relative felt, “fully included in each stage of [their] mother’s care”. We were told these were the only recent surveys received. One of these three forms raised concerns about a lack of monitoring from critical care unit staff for step-down patients.

There were also other patient feedback forms in place which determine how likely people are to recommend the service to friends of family. We saw 17 were completed of which five were “likely” and 12 were “extremely likely” to recommend. There were three negative comments on these forms which included comments such as, “There was nowhere appropriate for a visitor who is next of kin to sleep in terminal cases”, and two patients did not feel they had questions about care planning fully answered.

Patients and relatives told us that staff communicated well with them to ensure they understood care, treatment and condition. We observed the medical team ensuring that the families of patients received all the information they needed whilst taking time to explain the care plan being delivered to the patient.

We also saw examples where patients were involved in their care. This included basic care and complex healthcare decision making. One nurse effectively communicated with a patient who was moderately sedated to ask if they would like mouthcare (oral hydration via soaked sponge). Another nurse, who was caring for a ventilated patient who was not able to communicate, was seen consistently telling the patient what they were doing and why, in a gentle manner, whilst caring for their needs.

Staff told us that a critical care consultant approached relatives for organ donation questions when treatment was being withdrawn, and the doctor then referred to the hospital’s specialist nurses for organ donation (SNODs) who then speak with families further. Staff told us that this type of discussion is always carried out sensitively.
Is the service responsive?

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

The critical care unit consisted of an eight-bed unit providing care at level two (high dependency) and level three (intensive care) to adults who required a higher level of care than could be provided on the wards.

Between September 2017 and August 2018, there were 427 admissions to the critical care unit.

There was a critical care outreach team (CCOT) to support acutely ill patients, prior to their transfer to the critical care unit, tracheostomy patients, or to follow up on patients discharged from the unit, all in other areas of the hospital. The CCOT led by three specialist nurses supported by a critical care consultant, they were available seven days a week for daytime cover between 08:00am and 08:00pm, with plans in place to increase to a 24 hour, seven day a week service.

There was a new follow up clinic available for patients who had been discharged from the critical care unit who met specific criteria. This clinic had been running for three weeks at the time of inspection.

A weekly tracheostomy MDT ward round for all patients with a tracheostomy involved the critical care team. The tracheostomy team included a critical care consultant, CCOT nurse, an ears, nose and throat (ENT) consultant, speech and language therapy and physiotherapy.

The trust told us that there had been no needs assessment conducted to support the planning of the critical care service.

There was a small relatives’ room outside the entrance to the critical care unit. Staff showed us a chair which adapted to become a bed to allow those close to patients overnight stay in the hospital. We saw that this chair was marked and appeared dirty. All six relatives we spoke with told us that this room was not responsive to their needs. One relative told us, “It was awful, nothing bright and too claustrophobic”. All relatives told us that this room was not a suitable environment when a person was emotional or distressed.

Visiting hours for the critical care unit were between 3:30pm to 7:30pm, seven days a week however; staff told us that these hours were flexible dependent on people’s needs, or if a patient was very sick then visiting hours would be “open”. We saw a relative be allowed in to the unit outside of these hours due to personal circumstances.

There were facilities within the hospital site where those close to patients could purchase food and drink, such facilities were available always. However, there were no facilities within the critical care unit, which three relatives of patients we spoke with told us would be useful.

**Meeting people’s individual needs**

Staff told us there were translation services available through face to face contact and via telephone. They told us that booking translation services was easy and gave examples showing the service was used. We also saw notices advertising translation services in public areas.

We saw notices throughout the service informing people about advocacy service available to patients and those close to them. Staff were familiar with such services when we asked.

Patients who were able to eat and drink could choose their meals from a selection of menus. These included vegan, gluten-free, kosher and halal choices. We saw that different textured food was also available.
Staff were unaware whether there was any patient literature that could be made available in different languages. A manager confirmed that most patient literature was provided in English.

Staff told us they had access to the hospital’s psychiatric liaison team 24 hours a day, seven days a week. They gave examples where they had accessed this service and told us that this team were quick to respond to referrals and effective.

We asked staff whether there were any aids available in the unit to assist communication between staff and patient’s living with a sensory loss, such as hearing loss, dementia or delirium. Staff told us that interpreters were available for sign language were available and clinical nurse specialists could provide additional supporting for patients living with dementia or delirium. We were shown a print out of the alphabet in English language, which two nurses told us they could and have used.

Staff told us they could access additional advice and support for patients living with a learning disability, and, or dementia, through the trust’s clinical nurse specialists (CNS) for learning disability, and dementia and delirium.

Training records showed that 97% of nursing and 100% of medical staff had completed dementia awareness training. A notice in the staff room showed that one of the critical care nurses was a link nurse for dementia and delirium.

We observed the critical care follow up clinic during our inspection and were told that it was the second clinic since the service was introduced in August 2018. Staff told us that the clinic ran monthly with three to four selected patients invited to attend. During the clinic we saw a thorough and holistic assessment carried out for the patient, including lifestyle before being unwell and a psychological analysis. Doctors explained to us the services they could refer patients to via the patients GP as required. This included community smoking cessation and mental health services.

**Access and flow**

From December 2017 to January 2018, Barts Health NHS Trust has seen a stable trend in monthly bed occupancy rates. Overall performance was generally worse than the England average.

Note data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month. During this period there were 2,920 available bed days. The percentage of bed days occupied by patients with discharge delayed more than 8 hours was 9.0%. This compares to the national aggregate of 4.9%. This meant that the unit was not in the worst 5% of units. The figure in the 2015/16 annual report was 5.7%.
<table>
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<th>Metric</th>
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<th>2016/17</th>
<th>National aggregate</th>
<th>Asp Standard</th>
<th>Comparison</th>
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</thead>
<tbody>
<tr>
<td>20 available</td>
<td>Crude delayed discharge (% bed-days occupied by patients with</td>
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<td>9.0%</td>
<td>4.9%</td>
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During our inspection we looked at more recent data from January to September 2018 which showed that there had been 78 delayed discharge incidents of more than eight hours during that period of time, with 52.5% delays being due to a lack of ward beds. These rates were similar compared to 2017 where there had been 130 delayed discharges.

Data from 2016/17, showed there were 384 admissions, of which 1.8% had a non-clinical transfer out of the unit. This was within expected range. The figure in the 2015/16 annual report was 1.2%.

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<tr>
<td>384 admissions</td>
<td>Crude non-clinical transfers</td>
<td>1.2%</td>
<td>1.8%</td>
<td>0.4%</td>
<td>0%</td>
<td>Within expected range</td>
</tr>
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Records we checked during our inspection showed that there had been no non-clinical transfers from the critical care unit from January to September 2018.

During our inspection data demonstrated that out of hours discharges to the ward were high. Between January to September 2018 43% (23 incidents) of all critical care unit discharges took place between 10:00pm and 6:59am. In 2017 there were 69 recorded incidents of out of hours discharges to the ward.

Managers told us that the recovery area in main theatres was available and staffed as necessary, for critical care patients if the critical care unit capacity was reached. We were shown an up-to-date standard operating procedure (SOP) document which provided a framework to support this procedure.

**Learning from complaints and concerns**

From April 2017 to March 2018, there were three complaints about the critical care services. The trust took an average of 58 days to investigate and close complaints, this is in line with their complaints policy, which states complaints should be completed between 10-60 days.

All three complaints were for the critical care unit, two of which related to diagnosis/ treatment; patients feel they received poor care from staff and one complaint was due to poor communication from nurses.

We checked the complaint responses for three complaints. We found that complaints were investigated appropriately, handled effectively and were responded to in a timely way.

Senior staff could demonstrate that lessons were learnt from concerns and complaints and that action was taken as a result to improve the quality of care. For example, staff were able to tell us
about all the serious incidents that had happened in the past year and what changes had been made to practice.

Throughout the service we observed notices which informed patients and visitors how to make a complaint or raise concerns. This included details of the trust’s Patient Advice and Liaison Service (PALS) and the PHSO.

Is the service well-led?

Leadership

The critical care service was part of the hospital surgical division which was headed by a clinical director, a lead nurse and general manager.

The service had clear management structure at local level. This included a designated clinical lead who was an accredited critical care consultant, and a lead nurse who was a matron (Band 8a) with overall responsibility for the nursing elements of the service.

There was an allocated lead consultant and supernumerary clinical coordinator (charge nurse band 7) on duty 24 hours a day, seven days a week. The CCOT who were available between 08:00am and 08:00pm reported to the lead consultant for the service daily.

Staff across all levels consistently told us that local managers were supportive, visible and approachable.

We saw service leads encourage appreciative supportive relationships among staff. Staff we spoke with confirmed this and told us that the culture of the service internally had improved greatly since new management had been appointed, particularly in terms of medical leadership. Staff also spoke highly of nursing leaders. Numerous staff members praised the practice development nurse (PDN), who they recognised as making significant improvements to learning and development in the past year.

Leaders demonstrated to us they had the skills, knowledge, experience and integrity to lead the service. The clinical and nursing lead for the service were responsible for the critical care service alone and demonstrated they had the capacity for effective leadership.

Due to the collective concerns we have raised about the service in this report the leadership requires improvement. We identified concerns with staff hand hygiene, equipment checks and cleaning not being recorded, multiple policies and procedure which staff accessed being out-of-date, there was a lack of patient literature available in alternative languages, the relatives room was not responsive to relatives needs and a there was a lack of formalised action plans in relation to identified risk.

However, we also recognise that some of the additional concerns we have identified are beyond the hands of local staff. This includes concern about the premises, which continues not to meet national guidelines for critical care facilities that we raised as a concern in 2015; and poor patient flow out of the critical care unit including high out of hours discharges and delayed discharges due to lack of ward beds. Staff locally demonstrated that they have acted to mitigate risk where possible and escalate concerns about these issues to senior hospital managers on multiple occasions, however, that little or no action has been taken subsequently. Therefore we found the critical care service was not being supported by senior management and above to make necessary safety improvements where required.
Vision and strategy

Staff were familiar with the trust’s set of values, which were displayed on notices throughout the service. They also demonstrated that quality and safety was a top priority in terms of service vision and aims.

There were no formalised vision and strategy for the critical care service which leaders confirmed. However, they could demonstrate through talking and showing us data, including the service risk register, what the services priorities were and that necessary action was being taken to achieve these risk as much as was in their control. This included the recent approved business case for increasing the CCOT service to 24 hours, seven days a week service which we found being actioned and on the services risk register.

Culture

Staff across all levels told us that the entire multidisciplinary team (MDT) worked well together, and they felt valued and respected by one another. One member of staff told us that the critical care unit was a, “nice friendly unit”, and another said that staff were all, “supportive, kind and hardworking”. A manager told us that, “[w]e do what we can to make the best of what we have here”.

We observed excellent collaborative working between all staff groups who evidently shared responsibility to deliver good quality care, with culture centred on the needs and experience of people who used the service.

Staff were familiar with duty of candour (DoC) requirements. They could explain what DoC meant and their role relating to this. We saw evidence that DoC was applied appropriately where required.

Throughout the inspection we found that staff were open and honest to us about what worked well in the service and where improvements were required. The provision of data by staff was prompt onsite when we requested this and reflected what we were told.

Governance

The service had a clear governance framework in place to support the delivery of good quality care. However, as there was no formalised strategy for the service we were unable to fully determine if this framework was effective to support the delivery of service objectives as none had been set in this manner.

All staff we spoke with were clear about their roles and understood what they were accountable for. Senior managers for the service were able to explain the leadership structure for the service and understood what each leader was responsible for.

There were suitable systems and processes in place to measure quality, performance and risk. This included a service risk register, critical care performance tool called a “multi-activity record”, and incident and complaints logs. We found that leaders had good oversight and understanding of service performance.

We reviewed the risk register for the critical care service and found that this was up-to-date, with staff allocated and accountable to different risks, and generally that risk captured reflected what staff told us was on their “worry list”. However, we found that out of hours discharges were not on the service risk register.
The service used a performance dashboard they called a “multi-activity record” this showed data from 2016, 2017 and 2018 including out of hours discharge, admission, readmission and standard mortality ratio rates.

The NHS safety thermometer was used and records showed this was reviewed regularly.

The service operated a local and national audit programme which we have discussed fully under the effective domain in this report.

We were concerned about the management of third party working arrangements. This is in relation to the maintenance of equipment by an external company of which we have discussed under the safety domain in this report.

Overall the governance framework arrangements allowed for a holistic understanding of service performance, which integrated the views of people who used the service with safety, quality, activity and financial information.

There were assurance processes in place to ensure that data collection was reliable and accurate. The audit lead received regular computer software training and updates to support data collection for the service. They also had a contact for ICNARC as required and had completed ICNARC training.

We asked to see the procedure or approved business case for the critical care follow up clinic, however, managers told us these had not been completed. Staff told us that they started this service as a “volunteer project” and that when they can demonstrate that it meets a need a business case will be submitted. We did however see that a “feasibility proposal” for the service had been completed initially which was in line with the trust’s business case protocol. However, the lack of foundation in terms of business case and agreed statement of purpose meant that we could not be assured the clinic was for the long-term and sustainable. The Guidelines for the Provision of Intensive Care Services (2015) state that patients discharged from intensive care services should have access to a critical follow up clinic.

Management of risk, issues and performance

There were systems and processes in place to ensure that risk, issues and performance were regularly reported on, monitored and managed, with necessary action taken to mitigate risk and issues where required.

Reports included the service’s risk register, monthly “multiactivity” reports, quarterly and annual ICNARC reports and audit reports including monthly NEWS audits by the CCOT team which we have discussed under the safety and effective domain in this report. We found that the risk register reflected the concerns we identified about the critical care service, with exception to the high number of out of hours discharge rates which was not recorded.

There were regular meetings where such risk, issues and performance reports were monitored and managed. This included senior staff critical care unit meeting, governance meetings, deteriorating patient group, mortality and morbidity and senior nurse meetings, which all took place monthly. We reviewed the last three meeting minutes for the critical care unit, mortality and morbidity and senior critical care unit nurse meetings and saw evidence of monitoring and management of risk.

Hospital wide meetings called “safety huddles” took place each week day to identify potential risks and allocate resources effectively. We observed one of these meetings and saw that there was a representative for the critical care service who escalated concerns about two patients that required step-down from the critical care unit.
There were also three-time daily bed management meetings which we saw the matron attended daily to represent the critical care service and provide data about the service.

We saw examples of action taken to mitigate risk and improve service provision after reporting and monitoring, which included, fire risk and pressure ulcer management. However we also found that necessary action to improve the service had not been taken, despite known risk. This included the relatives room which was not responsive to relatives needs which we raised concerns about to the trust in 2015, poor compliance with hand hygiene, the premises not meeting national building guidelines for critical care facilities and high numbers of out of hours discharges and delayed discharges. We have discussed this fully under the “Leadership” subheading above.

Following our inspection, on 17 October 2018 senior hospital managers told us that they had taken some immediate action in relation to the new concerns we raised. This included the introduction of daily hand hygiene audits for the critical care unit, aesthetic improvements to the relatives room including the room being newly painted and brighter, with a television and lamps put in place; and a review of policy and procedure throughout the service to ensure that these were up-to-date and accessible to staff.

**Information management**

Paper records were generated for each patient admitted to the critical care unit and included a daily observation chart and two folders, one for nursing and allied healthcare professionals and another for the medical team. These were easily assessable to all staff, stored at each patient bedside as they were in constant use.

When patients were discharged from the critical care unit, staff were seen to give a thorough handover to the ward via telephone, they accompanied the patient to the ward, gave a face-to-face handover to the ward nurse and gave the patient’s healthcare records including the formal critical care unit handover document to the ward staff, which contained admission history, treatment, care and follow up plan.

We saw a patient board on the critical care unit which contained sufficient yet non-patient identifiable information about patient’s individual nutrition and hydration needs. This was used by hostess staff and updated daily with the lead critical care unit nurse.

Staff across the service demonstrated that they were able to access trust-wide systems for patient’s blood and radiology results as authorised. However, several members of staff told us that computer systems were very slow, which was frustrating, and required upgrading.

We were told that patient’s past medical records could be requested and accessed by the service at all times.

Leaders demonstrated they had access to necessary information they required in relation to their leadership and governance role. This included immediate access to patient information, staffing rotas, the service risk register and performance dashboard.

We saw that staff could access the staff intranet system which contained links to policies, guidelines and general trust wide information. However staff mainly used paper copies of policies and procedures which were found in folders throughout the critical care unit. We saw that many of the policies and procedures we checked were either not up-to-date or were not copies of the most recent versions.

Staff told us they could access their work email account and that they received information from managers, such as the monthly critical care newsletter, regularly.
Engagement

Patients and those close to them were encouraged to give feedback about their experience of the service. We saw one feedback form being given to a patient who was stepping-down from the critical unit to the ward.

Staff could give one example of how patient feedback was used to shape and improve the service. For example, staff told us there had been a few comments from patients and visitors that the critical care unit was very noisy at times. As a result of this, staff told us they had been reminded to keep noise to a minimum where possible, particularly of a night, which they said they did.

There were notices throughout the service which informed patients and those close to them how to raise comments and concerns. This included information provided about the hospital’s Patient, Advice and Liaison Service (PALS).

Staff told us that there had been past opportunities to be involved in the plans for future service redesign. They also told us that they were able to raise any matters at critical care unit staff meetings which they were invited to, and that managers could be approached at any time to discuss issues.

Staff told us they had been invited to participate in staff surveys. We checked the results from the last staff survey which took place in January 2017. Staff had reported that they often or always enthusiastic about their job and that they were supported by their manager to receive training, and that learning and development had been identified in appraisal. Areas that needed improving included staff compliance with mandatory training in past twelve months, organisation encourages reporting of errors and team members often meet to discuss the team’s effectiveness. However during our inspection we saw that improvements had been made in relation to these areas since then of which staff further confirmed.

There was a staff notice board in the staff room containing updates about the service. This included the names of critical care link staff and their speciality, and a recent tissue viability update about how grading of pressure ulcer is a specific category to be completed within the incident report form.

Staff gave us examples of how their views had led to improvements. One doctor told us that after a junior doctor coming up with the idea, the medical team now completed the “ten by ten” training sessions which were brief, succinct learning sessions which happened daily.

Learning, continuous improvement and innovation

Numerous staff members praised the new medical lead and practice development nurse (PDN), who they recognised as making significant improvements to the service in the past year. This included the PDN who had introduced relevant study days and the critical care service newsletter.

The service carried out “safety briefings” which were communicated at the beginning of each shift. These were safety updates relative to the critical care service.

The service participated in local and national benchmarking. Local benchmarking occurred through participation in the “North East and North Central London Adult Critical Care Network”. The clinical lead for the service was the Newham University Hospital critical care service representative and records we saw showed they attended regular network meetings, contributed to these meetings and shared from these with staff at Newham University Hospital critical care unit.

After a junior doctor coming up with the idea, the critical care team since completed the “ten by ten” training sessions which were brief, succinct learning sessions which happened daily.
A consultant from the critical care unit conducted a recent audit titled, “Can nasal high flow support be used in Type 2 respiratory failure”, which identified that “high flow oxygen therapy (Optiflow) has changed the outcome and quality of life in our patients in the wards”. We saw that these results had been published in the “American Journal of Respiratory and Critical Care Medicine” earlier this year and the results had led to agreed changes in practice.

The service had started running simulation training for a variety of subjects. Records showed that “trache” simulation morning was held in August 2017 and a fire evacuation simulation happened in September 2018.

## Services for children and young people

### Facts and data about this service

Children and young people’s services at Newham University Hospital are consultant-led. Children and young people are admitted for a range of medical and surgical conditions, including oncology, general surgery and ear, nose and throat (ENT) services. Admissions are via the emergency department, outpatients and waiting lists.

The Rainbow Centre for children and young people opened in February 2017 after a major refurbishment funded by Bart’s Charity. The Centre’s accommodation consists of children’s outpatients, day care and inpatient beds. There are five outpatient consulting rooms and two six-bedded bays for day care. Inpatients has seven cubicles, two six-bedded bays and a two-bedded stabilisation unit. All single rooms are en-suite.

The Neonatal Unit (NNU) is a designated level 2 NNU within the North Central and East London Neonatal Network. The NNU provides intensive care (two cots), high dependency care (four cots) and special care (17 cots). The level of care provided within the unit allows for all categories of neonatal admissions apart from babies who require complex or long term intensive care. (Source: 20180517 RPIR Acute - NUH Documents – Context)

The trust had 16,184 spells across all sites from April 2017 to March 2018. Emergency spells accounted for 56% (9,060 spells), 36% (5,882 spells) were day case spells, and the remaining 8% (1,242 spells) were elective.

Percentage of spells in children’s services by type of admission and site, from April 2017 to March 2018, Bart’s Health NHS Trust:
Total number of children’s spells by Site, from April 2017 to March 2018 at Bart’s Health NHS Trust:

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Royal London Hospital</td>
<td>9,389</td>
</tr>
<tr>
<td>Whipps Cross University Hospital</td>
<td>3,852</td>
</tr>
<tr>
<td>Newham University Hospital</td>
<td>2,817</td>
</tr>
<tr>
<td>St Bartholomew's Hospital</td>
<td>121</td>
</tr>
<tr>
<td>This trust</td>
<td>16,184</td>
</tr>
<tr>
<td>England average</td>
<td>1,114,797</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode statistics)

Is the service safe?

Mandatory training

The trust set a target of 85% for completion of mandatory training. A breakdown of compliance for mandatory courses as of the 4 June 2018 for nursing staff in children and young people’s services is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Assessment for Managers</td>
<td>11</td>
<td>11</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling - Patient Handling Low Risk</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Security</td>
<td>65</td>
<td>66</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness</td>
<td>65</td>
<td>66</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Working at Bart’s Health</td>
<td>65</td>
<td>66</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Emergency Planning</td>
<td>65</td>
<td>66</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fraud Awareness</td>
<td>65</td>
<td>66</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>65</td>
<td>66</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Clinical Documentation</td>
<td>64</td>
<td>66</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Complaints</td>
<td>64</td>
<td>66</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety</td>
<td>64</td>
<td>66</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Nutritional Care</td>
<td>63</td>
<td>65</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Harms - Catheter Acquired Infections</td>
<td>63</td>
<td>65</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Topic</td>
<td>Code</td>
<td>Code</td>
<td>% Complete</td>
<td>% Target</td>
<td>Status</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>------</td>
<td>------</td>
<td>------------</td>
<td>----------</td>
<td>--------</td>
</tr>
<tr>
<td>Early Warning Systems</td>
<td>63</td>
<td>65</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>63</td>
<td>65</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Harms - Pressure Ulcer Prevention</td>
<td>63</td>
<td>65</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>59</td>
<td>61</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Privacy and Dignity</td>
<td>63</td>
<td>66</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Harms - VTE</td>
<td>62</td>
<td>65</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical Gas Safety</td>
<td>60</td>
<td>63</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling - Inanimate Loads</td>
<td>36</td>
<td>38</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Harms - Slips, Trips and Falls (Patients)</td>
<td>61</td>
<td>65</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>61</td>
<td>66</td>
<td>92%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention and Control - Clinical</td>
<td>61</td>
<td>66</td>
<td>92%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>58</td>
<td>63</td>
<td>92%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Investigation of Incidents</td>
<td>10</td>
<td>11</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>51</td>
<td>66</td>
<td>77%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling - Patient Handling Practical</td>
<td>20</td>
<td>27</td>
<td>74%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation - Basic Life Support</td>
<td>47</td>
<td>66</td>
<td>71%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing and midwifery staff exceeded the trust’s 85% completion target for 26 out of 29 mandatory training modules. During our inspection we found that the overall completion rate had increased to 89.94%, and Fire Safety, Moving and Handling and resuscitation had improved to meet the trust target.
A breakdown of compliance for mandatory courses as of the 4 June 2018 for medical staff in children and young people’s services is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/ No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Transfusion</td>
<td>28</td>
<td>32</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>27</td>
<td>32</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling - Patient Handling Low Risk</td>
<td>27</td>
<td>32</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Security</td>
<td>27</td>
<td>32</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>4 Harms - Slips, Trips and Falls (Patients)</td>
<td>26</td>
<td>32</td>
<td>81%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>26</td>
<td>32</td>
<td>81%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>4 Harms - VTE</td>
<td>26</td>
<td>32</td>
<td>81%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Clinical Documentation</td>
<td>26</td>
<td>32</td>
<td>81%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fraud Awareness</td>
<td>26</td>
<td>32</td>
<td>81%</td>
<td>85%</td>
<td>No</td>
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<tr>
<td>Consent</td>
<td>26</td>
<td>32</td>
<td>81%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Nutritional Care</td>
<td>26</td>
<td>32</td>
<td>81%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>4 Harms - Catheter Acquired Infections</td>
<td>26</td>
<td>32</td>
<td>81%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>4 Harms - Pressure Ulcer Prevention</td>
<td>26</td>
<td>32</td>
<td>81%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety</td>
<td>25</td>
<td>32</td>
<td>78%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Privacy and Dignity</td>
<td>25</td>
<td>32</td>
<td>78%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Dementia Awareness</td>
<td>25</td>
<td>32</td>
<td>78%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Emergency Planning</td>
<td>25</td>
<td>32</td>
<td>78%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>24</td>
<td>32</td>
<td>75%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Early Warning Systems</td>
<td>24</td>
<td>32</td>
<td>75%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>24</td>
<td>32</td>
<td>75%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention and Control - Clinical</td>
<td>22</td>
<td>32</td>
<td>69%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Working at Bart’s Health</td>
<td>22</td>
<td>32</td>
<td>69%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Medical Gas Safety</td>
<td>12</td>
<td>20</td>
<td>60%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation - Basic Life Support</td>
<td>17</td>
<td>32</td>
<td>53%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>
Medical and dental staff only exceeded the trust’s 85% completion target for one out of the 24 mandatory training modules. The lowest scoring module was resuscitation – basic life support with 53% (Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training). During our inspection we saw documentary evidence that mandatory completion rates medical staff had improved but remained below the trust target.

**Safeguarding**

The trust set a target of 85% for completion of safeguarding training. A breakdown of compliance for safeguarding courses as of the 4 June 2018 for nursing staff in children and young people’s services is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Level 1</td>
<td>66</td>
<td>66</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>65</td>
<td>66</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>63</td>
<td>65</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>60</td>
<td>66</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 3</td>
<td>56</td>
<td>65</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Nursing and midwifery staff exceeded the trust’s 85% completion target for all five safeguarding modules.

A breakdown of compliance for safeguarding courses as of the 4 June 2018 for medical staff in children and young people’s services is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>30</td>
<td>32</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 1</td>
<td>30</td>
<td>32</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>30</td>
<td>32</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 3</td>
<td>13</td>
<td>16</td>
<td>81%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>23</td>
<td>32</td>
<td>72%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical and dental staff exceeded the trust’s 85% completion target for three out of five safeguarding modules (Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training). During our inspection we sought an update from the service about the
outstanding targets for safeguarding children level 3 and safeguarding adults level 2 and documentary evidence provided by the trust showed completion rates had improved to 87.8% and 84.3% respectively.

Nurses we spoke with in the Rainbow Centre were aware of the process for escalating safeguarding concerns. Nurses received training for safeguarding level 2 or 3 depending on their level of responsibility. Some nurses told us they had attended safeguarding strategy meetings on the ward.

There was a named nurse for safeguarding in the hospital reporting to the named nurse for the trust. There was also a named midwife for safeguarding and a named doctor. The named nurse provided a safeguarding on call telephone advice service during out of hours and weekends. Staff across CYP services told us the hospital safeguarding team was accessible when needed.

The service had a safeguarding protocol for discharging young people with mental health concerns, which involved other professionals in the community to ensure support provision was available once the patient had left hospital. This included the local safeguarding children board. The trust was investing in staff training to help improve their confidence in working with children and young people with mental health support needs.

The service improved the support available for patients as part of the learning from a safeguarding case review. For example, the service developed the ‘do you feel safe’ campaign and displayed posters with supporting information for children and young people who were being bullied.

The safeguarding record forms in the neonatal unit were reviewed and amended following a serious case review to include new observations for parental visits and their length of stay, parental interactions with the baby, father details and if the father’s access to the unit was restricted, as these were identified as indicators of potential safeguarding concerns.

There was a flagging system on the trust incident reporting system to highlight safeguarding concerns, which shared the incident report with the relevant safeguarding staff. The service held debriefings for staff following safeguarding incidents to identify learning.

We tracked a safeguarding record and found that the safeguarding protection plan on the electronic patient record contained relevant detailed information recorded by relevant clinicians and practitioners. The record provided a clear narrative of actions taken, plans, mitigations and the decision making by the accountable member of staff. It included notes of case conferences and decisions. The record included admission summary, postnatal notes, daily nursing and medical interventions in chronological order, discharge planning meeting notes and psycho-social meeting notes.

The staff we spoke with were aware of how to identify safeguarding concerns such as domestic violence and female genital mutilation (FGM) and those patients at risk. Staff could explain the processes for escalation to the safeguarding team. FGM awareness was included in mandatory safeguarding training.

The hospital safeguarding team had set out a comprehensive audit programme for 2018/19, but at the time of our inspection it was too early to see the impact of this work.

Every Tuesday there was a safeguarding meeting which included discussion of all children requiring psycho-social support including children with learning disabilities, young people with mental health support needs, children with child protection plans, and those at risk of self-harm.

Nurses in the neonatal centre highlighted that they frequently cared for infants with potential safeguarding risks, for example substance misuser parents. In such cases, the nurses liaised with
the hospital social work team while the mother and baby were on the labour ward. There were meetings to plan interventions and safeguards. Nurses told us the process worked well as all staff involved in the mother and infant’s care were informed about the concerns, understood their responsibilities and had knowledge of the situation before the baby left the delivery suite.

We saw there was good attendance at initial child protection conferences for unborn babies, with reports submitted, and minutes and plans uploaded onto electronic patient record and copies filed in the paper record to ensure clinicians had access to the information when the baby arrived.

Cleanliness, infection control and hygiene

In the CQC Children and Young People’s Survey 2016 the trust scored 8.42 out of ten for the question ‘How clean do you think the hospital room or ward was that your child was in?’ This was about the same as other trusts (Source: CQC Children and Young People’s Survey 2016, RCPCH). Patients and relatives we spoke with during the inspection were satisfied with the level of cleanliness on the wards.

All the children and young people (CYP) clinical areas were visibly clean and clutter free. Hand sanitisers were available throughout the Rainbow Centre and neonatal unit and at points of entry. There were clear, child friendly handwashing instructions at handwashing basins as well as signage to inform visitors to use hand sanitisers. Posters on the ‘seven steps to good hand hygiene’ were displayed by sinks.

At the entrance to the neonatal there was a painted red line on the floor at the entrance to the ward which served as a very visual notice to visitors to wash their hands at the sink located at the entrance to the unit. We observed the receptionist on the unit inform and remind all visitors that they had to wash their hands according to the instructions displayed by the sink.

Staff told us they felt confident to challenge staff to ensure they were ‘bare below the elbows’ and used personal protective equipment (PPE) such as gloves and aprons. There was easy access to PPE such as aprons and gloves throughout the wards and at the entrance to side rooms. We witnessed staff using PPE effectively.

Throughout our inspection staff were observed to be ‘bare below the elbow’ and adhered to infection control procedures, such as hand washing and using hand sanitisers when entering and exiting the unit and bed spaces. We observed medical and nursing staff washing their hands and change PPE between all patient contact.

Infection, prevention and control (IPC) was part of mandatory training and trust records showed it was completed by 81% of nursing staff as at September 2018. This was slightly below the trust’s target of 85%. For medical staff, infection control training completion was 77% which was below the trust’s target.

The IPC standard operating procedures we reviewed were up to date and accessible by staff on the hospital intranet.

There were three dedicated cleaners assigned to each part of the CYP service. The staff we spoke with felt that this helped ensure cleanliness as the regular staff had a stake in ensuring it was kept clean as they were connected to the ward and held accountable. We observed cleaners working throughout the day maintaining the cleanliness of the ward. Cleaners worked to standardised cleaning schedules which detailed the types of cleaning tasks that needed to be completed. The cleaning schedules we saw were fully completed, dated and signed.

We reviewed patient areas across the wards as well as clean and dirty utility rooms and treatment rooms. All areas we checked were visibly clean. However, the neonatal decontamination room
was recorded on the service risk register because there was insufficient space to completely ensure the safe segregation of clean and dirty equipment. We saw documentary evidence of plans to move the clinical preparation rooms and decontamination rooms around to make more space and make them more usable, which were reviewed by the trust’s Investment Steering Committee. Architects had surveyed the area and produced floor plan drawings, which were in the process of gaining sign off by the site leadership.

We inspected various items of equipment, such as commodes, bed tables, wheelchairs, weighing scales and blood pressure cuffs and found a good level of cleanliness. We checked a sample of toilets and shower rooms on the wards and found them to be visibly clean. The service used ‘I am clean’ stickers to identify equipment that had been cleaned and was ready for use. All the equipment and stickers we sampled were clean and the date was recorded.

Isolation procedures were in place for patients with infections and cubicles were marked clearly with a red poster to alert staff and visitors of an infectious patient with instructions of the precautions to take prior to entering the cubicle. On the neonatal unit there were isolation rooms for babies at risk of infection or with infections. The procedure was for babies to have three clear swabs before they were cleared to go into a bay with other infants. We observed staff adhering to isolation protocols and doors remained closed. We saw leaflets were available for patients and visitors about infection control and isolation. These provided details about the purpose of isolation and what was required.

Waste management and removal, including those for contaminated and hazardous waste was in line with national standards. There were waste disposal bins in appropriate locations on the ward and those we checked were not overfull.

There was an outbreak of *Methicillin-resistant Staphylococcus aureus* (MRSA) on the NNU in February-April 2018. There was a further case in August 2018 which was contained. The service had taken appropriate action to prevent recurrence and learning was shared in response to both cases.

**Environment and equipment**

The Rainbow Centre re-opened in February 2017 after a period of major refurbishment and redevelopment, which was funded by the trust charity. The investment resulted in an environment that was bright, clean, welcoming and designed in a coherent and child-friendly way which flowed well. Walls displayed bright children’s characters, murals and stickers to make it feel less clinical. Staff consistently told us the new environment and facilities made a big different to their work and they felt reinvigorated and motivated by it. In our previous inspection of the CYP service at Newham University Hospital in November 2016 staff reported many issues with the environment, for example limited ventilation. During this inspection we found this had improved as there were no problems with ventilation or air circulation and staff were happy with the new set up.

The Rainbow Centre accommodation consisted of children’s outpatients, day care and inpatient areas. There were five outpatient consulting rooms and two six-bedded bays for day care. Inpatients had seven cubicles, two six-bedded bays and a two-bedded stabilisation unit. All single rooms were en-suite. We found all waiting areas, wards and clinical treatment areas were spacious, well-lit, tidy and free of clutter.

The stabilisation room was very well equipped with state of the art equipment and was well designed to ensure sufficient space for staff and equipment to move around as patients were being stabilised. There was a digital timer on the wall for each bed in the room to keep accurate records during resuscitation situations.
There was a separate paediatric recovery in the hospital operating theatres to provide children and young people with a dedicated space away from adult patients after their surgery.

There were indoor and outdoor play areas for children. The outdoor space had been redeveloped to include a garden zone, a ‘chill out’ hut for teenagers, and a dedicated secure space for parents to store their buggies away from the clinical area. The ward also had a dedicated adolescents’ room to provide a separate space for older children.

The Day Care area had bright coloured cots for young children and comfortable seating for parents which turned into beds for when parents wanted to rest.

The Rainbow Centre also had a baby feeding room and separate baby changing facilities in the outpatients area. There was a dedicated breast feeding and expressing room in the NNU with two spaces, which some staff felt was insufficient because there were times of high demand. There were curtains which could be drawn between each space to maintain privacy and dignity. Sterilisers were also available in the parents’ room on the neonatal unit. Parents did not have access to the milk storage room on the ward.

We saw evidence that equipment was routinely and regularly serviced and calibrated. The equipment store room was well organised and clean with secure access. We checked various items of equipment such as defibrillators and blood pressure monitors and found they had been safety tested and were all within service date. Most of the equipment we checked was purchased new at the time of the Rainbow Centre redevelopment. The service used specialised age appropriate equipment such as paediatric blood pressure monitors and cuffs. Fire extinguishers and oxygen tanks were stored securely and were in date.

In the neonatal unit daily equipment checks were completed on cots. We saw that baby scales were properly calibrated. However, some staff in the NNU told us the service would benefit from investment in more contemporary equipment such as new baby monitors, new incubators and new therapy lights, although they recognised this was not a priority. Some doctors in training on the neonatal unit also reported some challenges finding specific equipment or consumables such as ‘broken needles’ (short needles used for taking bloods from babies. While not technically essential they are useful and cheaper than using cannulas for blood tests which would be the alternative if they cannot be done by heelprick, due to size of baby, volume of blood needed and type of test needed).

Additionally, some doctors in training told us about instances where resuscitaires in the neonatal unit did not have all necessary equipment on them, for example a stethoscope or a range of mask sizes, which presented potential patient safety risks. During our inspection the resuscitaires we checked had all expected equipment available. The doctors in training we spoke with wanted more involvement in equipment and consumable procurement decisions and they told us the service was receptive to this.

Needle sharps bins were available throughout wards and within the medication preparation area. The bins we inspected were correctly labelled and none were filled above the maximum fill line.

Sensory equipment and projectors were available in playrooms and rooms for children with learning disabilities.

Stocks of consumables were well managed, and staff told us they were mostly easy to locate and regularly replenished. Stores were well labelled and organised in alphabetical order. In times of high demand, the service could courier consumables from other hospitals within the trust.

There was specialist equipment in the Rainbow Centre and neonatal unit which facilitated more timely treatment and interventions. For example, there were two x-ray machines on the neonatal
unit so that radiographers did not need to bring equipment to conduct an x-ray on an infant. There was a high flow respiratory support system for paediatric and neonatal continuous positive airway pressure, meaning patients with acute respiratory needs did not need to be transferred elsewhere. The service also had two dedicated blood gas analyser machines in the Rainbow Centre and Neonatal Unit. This meant clinicians could obtain instantaneous blood test results as the samples did not need to be collected and analysed by a separate pathology team. All nurses, doctors and healthcare assistants (HCAs) in both units were trained to use the machines during their induction to the unit. This made treatment response times much more rapid. Such equipment was not frequently seen in other units of this size in other NHS trusts.

Assessing and responding to patient risk

In the CQC Children and Young People’s Survey 2016 the trust scored 7.98 out of ten for the question ‘Were the different members of staff caring for and treating your child aware of their medical history?’ This was about the same as other trusts.

In the CQC Children and Young People’s Survey 2016 the trust scored 9.82 out of ten for the question ‘Were you given enough information about how your child should use the medicine(s) (e.g. when to take it, or whether it should be taken with food)?’ This was better than other trusts (Source: CQC Children and Young People’s Survey 2016, RCPCH).

Planned staff rota ensured there were sufficient numbers of doctors and nurses on shift with the required level of paediatric life support training including Advanced and European paediatric life (APLS and EPLS). There were daily multiprofessional ‘safety huddles’ to identify patient risks and discuss clinical interventions, acuity, discharge arrangements and any social and family matters or safeguarding concerns relating to each patient.

There was a security system in place to control access to the Rainbow Centre and neonatal unit. All the CYP clinical areas were secure entry with key codes, CCTV and buzzers to control and monitor who entered and exited the wards. Ward clerks sat at desks at the entrance to the Rainbow Centre and neonatal unit to check in visitors. There were further secure entry points in the Rainbow Centre inpatient and day case areas.

Infants in the NNU were security tagged to prevent unauthorised removal from the unit. In such cases the security system automatically closed and locked all major doors in the hospital and a computer panel by the nurses’ station displayed which baby had been removed. Staff could disable the tagging alert if a baby was required to leave the unit, for example to attend a service off-site. The system was believed to have been introduced because of an attempted abduction at another hospital within the trust. There were regular abduction drills on the Newham neonatal unit.

In the Rainbow Centre there was an emergency call bell in each side room to alert staff. There was a central console at the nurses’ station to identify where the call bell was coming from. In the NNU there was one alarm speaker for the neonatal unit, the labour ward and the birth centre. Nurses told us they had to check the control panel each time the alarm went off to check it related to patients in the NNU. They had raised this with senior staff as it had caused some unnecessary stress on the unit, particularly during times of high acuity or when the unit was short staffed or at full capacity.

The neonatal unit used a password system for parents calling the unit so that staff were assured they were speaking with the correct person and ensure the confidentiality of sensitive and personal information. During ward rounds only parents of the baby being discussed by clinicians were allowed in the room to ensure confidentiality.
Children and young people were monitored for signs of deterioration using a paediatric early warning score system (PEWS). Vital signs were measured every four hours and recorded using a paper PEWS form which was included in patient notes and on the inpatient ward board. Observations protocols were clearly displayed by the nurses station. Nurses we spoke with were aware of escalation protocols if a patient scored higher than expected. Senior nurses received in depth one to one training on the use of the PEWS chart and sepsis tool. All clinical staff in the service received training in the recognition and care of sepsis in children and young people.

We reviewed nine patients’ nursing records and found that the PEWS was recorded in all cases. The trust-wide policy for the prevention and management of the deteriorating patient was current. The PEWS charts and guidance contained a clear escalation plan with actions and contact details in the event of a deteriorating patient. In emergency situations the policy instructed nurses to call the hospital critical care outreach team if there was a ‘crash’. There were emergency ‘grab bags’ and resuscitation trolleys in convenient locations within the service for such emergencies.

At the time of our inspection the hospital neonatal unit did not use new-born early warning trigger and track (NEWTT) to identify deterioration. However, we found clearly recorded and fully completed observation charts for each infant. A separate chart was also completed each day documenting whether parents visited and their interaction with the baby (bathing, nappy changing and feeding). Some neonatal nurses were trained to do new-born and infant physical examination (NIPE) screening checks, but this was usually completed by a doctor. In NNU the nurses also checked scores for wounds and cannulation on each infant, using the Visual Infusion Phlebitis (VIP) score. The VIP score is a tool that facilitates the timely removal of short peripheral intravenous catheters at the earliest signs of infusion phlebitis. Not all neonatal units did this but clinicians told us that it had reduced incidence of babies having abscesses or infections as a result.

In theatres two members of staff were allocated to each child in recovery. There was a paediatric resuscitation trolley in the recovery area and all staff caring for children in theatres were required to complete paediatric immediate life support (PILS) training.

**Nurse staffing**

Newham University Hospital reported the following nurse staffing numbers for children and young people’s services in March and April 2018. The trust’s fill rate remained the same for both reporting periods.

<table>
<thead>
<tr>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Services for Children and Young People</td>
<td>63.7</td>
<td>77.3</td>
<td>82.4%</td>
<td>63.7</td>
<td>77.3</td>
<td>82.4%</td>
</tr>
</tbody>
</table>

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

From May 2017 to April 2018, Newham University Hospital reported a vacancy rate of 20.9% for nursing staff in children and young people’s services, this was higher than the trust target of 6.3% (Source: Routine Provider Information Request (RPIR) P17 Vacancies).

We sought an update from nurse leaders during our inspection who confirmed that the vacancy rate had decreased. At the time of our inspection there were no vacancies for band seven nurses.
and two vacancies for band six nurses (against an establishment of 22). There were four vacancies for band five nurses (against an establishment of 19) and four newly qualified nurses had been recruited to fill these posts. There were vacancies for 2.87 WTE band four nurses (against an establishment of 10.87) for which one existing HCA had been recruited following completion of training.

From May 2017 to April 2018, Newham University Hospital reported a turnover rate of 19.6% for nursing staff in children and young people’s services, this was higher than the trust’s target of 13% (Source: Routine Provider Information Request (RPIR) P18 Turnover).

Nurses in the Rainbow Centre told us that their workload was more manageable now that the new matron was in place, but with some peaks and troughs of demand. This had resulted in fewer staff leaving the unit because of work pressures. The nurses we spoke with in the NNU also told us their workload was manageable despite regular peaks in demand.

From May 2017 to April 2018, Newham University Hospital reported a sickness rate of 5.1% for nursing and midwifery staff in children and young people’s services, this was higher than the trust’s target of 3% (Source: Routine Provider Information Request (RPIR) P19 Sickness).

During our inspection senior staff told us that vacancy, turnover and sickness rates had reduced in the period April to August 2018.

From May 2017 to April 2018, Newham University Hospital had a total of 3,942 nursing staff shifts. A breakdown of locum and agency usage and unfilled shifts within children and young people’s services is shown below:

<table>
<thead>
<tr>
<th>Bank and agency</th>
<th>Number of shifts (% of total shifts)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank</td>
<td>2,463 (62.5%)</td>
</tr>
<tr>
<td>Agency</td>
<td>694 (17.6%)</td>
</tr>
<tr>
<td>Not filled</td>
<td>251 (6.4%)</td>
</tr>
</tbody>
</table>

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

Senior nurses told us agency staff were rarely used as there was an established bank of nurses available to fill shifts. Bank staff were booked in at the start of a rota. Two bank nurses had ‘nurse in charge’ status and all bank nurses were familiar to the unit and fully inducted and oriented. Agency nurses were required to be current with mandatory training completion and there was an induction for agency staff when required.

Nurses told us that the new matron had worked to improve skill mix of nurses in the Rainbow Centre and they felt that this rebalancing had improved the care for children and the morale of nurses working in the unit. Senior nurses confirmed that 50% of all staff nurses were qualified for less than two years. There was still a focus on developing band five nurses into band six nurses to improve capability on the unit as external recruitment of more qualified and experienced nurses had been challenging. The service flexed nurses between inpatient, outpatient and day care areas to meet demand as required. The service was working with local universities to keep a steady stream of local new nursing recruits. Senior nurses told us the hospital management team was receptive to their requests for increased staff resources to meet demand.

The nursing establishment at the time of our inspection met the requirement for a minimum ratio of 70:30 registered to unregistered nursing staff, and there was a minimum of two registered children’s nurses at all times in the inpatient and day care areas.
The hospital’s sickle cell service was not sufficiently staffed to meet local demand and this limited the ability of the service to support patients effectively. For example, there was no specialist sickle cell nurse for the 12 months before our inspection. The rota for the consultant doctor for the service was also unfilled during long term leave for illness.

**Medical staffing**

Newham University Hospital reported the following nurse staffing numbers for children and young people’s services in March and April 2018.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Services for Children and Young People</td>
<td>36.5</td>
<td>41.0</td>
<td>89%</td>
<td>34.0</td>
<td>41.0</td>
<td>82.9%</td>
</tr>
</tbody>
</table>

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

From May 2017 to April 2018, Newham University Hospital reported a vacancy rate of 9.5% for medical and dental staff in children and young people’s services, this was higher than the trust target of 6.3% (Source: Routine Provider Information Request (RPIR) P17 Vacancies).

Consultant doctors worked ‘one in five’ on call rotas and ‘one in five’ weekend rotas and told us they were content with this model. However, there was recognition that the service needed to recruit more clinicians to improve capacity and resilience in paediatric and neonatal consultant body. At the time of our inspection the service was not currently meeting the Royal College of Paediatrics and Child Health (RCPCH) ‘Facing the future’ guidelines target for every non-elective paediatric admission to see a consultant doctor within 13 hours. This was particularly acute for weekend admissions as the rostered on-call consultant tended to leave around 2-3pm (but returning for any emergency). To do so the service needed to recruit more consultant doctors to be on site until 10pm each day. At the time of our inspection the on-site consultant week day rota was up to 7pm. The on-call consultant attended evening handover at 4.30pm and is then on site until 7pm, after which they were on call from home. In the NNU the consultant was on site until 6pm and on call thereafter.

From May 2017 to April 2018, Newham University Hospital reported a turnover rate of 0% for medical and dental staff in children and young people’s services. (Source: Routine Provider Information Request (RPIR) P18 Turnover)

From May 2017 to April 2018, Newham University Hospital reported a sickness rate of 1.1% for medical and dental staff in children and young people’s services, this was lower than the trust’s target of 3%. (Source: Routine Provider Information Request (RPIR) P19 Sickness)
From May 2017 to April 2018, Newham Hospital had a total of 835 medical staff shifts. A breakdown of locum and agency usage and unfilled shifts in children and young people’s services is shown below:

<table>
<thead>
<tr>
<th>Locum and agency</th>
<th>Number of shifts (% of total shifts)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Locum</td>
<td>408 (48.9%)</td>
</tr>
<tr>
<td>Agency</td>
<td>2 (0.2%)</td>
</tr>
<tr>
<td>Not filled</td>
<td>95 (11.4%)</td>
</tr>
</tbody>
</table>

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

In March 2018, the proportion of consultant staff and proportion of junior (foundation year 1-2) staff reported to be working at the trust in the children and young people’s core service were both lower than the England average.

Staffing skill mix for the 183 whole time equivalent staff working in children’s services at Bart’s Health NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>35%</td>
<td>42%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>3%</td>
<td>7%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>59%</td>
<td>44%</td>
</tr>
<tr>
<td>Junior*</td>
<td>3%</td>
<td>6%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen speciality
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

At the time of our inspection there were no vacancies for doctors in training within pediatrics or neonates and the service was allocated a full complement of different tier trainees from the local education and training board (LETB) apart from some gaps in allocations to middle grade doctor in training posts, for which there were national gaps. The service had employed clinical fellows and staff grade doctors to fill the gaps in the middle grade rota. Clinical fellows told us they were treated equitably to doctors in training, with the same levels of supervision and access to learning opportunities. Of 16 doctors in training on the ‘senior house officer’ (SHO) rota, three were clinical fellows. Some of the clinical fellows had worked at the hospital for many years and were considered ‘senior’ so helped to deliver the local induction. There were sufficient numbers of higher tier doctors in training (ST4-5) for the acuity and complexity of clinical activity in the Rainbow Centre and NNU.
The rota for doctors in training were managed by one of the SHO doctors in training with support from a consultant doctor. Although the doctor in training rota were well staffed, many of the doctors in training we spoke with, across training grades, reported high levels of work intensity, challenging case presentations and heavy throughput of patients which sometimes pushed them to the limits of their competency and capacity. For example, high numbers of baby checks to complete in one day. Most doctors in training told us they finished their shifts on time. However, there were some instances of intense rota where for example, a doctor may work two weekends in a row, or go from day time shifts to night shifts with one day off in between. While they commented this did not compromise safe patient care, in some cases it did impact on their well-being.

Records

We found the completion of records was good throughout children and young people services. We reviewed 10 sets of care records. Overall, we found that notes were legible and all staff involved in the care of children and young people completed them accurately and recorded relevant information. All the records we reviewed were well organised and person centred. The notes we reviewed in the neonatal unit were well organised and baby centred.

All CYP services used paper documentation to record patient care and nursing interventions. Doctor notes were also paper-based. Paper documentation included a range of risk assessments, pain scores, paediatric early warning scores (PEWS), allergies and care plans for patients. PEWS observation charts were uniform across the trust. There was a paper prescribing system. The patient record did not have a specific designated section for documenting communication with parents.

Paper records were stored in secure trolleys by the nurses’ station. The trolleys were kept locked at all times apart from during ward rounds to enable easier access.

All test results were available via computer on the trust’s electronic records system. Staff told us the system was easy to navigate. The electronic record had a ‘flag’ system to alert staff to children with specific concerns, for example child protection plans and other confidential social information which only the relevant clinicians could access.

Clinicians and nursery nurses in the children’s outpatients area recorded information in the Personal Child Health Record ‘red books’ and used recognised growth charts.

Information governance and data protection training formed part of the mandatory training which all staff were required to complete. Data provided by the trust showed that by September 2018, 84% of nursing staff had completed information governance training which was just below the trust target of 85%. 80% of medical staff had completed, which was below the trust target.

A link nurse conducted weekly audits of PEWS documentation. The link nurse reviewed a sample of completed PEWS forms and provided immediate feedback on areas for improvement. This feedback was then shared more widely in monthly staff meetings.

Medicines

During our inspection a CQC medicines inspector reviewed medicines management within the CYP service. We found that medicines management was generally good. Staff understood their responsibilities for safe medicines management and followed safe procedures for storage and administration.

Each clinical area had a medicine preparation area and supplies. Pharmacy supplies were replenished each week or as needed. Expiry dates of all drugs were checked at least weekly by
nursing staff and regularly by a pharmacist. All the liquid medications we checked had labels of date of opening and expiry date.

However, during the inspection, we found an instance of a missing ‘FP10’ prescription form. We also found there was no system for recording the balance of FP10 forms against what was available. We notified the trust pharmacy team of the missing form and it was recorded as an incident on the trust incident reporting system for investigation. The trust provided an update following our inspection, which found a doctor had completed the form. In response to the incident the lead pharmacist decided to remove excess prescriptions and to leave a smaller amount of 10 (rather than original 50). Daily checking and counting of the pad was instigated and communicated with the senior nurse in charge that this was to continue daily.

Emergency trolleys were available on every ward and were secured with plastic snap locks so it was clear if someone had accessed the resuscitation equipment. Trolleys were checked daily and weekly with staff signing a log to confirm the checks had been made. Consumables and equipment were appropriately stored and labelled and the paediatric cardiac arrest box was secure and dated. We checked various consumables, such as fluids and found that they were sealed and in date.

Paper medication records and drug charts were completed for infants, children and young people. A medicine administration record was used to record medication prescribed and administered and we saw these had been completed appropriately for most of the records we reviewed. Each child or young person had their weight checked and prescriptions were written accordingly. Allergies and children’s weights were clearly documented. However, there were gaps in some records, for example the units of prescribed drugs (micrograms or milligrams) were not circled. We also found that the prescriber did not always include their name and bleep number, only their signature. This did not conform to good practice.

Medication management was part of mandatory training. Compliance was 79% for nursing staff which was below the trust target of 85% as at September 2018.

The hospital used a paper prescribing system and staff told us the system was effective and easy to use. Staff reported good access to the hospital pharmacy team who visited the Rainbow Centre and Neonatal Unit daily. The pharmacists regularly checked prescription charts and controlled drugs (CD) books.

Nursing staff were aware of the policies on the administration of controlled drugs (CDs). CDs are medicines requiring additional security. They were stored in lockable, wall-mounted cupboards. In the Rainbow Centre and NNU the keys for the CD cupboards were held by the nurse in charge. During our inspection we found this was managed safely and effectively. The hospital pharmacy team conducted quarterly audits of CD management. Children and young people with their own prescribed CDs had a CD book to record administration and these were also checked daily.

Registers containing details of the contents of the CD cupboards were stored within the cupboard and identified the expected stock of each medicine. Two members of staff checked the CD stock levels collaboratively daily. We checked the CD stock levels documented in the stock books and found them to be accurate. We checked a sample of controlled and non-controlled medicines and found them all to be in date.

Medicines to take out were stored securely until the patient was discharged.

Medicines were stored in dedicated medicine fridges which were locked and fridge temperatures were recorded daily. The fridge temperature logs that we checked were all within acceptable tolerance and there were no recording gaps. The ambient room temperature where medicines
were stored was also recorded and checked daily and the records showed it did not exceed recommended levels. However, during our inspection we noted that the temperature of the medications room on the NNU was higher than expected at 28.5°C. There was an electric fan in the room which was on, and nurses told us the door was sometimes kept open to reduce the temperature. This was not recorded as a risk on the service risk register.

**Incidents**

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

From August 2017 to July 2018, the trust reported no incidents classified as never events for children and young people’s services at Newham University Hospital (Source: NHS Improvement - OBIEE NRLS STEIS).

In accordance with the Serious Incident Framework 2015, the trust reported three serious incidents (SIs) in children and young people’s services at Newham University Hospital which met the reporting criteria set by NHS England from August 2017 to July 2018.

The types of incident reported were:

- Diagnostic incident including delay meeting SI criteria (including failure to act on test results): one incident
- Medication incident meeting SI criteria: one incident
- Treatment delay meeting SI criteria: one incident

(Source: NHS Improvement - OBIEE NRLS STEIS)

For the six-month period before our inspection (February to August 2018) the service reported a total of 98 incidents. One of these incidents was rated as moderate harm and required discharge of Duty of Candour responsibilities. The main themes of reported incidents related to medication errors, estates and facilities, and non-medical equipment.

For the period October 2017 to September 2018 the total number of incidents reported in childrens and neonatal services was 281. At the time of our inspection 275 of these incidents were classed as addressed and closed. Data submitted by the trust showed the average number of days from reported to closed was 35.5 days and 215 (76%) incidents were not investigated and closed within the time set by trust policy. The trust standard was 14 calendar days from incident being reported to being closed.

The trust used a model of local incident ‘handlers’ at each hospital to investigate incidents and the trust-wide corporate governance team reviewed and closed incidents on the trust’s electronic incident reporting system so the averaged figure represents a combination of both processes.

The matron of the Rainbow Centre explained that senior leaders of the service were working to encourage staff to report incidents as they felt reporting could be improved. They had introduced a ‘trigger list’ to help staff understand the kind of incidents that should be reported and the thresholds for doing so. Incidents were discussed in staff meetings and there was a focus on learning rather than what went wrong. The matron reflected that some staff were reluctant to report incidents because it required time and effort to do so as it took a long time to complete a report using the online reporting system. There were some isolated comments from nurses that they felt penalised for reporting incidents. However, this was not reflective of all staff we spoke with. Most of nurses we spoke with told us they received feedback from incidents and that the
shared learning was useful, but some staff told us they did not always hear about the overall outcome of an investigation.

There were monthly ward quality and safety meetings and monthly ward meetings used to share learning from incidents. In the NNU incidents were discussed on a weekly basis, including reviews of all term admissions to the unit.

Serious incidents were investigated using a root cause analysis model. Investigations were conducted by staff independent of the incident, for example in other services or from other hospitals within the trust. The trust provided training for relevant staff on conducting incident investigations.

There was evidence of learning and changes to practice because of incidents. For example, following an incident of a baby in the neonatal unit wearing wool mittens which caused restricted blood flow, the service had changed its policy and no longer used wool mittens.

Senior nurses could recall examples of incidents which had required discharge of Duty of Candour and were well-briefed on the process involved. All staff we spoke with were aware of the principles of openness and accountability when things go wrong.

There was evidence of cross-departmental learning and challenge. For example, there were monthly joint multidisciplinary morbidity and mortality meetings (M&M) with paediatric A&E staff which reviewed serious incidents, neonatal transfers to level 3 paediatric intensive care units (PICU), safeguarding concerns and deaths. There were also bi-monthly joint M&M meetings with the hospital maternity service. Doctors in training told us the learning from these meetings was useful and senior clinicians had made efforts to make learning transferable to different scenarios.

There were some attempts at introducing formalised ‘safety huddles’ as recommended by the Royal College of Paediatrics and Child Health (RCPCH) situation awareness for everyone (SAFE) programme. The programme toolkit supports child health professionals to use quality improvement principles as it can help improve communication and build a safety-based culture. Consultant doctors told us the board round meeting was used as a safety huddle to identify potential risk factors for each patient, but some of the consultant doctors we spoke with were not familiar with the programme. One of the sister hospitals within the trust was one of the first 12 hospitals in the UK to introduce paediatric safety huddles and this was presented at a previous RCPCH conference. The staff we spoke with were not able to recall shared learning between the hospital sites regarding safety huddles.

**Safety thermometer**

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

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

Data from the Patient Safety Thermometer showed that the trust reported one new pressure ulcer, zero falls with harm and zero new urinary tract infections in patients with a catheter from June 2017 to June 2018 for children’s services (Source: NHS Digital). Patient safety information was clearly displayed on notice boards in the Rainbow Centre and neonatal unit.
Is the service effective?

Evidence-based care and treatment

The trust’s care pathways for children and young people (CYP) services were delivered in line with referenced national clinical guidance. Senior service leaders regularly reviewed their service outcome data, such as Patient Reported Outcome Measures to ensure provision was meeting the needs of children and young people.

There were neonatal and paediatrics specific guidelines available for staff on the trust intranet. Staff could easily access protocols, policies and guidance for clinical and other patient interventions and care on the intranet. Nurses and doctors in training showed us how to find information on the trust intranet using a key word search function and they were adept at finding the relevant documents.

We reviewed a sample of trust policies including those for safeguarding processes and found they were within date and appropriately referenced current good practice and national guidelines from organisations such as the National Institute for Health and Care Excellence (NICE) and Royal Colleges. They contained appropriate guidance for screening, referrals, escalation, specific interventions and further sources of advice and information.

There were effective processes for the identification and implementation of new clinical guidelines from external bodies such as Royal Colleges and NICE. One of the neonatal clinical leads was the College Tutor for the hospital and was responsible for identifying and auditing compliance with new guidelines. New guidelines were shared at twice monthly clinical governance meetings which were attended by all consultant doctors and doctors in training. Compliance audits and gap analyses were also presented at these meetings. Consultant doctors provided examples of practise changes because of new clinical guidelines, including new national guidelines for hypoglycaemia and care of children with nephrotic syndrome. Doctors in training told us guidelines were easy to find on the trust computer network and they were referenced in local teaching sessions. The paediatric staff within the emergency department had prepared ‘one-page guidelines’ which contained all of the information in a simple and accessible format. Some doctors in training were involved in developing new local guidelines, for example paediatric pulmonary hypertension guidelines, which they presented at external conferences.

Staff from the hospital attended trust-wide network groups for paediatric and neonatal practitioners such as networks for paediatric oncology and paediatric surgery. These networks provided a forum for staff to ensure each hospital was effectively responding to national priorities, reviews and system changes.

Understanding of and adherence to NICE guidelines was embedded in multidisciplinary working and evidenced using audit programmes to benchmark practice. There were regular quantitative and qualitative audits including regular audits of hygiene and infection control, pain management, environment and equipment, vital signs recording, microbiology and patient feedback amongst many others. There was a central clinical effectiveness unit which monitored completion of audits. The results of these audits were shared at clinical governance meetings.

The service was involved in some research projects, including national multicentre randomised control trials for neonatal continuous positive airway pressure (CPAP), the NEOPAIN study into the effects of morphine analgesia in ventilated preterm neonates, research on nephrotic syndrome and sickle cell disease. Clinicians in the service were also conducting independent research into parental perceptions of obesity in school age children. However, as a district general hospital there was a limited research focus which was mostly medically led.
Doctors in training were encouraged to lead and participate in local audits and quality improvement projects by their training supervisors. Some of these audits had informed changes to practise, for example an audit of febrile neutropenia resulted in new pro forma documents which were introduced across the trust. However, some of the doctors in training we spoke with felt they needed more guidance and support to deliver audits that added value to the service and resulted in direct improvements to practice.

The service was actively engaged in responding to local pilots and quality and innovation commissioning priorities (CQUIN). For example, neonatologists in the neonatal unit (NNU) identified the need for a pilot study to review effectiveness of 24 hour follow up checks for babies with rebound jaundice after phototherapy, which was accepted by the central commissioner. The service had also developed an in-reach neonatal community clinic.

**Nutrition and hydration**

There were appropriate processes in place to ensure that patients’ nutritional needs were met. The service used evidence-based tools to screen for malnutrition, including STAMP (Screening Tool for the Assessment of Malnutrition in Paediatrics). The STAMP assessment was done at the time of initial assessment and recorded in the admission booklet. This included evidence based measurements and risk factors to determine nutritional needs for children aged 2-16 and if a referral to dietetics support was required.

There was one band 7 dietician on site on weekdays only from 9-5pm. Nurses told us that the dietician was responsive and accessible. The hospital dietician attended the Rainbow Centre and NNU to support nutrition planning, management of Percutaneous endoscopic gastrostomy (PEG) and nasogastric feeding, and provided advice and guidance to nurses on patient suitability for food. The dietician liaised with community dietetics services to arrange support for patients on discharge.

Dietary plans were included in patient care plans. The dietician made arrangements for special menus. There were specific food menus for different patient groups including those with specific needs, such as patients with dysphagia, allergies or food intolerances, and those requiring low fat or high calorie diets. Nurses told us the hospital catering team was very responsive to specific dietary needs, for example low calorie or high protein, as well as cultural specific diets.

There were protected meal times on children and young people in the inpatient ward and we saw these were respected by staff and visitors. This meant all non-urgent activities on the ward would stop and patients would be positioned safely and comfortably for their meal and staff would assist patients with their meals as necessary. Nursery nurses and healthcare assistants (HCAs) were available to support eating.

Pre-surgery fasting guidelines were in place to ensure patients were ready for their procedure. We checked a sample of milk formula on the NNU. All were sealed and within date. Bottles and teats were available to help feeding. Specialist powder milk was available for babies with dietary intolerances. Breast milk was stored appropriately and secured in dedicated fridges. There were checks in place to ensure it was managed safely. A milk fridge and freezer were in use for expressed breast milk and bottles were labelled appropriately with baby name, time and date of expression. Appliance temperatures were monitored and recorded twice daily. The records we reviewed showed appliance temperatures were within an acceptable range.

There was a breastfeeding specialist on the post-natal unit who attended the neonatal unit to provide support as required. The service had expressing machines in the neonatal unit which parents could borrow and take home if they did not have the resources to buy one.
Pain relief

There were very effective processes in place to ensure patients’ pain relief needs were met and pain was well managed in the children and young people service. Patients told us nurses were responsive to their pain relief needs. All the patients we spoke with were aware they could use the call bell to request additional pain relief. Feedback on the CYP noticeboard included: “Whenever I had pain it was taken seriously”.

Pain was assessed and recorded as part of routine observations. It was checked every four hours using the pain score on the paper PEWS chart.

Pain management protocols were clearly displayed on a noticeboard in the Rainbow Centre and were available on the trust intranet for staff to access. The noticeboard displayed pain management information in a child friendly way with pictorial depictions of 0–10 pain scale with 0 representing no pain. It also displayed the principles and professional responsibilities of nurses in ensuring patients’ pain relief needs were managed effectively. It included revised pain guidelines and pain chart as quick access guides for clinicians to refer to. The service used evidence-based visual analogue scales such as the Wong-Baker faces tool to help children communicate about their pain. They also used the face, legs, activity, cry, consolability scale or FLACC scale as a measurement to assess pain for children between the ages of two months and seven years or those who are unable to communicate their pain.

Nurses told us they always tried to ensure they consented the child when administering medication and if not, they would ask the child’s parents or carer to consent. We observed a nurse administering medication to a child and the nurse asked the child about their pain level and used the number scoring method. The score was recorded and analgesia was then administered.

The CYP service at Newham University Hospital did not use patient controlled analgesia pumps (PCA) so patients requiring this method of pain relief were transferred to the Royal London Hospital (another hospital within the trust) where the trust’s child pain service was based. Nurses in the Rainbow Centre reported some difficulties in getting staff from the child pain service to attend as there was heavy demand for their services across all sites in the trust. To mitigate this senior nurses in the Rainbow Centre had attended pain management study days at the Royal London Hospital and externally at a London university to be competent to act as a de facto child pain nurse for the site.

In preparation for surgery the play therapist spoke with children about what was going to happen and helped to reduce their anxieties. All children had a local anaesthetic cream applied to cannulation areas to reduce pain.

Patient outcomes

The trust contributed to relevant local and national patient outcome and performance audits, including benchmarking activities and peer review with other NHS hospital trusts.

At the time of our inspection the CYP service was completing the approving process for the UNICEF UK Baby Friendly Initiative, which supports breastfeeding and parent infant relationships by working with public services to improve standards of care. The service had invested in new resources and training to support this initiative.

The hospital participated in several national clinical audits, including 'MBRRACE-UK' (the national programme of work conducting surveillance and investigating the causes of maternal deaths, stillbirths and infant deaths), for which the trust overall was in the top decile of all participating trusts in England. The NNU participated in the national neonatal audit programme, for which data were collected every day. Clinical leads told us the hospital had previously ranked low for
indicators relating to neurodevelopmental assessment, but the service had introduced new clinics for the assessment and trained a consultant doctor to complete them, and it was hoped this improve performance and ranking in the audit.

The Paediatric diabetes audit 2015/16 measured HbA1c levels as an indicator of how well an individual’s blood glucose levels are controlled over time. Newham University Hospital data showed the average HbA1c value (adjusted by case-mix) at the trust was 67.8 % which was within the expected range compared to a national aggregate of 68.3%. This was an improvement as the previous year’s score was worse than expected. The proportion of patients receiving all key care processes annually was not available, but the previous year’s score was 13.3%. The median HbA1c value recorded amongst the 2015/16 sample was 68, compared to the previous year’s median which was 73. This indicated a clinically significant improvement (Source: National Paediatric Diabetes Audit 2015/16).

The data showed that from February 2017 to January 2018 no specialities, for the under one-year age group, within this core service had six or more readmissions within two days of discharge following elective admission. For the one to 17 years age group, the paediatric ear, nose and throat specialty had seven readmissions. The readmission rate was 0.5%, which is in line with the England average of 0.6%.

The tables below show the percentage of patients (by age group) who were readmitted following an emergency admission. The tables show the three specialities with the highest volume of readmissions and only those specialities where six or more readmissions recorded are shown in the table.

The data shows that from February 2017 to January 2018 there was a lower percentage of under ones readmitted following an emergency admission compared to the England average, and a lower percentage of patients aged one to 17 years old readmitted following an emergency admission compared to the England average, except for paediatric oncology, which had a higher percentage than the England average.
From February 2017 to January 2018, the trust performed better than the England average for the percentage of patients under the age of one who had multiple readmissions for asthma. The trust performed worse than the England average for the percentage of patients aged one to 17 years old who had multiple readmissions for asthma and diabetes. The trust performed better than the England average for the rate of multiple readmissions for epilepsy.

Note - For reasons of confidentiality, numbers below 6 and their associated proportions have been removed and replaced with ‘*’.

In the 2017 National Neonatal Audit, Newham General Hospital’s performance in the four
measures relevant to children and young people’s services was as follows:

- **Do all babies <32 weeks gestation have a temperature taken within an hour of admission that is 36.5°C-37.5°C?**

There were 55 eligible cases identified for inclusion, 55.9% of babies who had their temperature measured within an hour of admission had a temperature measurement between 36.5°C and 37.5°C. This was within the expected range when compared to the national aggregate where 61.0% of babies who had their temperature measured within an hour of admission had a temperature measurement between 36.5°C and 37.5°C. The hospital did not meet the audit’s recommended standard of 90% for this measure.

- **Is there a documented consultation with parents by a senior member of the neonatal team within 24 hours of admission?**

There were 449 eligible cases identified for inclusion, 99.9% of these cases had a first consultation with parents by a senior member of the neonatal team within 24 hours of admission. This was better than expected when compared to the national aggregate where 90.5% of cases had the first consultation within 24 hours of admission. The hospital met the audit’s recommended standard of 100% for this measure.

- **Do all babies < 1501g or a gestational age of < 32 weeks at birth receive appropriate screening for retinopathy of prematurity (ROP)**

There were 81 eligible cases identified for inclusion, 88% of babies with a weight of < 1501g or a gestational age of < 32 weeks at birth received the appropriate ROP screening. This was worse than expected when compared to the national aggregate where 94.2% of cases received the appropriate ROP screening. The hospital did not meet the audit’s recommended standard of 100% for this measure.

- **Do all babies with a gestation at birth <30 weeks receive a documented follow-up at two years gestationally corrected age?**

There were 44 eligible cases identified for inclusion, 25% of babies with a gestation at birth of <30 weeks received a documented follow-up at two years gestationally corrected age. This was worse than expected when compared to the national aggregate where 61.2% of babies with a gestation at birth of <30 weeks received a documented follow-up at two years gestationally corrected age. The hospital did not meet the audit’s recommended standard of 100% for this measure (Source: National Neonatal Audit Programme, Royal College of Paediatrics and Child Health)

**Competent staff**

From April 2017 to March 2018, 20 members of medical and dental staff were eligible to receive an appraisal, and they achieved 85% completion rate against a trust target of 85% (17 members of staff received an appraisal). The trust did not provide a core service breakdown for non-medical staff, therefore appraisal completion rates were unavailable for this core service (Source: Routine Provider Information Request (RPIR) P43 Appraisals).
The nurses we spoke with told us they had completed their annual appraisals and that they were done in a meaningful way that was useful. Nursing staff also had six monthly reviews of performance to identify any learning or support needs.

The nurses we spoke with in the Rainbow Centre and neonatal unit reported a supportive and developmental environment, with accessible and visible senior staff who helped and guided them. They reported good learning opportunities to maintain and develop their skills and knowledge. Most learning was delivered on the ward in direct teaching relevant to the role, for example in managing central lines, treating bronchiolitis and immunisations. There was monthly in-house training, including external speakers. Each week nurses could attend teaching by consultant doctors. There were also shadowing opportunities, supervision and access to formal training courses. Nurses could directly input into the training agenda to request specific teaching sessions. Nurses told us that the focus on learning and development was helping to attract new nurses to the service and make it a more attractive place to work.

Nurses on the neonatal ward told us there were opportunities for development including day courses and special care courses. There was one advance neonatal nurse practitioner (ANPP) who provided teaching for nurses on the unit, for example on new-born infant physical examination (NIPE) baby checks. The neonatal unit provided advanced neonatal training and monthly simulation for medical and nursing staff.

At the time of our inspection there was no practice development nurse (PDN) in the Rainbow Centre, but two existing band 6 nurses in the service had been appointed to job share the PDN role starting in October 2018. Plans for the PDN role were to develop and support band 5 nurses and identify their collective and individual training needs. For example, in preparation for winter pressures the PDNs planned to provide refresher training in nasal high flow respiratory support and bronchiolitis care, so the service was ready to respond.

Student nurses told us staff in the Rainbow Centre were supportive of their education and development needs and were accessible, with good supervision and learning opportunities. The service hosted lectures and visiting speakers which students could attend while on placement. Newly qualified nurses completed an 18-month preceptorship and were assigned a mentor.

Established nurses told us the trust’s support and training for revalidation was helpful and they found it straightforward to gather the necessary evidence for sign off by their line manager.

Health Care Assistants and nursery nurses were supported by the trust to complete the Care Certificate qualification, which included study leave and funding.

There was a trust policy on nurse supervision and nurses were offered monthly supervision which used the ‘signs of safety’ model to reflect on and develop their practice. Supervisors were trained to deliver this supervision.

Agency nurses had access to trust intranet so they could access policies and training online. They had access to mandatory training and could attend class-based training sessions, for example in paediatric resuscitation.

New staff were given time for orientation in the hospital and the unit as part of their induction. There was a half day trust corporate induction and then local departmental induction for two to three days where new staff completed statutory and mandatory training. Doctors in training told us the trust’s e-learning modules were basic, but direct training for example in level 3 safeguarding was in depth, interactive and useful. They received CYP specific training in paediatric and neonatal life support, choking, sepsis and diabetic ketoacidosis in the simulation centre. They
were given opportunities to lead different training scenarios to help them familiarise with their new environment.

Although doctors in training told us the trust and departmental induction was thorough, they reported some challenges getting computer network logins, activating smart cards and getting access to shared drives (to access the handover lists). They felt that this made the experience more stressful than it needed to be and did not enable them to get set up in a timely way. The hospital medical director was aware of these issues.

Doctors in training told us consultants were supportive, accessible and responsive to their specific teaching requests, such as on viral induced wheeze, in response to high prevalence in recent admissions. There was a journal club, case presentations and consultant teaching. However, some doctors in training told us they had been unable to access teaching because of their workload, or that their teaching time was not protected as they were still required to hold the bleep for emergencies. Many doctors in training stayed after a nightshift to attend training. While this was not mandatory, many of the doctors in training we spoke with felt that it would be disadvantageous to not attend teaching but recognised it was not optimal for learning or wellbeing and risked potential non-compliance with the requirement for eight hours rest between shifts.

The service received positive overall feedback from doctors in training in the GMC national training survey 2018, including from GP trainee on placement in the hospital. Most of the doctors in training we spoke with reported a good and support training experience. However, some doctors in training told us that they found the work intensity and acuity challenging and at times stressful and overwhelming. Some felt that they were working beyond the limit of their competencies, but that help and support was available when needed. They told us they were encouraged to seek help and in emergencies to make a crash call.

**Multidisciplinary working**

In the CQC Children and Young People’s Survey 2016 the trust scored 8.36 out of ten for the question ‘Did the members of staff caring for your child work well together?’ This was about the same as other trusts (Source: CQC Children and Young People’s Survey 2016, RCPCH).

There was an effective multidisciplinary team (MDT) working environment within children and young people services at Newham University Hospital. We found evidence of good multidisciplinary relationships supporting patients’ health and wellbeing. We observed multidisciplinary input in caring for and interacting with patients in the Rainbow Centre and in the neonatal unit.

The Rainbow Centre was nurse-led and we observed nurses were proactive at seeking support from other healthcare professionals. Nurses reported good working relationships with the medical team and they felt that consultant paediatricians were approachable and accessible.

There were joint medical and nursing handover meetings every Monday, and ward and board rounds were attended by both professions. There were daily ward rounds including on weekends, which were led by the consultant doctor except on Tuesdays and Fridays when it was led by a higher tier doctor in training as a learning and development opportunity.

The nurse in charge attended the daily morning medical handover to ensure nursing actions could be recorded and actioned. The nurse in charge led the daily board rounds, which focused on bed state, available cubicles, acuity and staffing. The board round also covered status and plans for each patient including discussion of clinical interventions, nursing tasks, any concerns and discharge arrangements. The Neonatal Unit handover commenced with a review of the sickest babies, transfers and concerns. This was a concept learned from the experience of another
hospital which helped staff focus on the most pressing needs so that actions could be planned and put in place earlier in the shift. This model was not adopted in the Rainbow Centre.

Doctors in training told us handover arrangements were well managed and used for education purposes when possible. In response to feedback from doctors in training, the matron of the neonatal unit had set up a regular meeting for nurses and doctors in training to improve their engagement with and connection to the unit and had changed the ward round to incorporate more teaching opportunities.

During our inspection we observed a multi-disciplinary ward round on the NNU which was led by a higher tier doctor in training. It was attended by a consultant doctor, doctors in training, the nurse in charge, a neonatal nurse and community practitioner. The ward round was at the cot-side. The ward round we observed had open and respectful dialogue between all staff present. It was well structured and there was good communication about the history of interventions, clinical updates and actions needed for each infant. The doctor in training leading the ward round explained decision making based on local guidelines and gave a clear and confident account of actions and planned actions which were then recorded. The doctor in training checked that all staff present were clear on the actions taken and that they were understood and agreed. The community practitioner gave an update on discharge arrangements and plans for parental support on discharge and there was candid discussion about social and family matters and discussion of potential safeguarding concerns. There were moments of informal teaching and sharing of knowledge and the ward round was professional and collaborative.

There was effective dialogue and joint working with other services in the hospital. Doctors and nurses in the neonatal unit reported good communication and links with the maternity unit. There were joint morbidity and mortality (M&M) meetings every two months to identify learning from cases linked to both services and neonatal consultants also attended the weekly maternal incident review meetings.

There were monthly joint paediatrics and emergency medicine M&M meetings and governance meetings for clinicians in both services to review and share learning from challenging cases such as child deaths and transfers to intensive care. The meetings were open to all staff working in both services, but the matron confirmed that mostly senior clinical staff attended. Minutes of the meetings were circulated to the whole team. However, while nurses in the Rainbow Centre told us the paediatric emergency department was very effective, there was limited crossover and day-to-day interaction between nurses in both services.

There was evidence of effective MDT partnership working with external agencies and professionals. For example, clinicians reported good communications with local GPs. Discharge summary letters were sent to the patient’s GP and parents and carers were encouraged to attend their child’s GP shortly after discharge. Consultant doctors told us they received a lot of support from the children’s acute transfer services for North and South London. They also reported good clinical working relationships between doctors across the trust locations, which facilitated rapid referrals and timely guidance from other paediatric and neonatal specialists. However, staff told us communication between the hospital sickle cell disease team and the community team was not effective. Patients who did not attend were handed over to the community team to chase but there was limited interaction otherwise because of limited staff capacity.

Nurses and doctors were supported by allied health and other professions in the Rainbow Centre and neonatal unit. There was a system of link nurses within the hospital for diabetes, asthma, oncology and high dependency support. There were developed plans to introduce a haematology nurse specialist in the hospital to meet the demand for support in this area. A community
practitioner led referrals to community care providers, liaised with the hospital safeguarding team and acted as a single point of contact for families. There was a hospital-based social work team and link social worker in place. Children and young people with child protection plans were flagged on the admission checklist for nurses to contact the social worker. During daytimes there was a play specialist and a family support worker in the Rainbow Centre, and a dietician and paediatric physiotherapist were also present daily. At the time of our inspection there were no allied health professionals (AHPs) directly allocated to the NNU and the service had to refer to specialist AHPs at other hospitals within the trust. All the nurses we spoke with told us the other professionals they worked with were accessible and responsive, but the level of demand for their input meant they had sometimes limited capacity to provide a consistent level of support for all patients at all times.

Seven-day services

The hospital delivered a full inpatient service for children and young people over seven days with on-site consultant paediatrician availability until 7pm each day per week. The children and young people service adopted a ‘consultant of the week’ rota system to ensure continuous consultant cover over seven days. However, senior leaders told us they were not presently meeting pan-London guidelines for all children and young people to be seen by a consultant paediatrician within 13 hours because they did not have sufficient consultant numbers to deliver an on-site rota until 10pm each day. This was recorded as a risk on the service risk register.

The hospital NNU was a level two unit which meant it cared for infants who are moderately ill with problems that are expected to resolve rapidly or who are recovering from serious illness. Consultant neonatologists were on site until 6pm each day, and on call thereafter. As a level two unit the service was not required to have 24 hour on site cover of neonatologists, higher tier doctors in training, neonatal nurses or respiratory therapists.

The Children’s outpatients provided some evening and weekend clinics, but these were limited to specialties which were seeking to reduce referral to treatment waiting times only.

Paediatric therapies such as physiotherapy and play therapy provided a week day 9-5pm service. There was no overnight or weekend cover for paediatric therapies, but out of hours physiotherapy support was provided by the hospital’s adult physiotherapy team.

Emergency mental health support was available in hospital A&E all day every day, including on weekends. The child family consultation service (CFCS) was based locally in the hospital. There was an automatic referral system from the paediatric A&E to CFCS. Nurses told us children and young people requiring mental health support were seen and treated rapidly. However, nurses told us that it was easy to get advice and support during the day, but if advice was required at weekends there was often a wait until the next working day, but they could contact the emergency psychiatry team for reassessment. Nurses told us there were joint assessments with local social services, but sometimes there were delays to discharge because of a lack of social care or mental health community provision.

Health promotion

Senior leaders of the service had a good understanding of local population needs and were planning service delivery to meet those needs. For example, in recognition of health indicators in the local community, the service was working with local GP surgeries on diabetes management, nutrition and healthy weight initiatives. This included providing dietician support for children with obesity and workshops for parents and children to educate them on healthy diets and exercise. They also provided links to a physical trainer.
Clinicians in the neonatal unit were involved in a local public health promotion initiative to engage local women on the important of vitamin D before and during pregnancy. This was in response to evidence of a high proportion of intrauterine growth restriction amongst the local population.

There was a range of information and support available for patients and their families and carers. Across all paediatric clinical areas there was a wide range of patient literature with informative content. There were patient literature stands with public health information on smoking cessation and applying for carer support. There were also leaflets on managing different health conditions for example for children living with epilepsy, dermatitis or disabilities, and how to access support services such as play therapy and pain management. All the information we saw was easy to read and written in plain English.

There were many examples across the children and young people service of staff helping patients manage their own health. This included the provision of teaching and learning opportunities for patients and their families, as well as support and guidance. For example, we observed a medical handover meeting where we heard that a patient’s discharge was postponed by a few hours so that staff could teach the child’s parents how to apply the correct inhaler technique (when the inhalers were next due). This was good practice to ensure the parents were equipped with the knowledge to administer the inhaler properly and facilitated optimal adherence to medications.

There were posters displayed in the NNU bays demonstrating patient learning information such as the benefits of skin to skin contact for both mother and father. There were also instructions on comfort holding and ‘kangaroo care’. These were good for parent education.

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

Mandatory training in Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) awareness was provided to all staff working in the hospital. This was incorporated into the trust’s safeguarding level 2 training. Data submitted by the trust showed that as of September 2018, Mental Capacity Act and Deprivation of Liberty training had been completed by 80% of staff within children’s services.

Staff in the service worked to Gillick and Fraser competencies to determine if a child of young person could comprehend and make an informed decision to consent to treatment without the consent of a parent or guardian and understand the implications of those decisions. Staff were aware of the situations where these principles would be applied. Patients and their parents and carers told us staff explained treatment and care and sought their consent before proceeding. The clinicians we spoke with were all aware of the concept of shared decision-making with patients.

The sample of patient records we reviewed demonstrated consent for treatment and surgery was completed in full and signed and dated appropriately. However, in our review of patient records there was no evidence that the direct consent of the child was sought. Instead we saw evidence of parental/carer consent in the records. Also, senior nurses told us consent for other clinical interventions was obtained verbally at the bedside but we also did not find evidence in records of consent for day-to-day interventions by clinicians. This meant that the service’s approach to consent did not align with current good practice for ensuring children and young people are consented and treated as partners in their care.

During our inspection there were several child and adolescent mental health support (CAMHS) admissions to the Rainbow Centre (three of the 12 inpatients), which was higher than other units of this size. Staff told us the unit regularly admitted one to three CAMHS inpatients each day. Staff we spoke with were aware of the requirements of their responsibilities as set out in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), although this only applied to
children and young people aged 16 and above. Staff told us they would refer patients to the hospital safeguarding team if they required a MCA referral. Staff told us they knew who to contact for advice in cases where a patient may require safeguarding support.

Patient records detailed individual patients’ specific mental health support needs, including whether the patient was allowed to leave the ward or clinical area. There were mental health management plans in paper form which were kept in medical notes.

There were posters throughout children and young people areas with information on MCA and DoLS assessments and decision-making processes and what it means for patients and families. Newly qualified nurses were taught about consent as part of their preceptorship which covered principles and practices of obtaining consent in intravenous medications and cannulation training. There was no additional training for established staff.

In the CQC Children and Young People’s Survey 2016, the trust performed better than other trusts for one question and about the same as other trusts for the remaining four questions relating to effectiveness. This was:

Q54: Did hospital staff play with you or do any activities while you were in the hospital: 6.11 – better than other trusts (Source: CQC Children and Young People’s Survey 2016, RCPCH)

Is the service caring?

Compassionate care

The trust performed about the same as other trusts for the 10 questions relating to compassionate care in the CQC Children and Young People’s Survey 2016. (Source: CQC Children and Young People’s Survey 2016, RCPCH)

Throughout our inspection we saw all clinical staff interacting with patients and their family members and carers in a caring, polite and friendly manner. All the people we spoke with during the inspection were very happy with the care and treatment provided by the service. Direct comments from patients including children and their parents and carers, which were representative of this feedback, included: “they have been so helpful, I really feel they have made this experience as good as it can be”. One mother told us staff were friendly and gave good support. We observed a healthcare assistant (HCA) speaking kindly to a mother and giving her time to talk while she was dressing the baby after their baby check appointment.

Staff displayed thank you cards from patients at nursing stations and on the ‘Compliments’ display boards throughout the Rainbow Centre. Written comments from patients and their families included “thanks for all the care you showed” and “thank you each and every one of you. You have helped all our dreams comes true”. Such positive feedback was consistent in all the cards we saw displayed. In the Rainbow Centre outpatients area the feedback board displayed comments including: “staff very friendly and professional, very welcoming for young children” and “encouragement and politeness from the doctors is highly commendable”.

The service participated in the NHS Friends and Family Test (FFT), the results of which were consistently good across paediatric and neonatal services, with an average ‘would recommend’ satisfaction score of 95% for the Rainbow Centre and 76% for the Neonatal Centre for the period July to September 2018. In the Rainbow Centre the average FFT response rate for the same period was 17%, and 33% in the Neonatal Unit, compared to an the England average of 30%.
Senior staff told us there had been considerable disruption to their ability to collect friends and family feedback because of a change in the trust’s provider of the FFT. The Neonatal Unit used narrative feedback from their ‘Standard of Care’ questionnaire instead of the FFT ‘would recommend’ question to inform improvements to practice. Results from the questionnaire demonstrated 89% of responses rated the service as ‘excellent’ or ‘good’ and 11% ‘satisfactory’.

There were paper FFT feedback forms and comments boxes by the nurses’ station in the Rainbow Centre and neonatal unit. The family support worker in the service had created a low-level post box so young children could post their feedback forms. This made the feedback experience more interactive and fun for younger children. Senior nurses told us their aim to embed patient feedback in the culture of ward so all patients are given a form and encouraged to complete it as soon as they have been identified as suitable for discharge.

Feedback forms were easy to read and child friendly. The family support worker in the service had applied the trust’s Baggins the Bear theme into the feedback forms with cartoon imagery and bright colours to make them more fun and accessible. This was in response to previous feedback from children about the format. The children and young people (CYP) service used the trust’s ‘MES’ system to record and collate patient feedback. All data and qualitative feedback was collated by the trust’s patient experience team and the summaries were presented at monthly staff meetings.

We reviewed a sample of FFT feedback and found that it was very complimentary and positive about the care received and the staff who delivered it.

In the Day Care Centre there was a feedback board by the nurses’ station which displayed FFT feedback results for the preceding month. It showed in August 2018 that 100% of patients and relatives surveyed would recommend the service. The display was in a child friendly format and include direct quotes from children such as “when I had pain the nurse made me feel much better” and “everyone was very helpful”.

There were ‘you said we did’ boards in the Rainbow Centre and neonatal unit (NNU) which displayed the names and contact details of senior staff responsible for the unit. The board displayed the trust values and there was a poster showing that the NNU was nominated in the Bart’s Health Heroes 2017/18 award scheme for respectful care.

There was very good rapport between nurses and patients. Staff spent time with children to help make their experience more comfortable, relaxed and home-like, for example by spending time making craft projects together in the day care unit. We witnessed nursery nurses pushing babies in prams around the ward and using soothing language to calm them. Theatre staff provided children with a certificate to mark their visit to theatre, which had received positive feedback from children and parents.

During our inspection we observed staff caring for a patient who was demonstrating challenging behaviours and abusive language towards staff. A care assistant was providing one to one care for the patient and we saw that they were professional, caring and dignified at all times, despite being subject to prolonged personal verbal attacks.

We saw that staff ensured the dignity of patients was maintained. In the NNU nurses politely asked parents to vacate the bay when other babies were being discussed. This ensured confidentiality. The parents we spoke with felt this was positive. Staff in the NNU provided screens for women who were breastfeeding on the ward, and also for fathers who were doing skin-to-skin contact to bond with their baby.
Emotional support

The trust performed about the same as other trusts for the five questions relating to emotional support in the CQC Children and Young People’s Survey 2016 (Source: CQC Children and Young People’s Survey 2016, RCPCH).

The service had a dedicated family support worker and a play specialist to support children, young people and families in the Rainbow Centre and in NNU. The play specialist supported patients across all CYP inpatient, day care and outpatients areas. During our inspection we observed the pay specialist leading arts and crafts sessions for children having blood transfusions in the day care centre. They were making cards and cross-stitch. The play specialist had set up a table in the middle of the bay with lots of craft materials and all patients in the bay were encouraged to participate to help relieve boredom and provide creative educational sessions.

The play specialist worked with external organisations such as the E17 Project and Captain Starlight to provide storytelling sessions, plays and participation sessions. These were provided once per week and were funded by charity donations.

There were two battery powered ride-on cars to transport young children from the Rainbow Centre to the hospital operating theatres. Nurses told us this was a useful distraction technique to help children who were having a surgical procedure. However, nurses told us that the surgical team was not keen on the cars for hygiene reasons.

The service had a supply of memory boxes and bereavement bags provided by an external charity. They contained sensitive mementos for bereaved families such as teddy bears, space for photos and locks of hair.

The service had a range of books and guidance materials to support children dealing with difficult emotional circumstances.

There was an oncology bell in the children’s outpatients area which was used to celebrate and act as a marker for when a patient had completed their treatment.

In cases of neonatal deaths there was a dedicated room for parents to spend time with their baby. This room was decorated and furnished comfortably to make it feel less clinical and provide a more suitable space for family members to grieve in private. The NNU had a ‘cuddle cot’ for parents to stay with their baby for longer.

Understanding and involvement of patients and those close to them

The trust performed about the same as other trusts for the 21 questions relating to understanding and involvement of patients and those close to them in the CQC Children and Young People’s Survey 2016 (Source: CQC Children and Young People’s Survey 2016, RCPCH).

Throughout our inspection we observed clinical staff including doctors and nurses communicate with children, young people and their parents and carers in a way that engaged and involved them in decision making about their care. We observed doctors, nurses and therapists working in partnership with parents and families. Staff demonstrated a patient-centred approach and encouraged family members to take an active role in their child’s healthcare. The parents we spoke with told us nurses were very supportive, explained treatments and what was going to happen. Doctors kept them informed of progress and clinical interventions. For example, we observed a medical consultation of a baby in the outpatients area and saw that the doctor communicated clearly, provided opportunities for the parents to ask questions, was focused on the baby and engaged with the baby in an appropriate way. The doctor explained to the parents the
treatment and what follow up appointments were required. The session was constructive, well managed and professional. The consultation demonstrated good history taking, with good interactions and pace. The doctor provided clear explanations, reassurance and appropriate advice.

A dedicated family support worker provided support to children, young people and their families across the Rainbow Centre and neonatal unit to help them access community services, GP, social care and local authority services.

We saw that staff worked to make sure children and young people were comfortable and spoken with in an age appropriate way so they understood their treatment and had opportunities to ask questions. Young people were given opportunities to speak with clinicians without their parents or carers being present.

There were patient literature stands throughout the children and young people areas of the hospital, which provided clear and accessible information on a variety of different subjects.

The service facilitated a parent support group twice per month to provide teaching and learning opportunities for parents on subjects such as basic resuscitation, as well as fun craft sessions. The service provided interpreters for these sessions as needed. Nurses told us the group was used to encourage parents to come in to seek support, particularly for mothers who may be isolated.

We spoke with the father of an infant in the NNU who told us that his family had received good care and staff made them feel welcome and supported. Both parents attended the ward round with the clinical staff and the father told us there were opportunities throughout to ask questions and get explanations. However, the father told us that it would have been useful to have an information pack on arrival to help provide guidance about the service so they knew what to expect. In this instance, the father told us it was a very difficult time when their baby came in, so there were many things he was told at the time that he could not remember, for example around preventing infections, so it would have been helpful to have the information in a pack to review in their own time. Nurses told us there was an information pack but they did not have any printed out.

Is the service responsive?

Service delivery to meet the needs of local people

Newham University Hospital was a district general hospital which provided a wide range of general and specialist services to children and young people predominately from the London Borough of Newham and surrounding areas of East London. Some parents told us they chose to attend the hospital even though it was not their local hospital because they felt well treated at Newham.

Services for children and young people (CYP) were delivered mainly in the Rainbow Centre, which opened in February 2017 and consolidated all CYP inpatient and day case services within the unit.

The Neonatal Unit (NNU) in the hospital was a designated level 2 NNU within the North Central and East London Neonatal Network. The service was centrally commissioned by NHS England. The unit admitted babies from 27 weeks gestation. Babies at 23 weeks gestation (and occasionally even earlier) may come to the unit prior to transfer to a Level 3 unit. The service provided intensive care (two cots), high dependency care (four cots) and special care (17 cots). The level of care provided within the unit allowed for all categories of neonatal admissions except for babies who required complex or long term intensive care, for which there were arrangements to transfer those babies to other level 3 units in East London.
The Newham NNU was funded for 23 babies, but staff told us they frequently cared for up to 26-28. At the time of our inspection the NNU high dependency care was operating at 120% of capacity and the local neonatal network was aware this. Staff were anticipating additional funding to procure more high dependency cots to meet demand.

There were routine paediatric outpatients clinics on different days including dedicated clinics for diabetes, neonatal screening and medical care. Most CYP outpatients clinics were delivered in the Rainbow Centre, however some services were provided elsewhere in the hospital, for example, fracture clinics, ophthalmology and otolaryngology clinics were provided in the main outpatients area. There was a blood clinic for children under two years of age in the Rainbow Centre, however the blood clinic for older children was in the main outpatients area. The main outpatients environment was not optimal for the care of children and young people as there was no play provision and the environment was not child friendly. Senior leaders of the service were aware of this and were liaising with other departments in the hospital and trust senior leadership to make more suitable provision and encourage services to consolidate CYP outpatients provision within the Rainbow Centre.

The Rainbow Centre sometimes hosted specialist outpatients clinics for visiting consultants from other London children’s hospitals as demand required. The service was also trialling a clinic for children with learning disabilities on alternate Thursdays, involving play leader and outpatient nurses to better support their needs with more targeted care.

The Day Case area had 12 beds in two bays. There were routine day case lists on different days including otolaryngology, general surgery, blood transfusions, MRI scans and pre-assessment clinics.

There were some specialist CYP services at the hospital, which reflected the health needs of the local population. For example, there was a paediatric oncology shared care service with oncology specialist nurses. The hospital was in the process of employing a clinical nurse specialist for non-oncology haematology and sickle cell disease as there was a high cohort of patients requiring local clinical support. There were plans to expand transfusion clinics to multiple days per week to meet demand.

Senior leaders of the service told us they had open and constructive engagement with local commissioners and there was a proactive approach to working in partnership to improve the health of the local community.

The hospital had some transition pathways for young people moving from CYP to adult services at 16-18 years of age. However, for some services this was more structured than others. For patients aged 14-16 with sickle cell disease there was a bi-monthly clinic with an adult haematologist and community nurse to support their transition to adult services. Transition pathways were less structured for children and young people requiring epilepsy, neurology and diabetes services, for which there were no joint clinics. Instead consultant doctors would correspond with the relevant adult services consultant to arrange an appointment. Most specialist services, for example for young people experiencing complex seizures, were provided by consultant doctors at the Royal London Hospital. Transition pathways for young people with learning disabilities were organised by the local community paediatric services provided by the local authority. We spoke with some teenagers in the day care centre and they told us they did not have transition plans in place.

There was an identified space in the NNU for postnatal and transitional care with 12 beds and the service had appointed health care assistants to provide care. Recruitment for suitably qualified nurses was ongoing at the time of our inspection. Clinicians told us that 45 to 50% of NNU admissions were for term babies, and some could be in postnatal or transitional care.
In the CQC Children and Young People’s Survey 2016 the trust performed better than other trusts for one question, worse than other trusts for one question and about the same as other trusts for the remaining 15 questions relating to responsiveness:

Q2: Did the hospital give you a choice of admission dates? 5.67 – Better than other trusts

Q57: Did you like the hospital food? 5.76 – Worse than other trusts

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Meeting people’s individual needs

The service had comprehensive provision to meet the individual needs of children and young people using services at the hospital, including vulnerable patients and those with specific needs.

The Rainbow Centre was very spacious, bright, welcoming and suitably decorated for children and young people. There were play areas, including an outdoor play area and garden, play rooms and adolescent rooms. The children’s playroom had age appropriate toys, books, a television and was decorated in bright colours. There were oxygen points in the room so children requiring oxygen support could still play. The adolescents’ room was separate, with age appropriate provision such as a games console, books, board games and comfortable seating. Some of the nurses we spoke with in the Rainbow Centre told us their ‘wish list’ included individual televisions for inpatients and to change the restrictions limiting access to the wireless internet within the hospital. They felt this would provide more entertainment options for children and young people, which would reduce some of the pressure on their parents and carers.

The centre had spaces for parents, carers and family members to use. Dedicated ‘family rooms’ provided visitors with access to a microwave, kettle, fridge and toaster so they could take a break or make hot drinks. The rooms had comfortable seating, tables and chairs.

Staff had sufficient access to appropriate translation and advocacy services to support patients with English as an additional language. Nurses told us translation services could be booked for direct face-to-face and remote telephone interactions. Staff told us the service was accessible and timely. The staff we spoke with understood when it was appropriate to use family member to translate and when to use a professional interpreter, for example when given specific clinical information and when obtaining consent.

The hospital catering service provided a wide variety of child friendly food and snacks and there were specific menus for children and young people. The menus included options for specific cultures, tastes and specific needs, for example Halal, Kosher or plain food. There were set, protected times for breakfast, lunch and evening meal, but the meal service was flexible around the needs of the patient. Nursery nurses and healthcare assistants were available to support patients during mealtimes if required, for example with bottle feeding.

The hospital cared for children and young people with learning disabilities. The hospital had introduced a learning disability ‘passport’ system, which was incorporated in paper notes. It identified the individual patient’s specific needs so that all clinical staff had immediate access to this information to help inform decision making to meet the needs of the individual. There was specific equipment for staff to use to help engage and care for children and young people with learning disabilities, for example multisensory toys.

The CYP service supported parents and families with specific support needs. For example, the Neonatal Unit had adjusted visiting times to enable a mother with limited mobility to visit her baby.
in the unit at a time that suited them. The mother’s wheelchair was cleaned on arrival to reduce infection risks. The service referred the family to community support before the baby was discharged and their needs were discussed at the discharge planning meeting and in weekly psycho-social meetings with other staff in the Rainbow Centre.

Parents and families could seek support and advice from the community lead practitioner and could access a support worker. The hospital’s community lead practitioner in the Neonatal Unit conducted home visits to make sure the home environment was safe and suitable for babies to be discharged to.

In the NNU there were two parent rooms with double beds, so that both parents could stay on site if their child was unwell or required support.

There was a Newham Neonatal Parent Advisory Group held twice per month which provided an informal forum for parents and carers to share their knowledge and experience, help build the confidence and skills of new parents, provide support with breastfeeding and advice on available support from local charities and community groups.

The hospital play therapist provided a comprehensive programme of play support to children aged 0-11 across all paediatric areas. The dedicated playrooms in the Rainbow Centre contained lots of multisensory equipment; toys for all ages and a book trolley. Playrooms were used only for play purposes. They were not used for any clinical interventions which preserved the sanctity and purpose of the play space. Each room was spacious enough for patients to go in with their wheelchairs or support equipment. The play therapist worked closely with the multidisciplinary team to incorporate play into daily routines and development plans for long term patients.

The play therapist utilised distraction techniques to help support children in outpatients clinics and before their surgical procedures. This helped calm children and help them express how they were feeling. The play therapist also provided support to parents and carers to help reduce their own anxieties about their child’s treatment. At the time of our inspection there was only one play therapist in the service available from 9-5pm Monday to Friday and there was no weekend or evening provision. However, feedback from nurses, doctors and parents was universally positive that the play therapist provided an invaluable service which improved and enhanced the hospital experience for children.

There was CYP-specific literature available to support young children going into operating theatre for surgical procedures. The design used the trust’s ‘Baggins the Bear’ theme to communicate what children could expect from their theatre experience in a way that was child friendly and accessible. The leaflet included fun cartoon imagery, learning activities and bright colours and this brought levity and fun to the content.

There were literature stands located throughout the Rainbow Centre and NNU with a range of leaflets, for example on childhood asthma, burns, head injury, pain relief, wound care. The leaflets in the NNU were supplied by BLISS charity and promoted local neonatal support provision and parental guides such as going home on oxygen. All the literature in the Rainbow Centre was in English. Some literature in the NNU was available in community languages but this was not comprehensive. Staff told us that literature in other languages could be requested as needed from the trust’s health advocacy team.

The Rainbow Centre had a dedicated school room with learning resources, however there was no hospital school teacher provision. Patients could use the room for educational purposes but had to make arrangements for their teachers or tutors to attend the hospital.
Access and flow

There was timely access to children and young people services and most specialities were meeting referral to treatment targets (RTT). There was a good overall compliance of 96% for RTT at the hospital and there were no breaches of the 52-week referral to treatment target limit. The children’s outpatients unit was also operating within 18-week RTT targets, with 4% delayed appointments. The trust recommenced RTT reporting in April 2018 so the data provided reflects the months of April to September 2018.

The flow within children and young people services from admission, through theatres, wards and discharge was mostly managed effectively at Newham University Hospital. We observed the patient journey through paediatric theatres and found that children and young people were transferred from the recovery area to the ward appropriately and without unnecessary delays. Theatres were located near the Rainbow Centre on the first floor of the hospital. There was a dedicated recovery area for children with space for two trolleys at a time. The ‘Where is Baggins’ theme continued from the anaesthetic room, through theatre, recovery and back onto the ward. There were child friendly transfer images on the walls of the recovery area. The recovery room was located directly opposite the theatres that were used for children. However, the route from paediatric theatre back to the Rainbow Centre was not optimal as patients had to be transported through the Rainbow Centre reception past the outpatients waiting area. This could potentially be distressing for some children, both as visitors and patients. However, we recognise the limitations of the hospital estate.

Trust referral protocols were recorded and available on the trust intranet and included internal and external referral processes for different services including therapies, social services, mental health, GP and community services. They included contact details and referral process details.

The average paediatric inpatient length of stay was recorded as 1.63 days for non-elective and 0.43 days for elective, which was a similar benchmark to other trusts.

Most of the parents we spoke with told us that discharge arrangements were managed effectively. However, there were some instances of discharge delays while waiting for medications or patient transport. In such circumstances, patients and their families remained on the ward so they could be more comfortable.

Parents and carers of children using the children’s outpatient unit told us the service was flexible with appointment times and they felt this better suited the needs of their children. Parents told us appointment letters were sent with sufficient notice and that if they missed an appointment or could not attend at late notice, the service was responsive in rescheduling another appointment at a time and date that suited them.

Although the hospital had a ‘did not attend’ (DNA) policy in place, we did not find evidence that compliance with the policy was audited. The DNA rate for all first outpatient appointments in the Rainbow Centre for the period October 2017 to September 2018 was 11%.

Learning from complaints and concerns

From April 2017 to March 2018, there were eight complaints about children’s services at Newham University Hospital. Seven of the eight complaints related to the hospital paediatric emergency department, which was managed separately to CYP services. The hospital took an average of 57 days to investigate and close complaints. This was in line with the trust’s complaints policy, which states complaints should be completed between 10 and 60 days. A total of seven complaints (figure includes children’s and neonates) took longer than 60 days to be responded to. The
general themes from complaints was that the staff were unfriendly and the care provided was inadequate (Source: Routine Provider Information Request (RPIR) – Complaints tab).

During our inspection we sought more current complaints data from the service which showed that for the period between February 2018 to August 2018, there were four formal complaints. All the complaints were closed. Themes from these complaints related to staff communication, clinical explanations and clear documentation. The matron of the service explained that the service received few formal complaints as most concerns were addressed at source by the nurse in charge.

From April 2017 to March 2018, there were 39 compliments given to Newham University Hospital. No core service breakdown is available.

There was a ‘you said we did’ board displayed at the entrance to the NNU which provided information to visitors about how to complain or report concerns. It displayed comments that patients had reported and what the service had changed in response to complaints and feedback. This included new parent support groups and parent catering. Learning vignettes were displayed on a governance information board in the Rainbow Centre to demonstrate how the service had responded to incidents, complaints and feedback. The information was short and accessible in clear language.

Is the service well-led?

Leadership

There was an established and stable leadership team in the children and young people (CYP) service. Staff told us senior leaders of the service were visible, approachable and supportive and they felt that CYP services were generally well-led. All the staff we met told us that service leadership had a good understanding of frontline challenges on wards and in clinical areas.

There was clear representation of CYP services at board level within the hospital. Senior leaders of the service told us CYP services had a direct channel to the senior nurses and managing director of the hospital, as well as trust leadership.

The trust’s Chief Medical Officer was the executive lead for children and young people matters at executive board level. At Newham University Hospital the divisional triumvirate leadership of CYP and neonatal services attended the Hospital Management Board and Divisional Performance Reviews where CYP issues were escalated and discussed with the hospital executive leadership team. The hospital executive leadership team was held to account for performance at the Site Performance Review meeting chaired by the trust CEO.

There was a trust-wide Clinical Children’s Health Board chaired by a consultant paediatrician and the trust’s Director of Nursing for Babies, Children and Young People. This board held oversight of CYP services and was responsible for developing the strategy for CYP services across the trust. Newham University Hospital was represented at this Clinical Board.

We found positive and collegiate working relationships between the triumvirate of medical, nursing and operational leadership. Managers told us they worked well together as a team and there was regular communication and meetings, which fostered an open, trusting and transparent culture. There were regular planned triumvirate meetings to discuss strategic and operational matters.

Consultant doctors told us they had good access to senior clinicians and the divisional clinical director, who was accessible and available. Senior nurses told us senior leaders of the service were very visible and attended clinical areas regularly. Band 5 nurses in the Rainbow Centre told us they felt well supported by senior nurses and they felt comfortable to seek help and support.
There was improved leadership capacity since our previous inspection with the recruitment of a new matron. Nurses consistently told us this had resulted in more support for senior nurses in the Rainbow Centre. All band 7 nurses within the service were expected to take on leadership responsibilities, such as teaching roles, and there was a cohort of well-established band 6 nurses with experience to support more junior staff. However, there were no regular planned meetings for senior CYP nurses to get together.

There were two matron posts within the CYP service: one for the Rainbow Centre and the other for the Neonatal Unit (NNU). Nurses in the NNU told us this was advantageous as many units do not have a dedicated matron post for NNU and it meant that neonatal matters were well understood and equally represented in decision making. Nurses in the NNU told us that having a dedicated matron for the service provided responsive leadership and support in challenging clinical situations and that there was better structure and organisation in the unit.

Vision and strategy

There was an overarching strategy for CYP services across the trust. The strategy incorporated Newham University Hospital, but there was no standalone strategy for CYP at the hospital. The main focus of the strategy for Newham University Hospital was to maximise the use of the Rainbow Centre and to be a hospital of choice for local patients. To do this the local strategy was to recruit more consultant doctors across paediatrics and neonates to meet increasing demand and reduce consultant work pressures. This would also enable the service to expand clinics and repatriate some paediatrics surgery to Newham. Senior leaders also told us of their aspirations to improve local acute provision for children and young people with learning disabilities, expand the paediatric allergy clinic to reduce external referrals, and recruit a clinical nurse specialist to expand sickle cell disease support. Expansion of the NNU high dependency service required investment in new intensive cots. Senior clinicians were liaising with clinicians in other services, notably otolaryngology (ENT) and ophthalmology to move their paediatric outpatients clinics the Rainbow Centre.

Senior clinicians in the service highlighted gaps in the available paediatric therapies support on site, particularly in physiotherapy and speech and language therapy. This was also identified in the National Neonatal Review in December 2017 and a review of the service by Healthy London. Since the reviews, the service had prepared a business case to secure funding for dedicated on site allied health professionals.

The service was working with the local authority to deliver public health priorities for local dental care in hospital and improving oral health in the population. The service was developing training packages for nurses to help promote oral hygiene and reduce dental surgical interventions.

The trust values were prominently displayed in the service on notice boards. In the Rainbow Centre there was a colourful poster painted by a child patient to present the trust values in a child friendly format. All the staff we spoke with were aware of and could recite the trust values.

Culture

We found an inclusive and constructive working culture within CYP services. We found dedicated staff who were positive, knowledgeable and passionate about their work and passionate about caring for children and young people. The staff we met understood their local challenges and demonstrated a desire to improve CYP services for the benefit of their patients.

All the staff we spoke with were very proud of the Rainbow Centre and their new resources and they found the new environment inspiring and energising. Staff at all levels could share ideas about how to utilise the new space.
The staff we met told us they enjoyed working at the hospital and there were several staff who had worked in the service for more than 10 years. Most of the clinical staff we spoke with reported approachable and supportive colleagues and an inclusive and welcoming working environment.

Senior leaders of the CYP service were proud of their teams and told us staff were committed, respectful to patients and colleagues and made a positive difference to their local community. They reported good relationships both within CYP and with the maternity and emergency departments.

Nurses on the Neonatal Unit told us the culture on the unit was necessarily very medicalised because of the nature of the work, but that it was collaborative and equitable, with full engagement and inclusion of nursing staff.

Students and newly qualified nurses told us they felt confident to contribute to clinical decision-making and felt secure to decline tasks that were beyond their competence. Doctors in training reported a similarly supportive environment. Individually they told us that staff were proactive in offering help and that there was good sharing of information.

There were some isolated comments from nurses in the Rainbow Centre and the NNU about bullying and harassment and not feeling supported or listened to when they raised concerns. Some nurses also felt that relations between doctors in training and nurses could be improved as there was a perceived need for better communication between them. However, this was not representative of most of the feedback we received from staff.

All the staff we spoke with were aware of the trust’s Freedom to Speak Up Guardian and the trust’s ‘Speak in Confidence’ service and knew how to report concerns and access to support. However, none of the staff we spoke with had accessed the service.

**Governance**

Governance structures were in place across the CYP and neonatal service and staff felt they were effective. The service held regular planned governance meetings which had standardised agenda and regular items for discussion. Governance meetings were minuted to record all actions and discussion points. There were forums and meetings for staff to monitor quality, review performance information and to hold service managers and leaders to account. For example, there was a monthly board meeting chaired by one of the triumvirate, which all CYP clinical leads attended. These meetings we supported by separate operational triumvirate meetings for the Rainbow Centre and the Neonatal Unit to focus on matters specific to each part of the service.

There were bi-monthly meetings for all staff in the Rainbow Centre to share information about incidents, complaints and other operational matters. There was a monthly ward meeting and monthly quality & safety meetings. There were weekly staff meetings for the neonatal team and daily ward huddles to share pertinent information. There were weekly consultants meetings to discuss clinical matters.

All performance and quality management information was escalated to the divisional performance review meetings which were attended by the hospital executive team. Information requiring further escalation was reported by exception to the hospital board.

Senior leaders and clinicians in the service worked closely with other hospitals in the trust. They attended the trust-wide Children’s Health Board, which was chaired by the Director of Nursing for babies and children.

There were monthly joint meetings between the paediatric emergency department and the Rainbow Centre where clinicians presented cases to discuss learning and areas for improvement.
Management of risk, issues and performance

Senior leaders and managers of the CYP service had a good understanding of risks to the service and these were appropriately documented in risk management documentation with named leads and actions. Risks were reviewed monthly and documentation submitted by the trust demonstrated clear action plans to address these risks.

There were eight recorded risks on the CYP and neonatal risk register, with serious risks escalated to the divisional risk register. The recorded risks in service documentation corresponded with the concerns that clinicians and senior nurses told us and with what we observed during the inspection. Two recorded risks were given the highest risk impact and likelihood score of 16. These related to insufficient consultant doctor staffing capacity (not presently meeting the pan-London requirement for all children to be seen within 13 hours of admission), and neonatal incubator obsolescence resulting in suboptimal patient care. Other themes within identified risks included paediatric therapy capacity and the decontamination room in the NNU.

All recorded risks included detailed narratives about the potential impact, mitigating actions and named leads. The service had submitted business cases to increase the number of consultant doctor posts, a replacement programme for new neonatal incubators and introduce dedicated on site paediatric allied health professionals. In response to the risks in NNU, the service had a plan to redevelop the NNU space by moving the clinical preparation rooms and decontamination rooms around to make more usable space.

Senior leaders of the service told us there was a commitment from the board for CYP services and that the board recognised CYP as a key part of the hospital and was prepared to invest in CYP services to mitigate and remove identified risks. The CYP divisional leadership team felt that they had a strong voice at hospital board level and that they felt listened to, which had enabled them to develop the service. This was evidenced in the development of the Rainbow Centre and approved funding for the new matron post.

Information management

The hospital intranet main page included links to organisational policies, protocols, national guidelines and major incident plans. Nurses showed us how to find documents and they were adept at finding relevant information using the system. There were no printed copies of policy documents in the Rainbow Centre to ensure staff only accessed the most up to date versions on the trust network.

There was a dedicated page on the hospital intranet on major incident plans, which included information on what this means for staff, processes and levels of command and testing of the plan.

There were computers on wheels in appropriate locations throughout the CYP service and staff told us workstations were accessible when they needed them. Some doctors in training told us it was sometimes challenging to find a spare workstation at times when there were lots of doctors on ward. Computer network access was via a smart card login system for secure access to documents and webpages.

There were printouts of useful documents posted on the wall by the nurses’ station including hospital guidelines, referral processes to other services, available training, preparing for emergency transfers, obtaining medicines out of hours, safeguarding contacts and contact details for other services. This meant staff has immediate access to this important information and did not have to search for it.

There were student notice boards containing information about teaching sessions in the hospital, link lecturer contact details, nursing forum, and nursing principles.
There were standardised quality information boards in the Rainbow Centre and NNU which provided current quality data such as staffing levels and safety performance. Notice boards along the ward corridors were neatly organised and were child friendly with information for staff and patients, including visiting hours, protected meal times and senior nurse contact details.

There were paediatric sepsis awareness posters throughout the CYP clinical areas, which included clear guidelines for identification and escalation of paediatric sepsis.

The CYP service used paper records. Throughout the service we saw that notes were stored in dedicated notes trolleys in a visible, secure area. Staff used individual password protected user details to access patient test results on the computerised record system.

Staff in the Rainbow Centre used paper forms to record patient vital signs to support monitoring and escalation of early warning scores. While this system is acceptable, it is not optimal as it did not facilitate timely audit of the data within and across clinical areas.

**Engagement**

Staff told us there was good communication from the trust and hospital leadership team and they felt that CYP was well represented in the hospital by the divisional senior team. The trust provided several communications in the form of regular newsletters and all staff emails which highlighted local news, achievements, changes and policy updates. There was a monthly CYP service ‘Rainbow’ newsletter which was used to welcome new staff, promote the trust vision and values and celebrate staff achievements.

The service had a ‘Star Staff Award’ scheme for children and young people using the service to nominate individual staff members for providing high quality patient care. This was intended to empower children and young people to provide direct feedback about their experience of their care while in hospital. Senior leaders told us that recognising and rewarding staff for their contribution was a priority area for the service and the hospital had a ‘Newham Stars’ programme to celebrate staff who had provided excellent care.

The trust did not use ‘You’re Welcome’ or ‘15 Step Challenge’ models of gathering patient feedback, but they had introduced other measures to gather feedback on the environment and experience for children and young people and their families. The service’s family support worker had created Baggins the Bear themed patient feedback forms to make the process more engaging for young children. The Newham Neonatal Unit also distributed a paper Parents Satisfaction Survey for parents using the service. This was a one-page survey which asked parents about their experience of the unit. It included free text boxes for parents to record their views, as well as tick boxes and ratings. Questions included staff communication and support, cleanliness and hygiene, information provision and parents’ facilities.

There were ‘you said we did’ notice boards in wards and clinical areas which provided information about patient feedback and what actions had been taken as a result. There was also a Rainbow news board which displayed photos of staff and patients, and recent events that have been held including plays, celebrity visits and charity activities.

Senior leaders of the service told us there was a focus on public engagement to promote Newham University Hospital as the hospital of choice for local residents and to encourage local young people to consider careers both in the hospital and in healthcare generally. They planned to introduce evening events and work experience placements for local college students to promote healthcare as a career. Some doctors in training at the trust were mentors for sixth form students who were considering a medical career and were applying for medical school.
Learning, continuous improvement and innovation

There were some examples of innovative practice in the CYP service at Newham University Hospital. The service had their own blood gas analyser machines in the Rainbow Centre and Neonatal Unit. This meant clinicians could obtain instantaneous blood test results, as the samples did not need to be collected and analysed by a separate pathology team. All nurses, doctors and health care assistants in both units were trained to use the machines during their induction to the unit. This made treatment response times much more rapid. This was not frequently seen in other units of this size in other NHS trusts.

The CYP service frequently cared for patients with mental health support needs, including some vulnerable and at-risk young people in crisis. The service worked in partnership with the local NHS mental health and community trust to develop a one-day training session for clinicians called ‘We Can Talk’ to equip them with the skills to better support patients in crisis when they are receiving urgent medical treatment. Young people with mental health conditions were involved in developing the training programme with the support of the Healthy Teen Minds and Common Room organisations and mental health professionals. From this the Trust had developed a training toolkit for hospital staff which was the only programme of its kind in the NHS. At the time of our inspection over 200 staff had attended the training, including children's nurses, health care assistants, doctors and ward clerks. All attendees recommended the training and 96 per cent reported it would make a big difference to the way they do their job. ‘We Can Talk’ was nominated for a national award.

End of life care

Facts and data about this service

End of life care (EoLC) encompasses all care given to patients nearing the end of their life and following death. Patients received care in any ward or within any service in a trust. It includes aspects of essential nursing care, specialist palliative care, bereavement support and deceased holding unit services.

The definition of end of life includes patients who are ‘approaching the end of life’ when they are likely to die within the next 12 months. This includes patients whose death is imminent (expected within a few hours or days) and those with:

- advanced, progressive, incurable conditions,
- general frailty and co-existing conditions that mean they are expected to die within 12 months,
- existing conditions that put them at risk of dying if there is a sudden acute crisis in that condition,
- life-threatening acute conditions caused by sudden catastrophic events.

End of life care was provided on most wards at Newham University Hospital (NUH), which is a 344 bed district general hospital. There were 529 patient deaths at Newham University Hospital between April 2017 and March 2018.

The SPC team provides specialist palliative care advice to colleagues, patients and their relatives. The role of the team includes assessment and care planning for patients with complex palliative care needs, information on disease process, treatment, medication, local and national services, advice on symptom control and psychological support for the patient and / or their carer.
During our inspection, we spoke with five patients and their relatives. We also spoke with 29 members of staff, which included the consultant lead for palliative care, the SPC team, mortuary staff, chaplain, general nursing staff, medical staff, bereavement officer and porters. We observed care and treatment within the wards, reviewed 13 care records and 28 Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) forms. We reviewed the trust’s performance data relating to end of life and palliative care.

Is the service safe?

**Mandatory training**

The trust did not follow the national standard for end of life care training for all staff, as end of life care training was not mandatory. End of life training was mandated by the National Care of the Dying Audit of Hospitals (NCDAH) 2014-2015 across all staff groups.

The trust end of life strategy 2017 - 2020 incorporates an education strategy for end of life care training for all staff groups. However, the strategy does not include working towards end of life care becoming part of the trusts mandatory training programme.

The specialist palliative care team (SPCT) had received specific training such as the five priorities for end of life care. The five priorities of care are:

- The possibility that a person may die within the coming days and hours is recognised and communicated clearly, decisions about care are made in accordance with the person’s needs and wishes, and these are reviewed and revised regularly by doctors and nurses.
- Sensitive communication takes place between staff and the person who is dying and those important to them.
- The dying person, and those identified as important to them, are involved in decisions about treatment and care.
- The people important to the dying person are listened to and their needs are respected.
- Care is tailored to the individual and delivered with compassion – with an individual care plan in place.

Prior to inspection, the trust did not provide any mandatory training data for nursing and medical staff in end of life care specific to Newham University Hospital.

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

Following the inspection, the trust told us that eligible medical and nursing staff in end of life care met the trust target of 85% for completion of mandatory training with a 97% overall compliance rate. These figures were for medical and nursing staff working across the trusts four hospital sites.

The trust provided details of the mandatory and statutory training courses that end of life care medical and nursing staff are required to attend which are as follows:

<table>
<thead>
<tr>
<th>4 Harms - Catheter Acquired Infections</th>
<th>Complaints</th>
<th>Equality and Diversity</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 Harms - Pressure Ulcer Prevention</td>
<td>Conflict Resolution</td>
<td>Fire Safety</td>
</tr>
<tr>
<td>4 Harms - Slips, Trips and Falls (Patients)</td>
<td>Consent</td>
<td>Fraud Awareness</td>
</tr>
</tbody>
</table>
Safeguarding

The SPCT were knowledgeable about their role and responsibilities regarding the safeguarding of vulnerable adults and children. They were aware of the referral process to the safeguarding team. All staff had access to the trust wide safeguarding policies and procedures. These were accessible via the trust intranet.

Staff we spoke with reported patients with mental health needs would be provided with specialist support from a mental health nurse for 1:1 observation.

Prior to inspection, the trust did not provide any safeguarding training data for nursing and medical staff in end of life care specific to Newham University Hospital.

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

Following the inspection, the trust told us medical and nursing staff in end of life care safeguarding training was as follows:

| Safeguarding Children Level 1 | Safeguarding Adults Level 1 |
| Safeguarding Children Level 2 | Safeguarding Adults Level 2 |

Cleanliness, infection control and hygiene

Following the last inspection, the trust replaced the existing fridges in the deceased holding unit (DHU) with temporary fridges and advised that monies had been ring fenced in the 2016/17 capital budget for a replacement fridge. The temporary arrangements were still in place. Senior staff advised the trust were still considering various options.

The DHU fridges were visibly clean and cleaning schedules were in place which were signed by the mortuary attendant when completed. Whilst this had improved since the last inspection, we found the cleaning schedules were mostly complete, and only demonstrated that the fridges were cleaned Monday to Friday. Arrangements were in place to cover the cleaning when the mortuary attendant was absent. Porters told us that at weekends they would wipe the trolleys down using...
antibacterial wipes following the transfer of bodies into the DHU; although, there was no record of the cleaning undertaken by porters at weekends.

Following the inspection, the trust advised there was no seven-day cleaning across Barts Health DHUs, however there were cleaning procedures to be followed by porters and clinical site managers after release of bodies and transfer of bodies into the DHU from the trolleys. The trust was seeking further advice and guidance regarding seven-day cleaning.

We inspected end of life care facilities provided for the use of patients and their families, which included the multi-faith rooms and the viewing room. All areas were visibly clean, tidy and well maintained.

Personal protective equipment (PPE) such as face shields, gloves and aprons were available for use by staff in relevant areas. Porters confirmed they had received training to ensure they were competent in deceased holding unit procedures.

**Environment and equipment**

The DHU and the baby and foetal fridge temperatures were monitored to ensure the deceased were stored at the correct temperature parameters and that when this had gone out of range arrangements had been made to move the deceased to an undertaker whilst the DHU was undergoing repair and maintenance. Whilst this had improved since the last inspection, we found the alarm checks of the DHU temperatures out of hours and at weekends were not being monitored by security staff on a two-hourly basis as detailed in the ‘Newham Mortuary Temporary Body Fridges Alarm Escalation Procedure Out of Hours’ 20 August 2018. However, the trust provided evidence to show that the checks undertaken exceeded best practice guidance according to the Human Tissue Authority.

The DHU had a local alarm which meant the DHU had to be monitored two hourly. Security staff advised they could not guarantee the two hourly checks as their presence may be required at in another part of the hospital. Records showed that between 4 and 5 August 2018 the DHU temperature was outside the accepted temperature range of +7 centigrade and with checks made at 11.15am, 07.14pm, 11.20pm on 4 August and on the 5 August at 03.25am, 07.15am, 11.20am, 03.15pm, 07.30pm, 11.20pm. The trust advised during the inspection that following contact with the manufacturer the DHU temperature remains constant in a breakdown scenario for up to 23 hours if the door remains closed.

According to the ‘Newham Mortuary Temporary Body Fridges Alarm Escalation Procedure Out of Hours’, time scales for the removal of the deceased to an undertaker was within four hours after the contractor arrived on site, if not repaired. The service level agreement with the external contractor had a four hour time frame in which to respond and checks meant to be two hourly. The escalation procedure was not being followed which meant that the trust could not be assured that the deceased were being transferred within the timescales set out.

During the inspection, the trust advised they had amended the procedure to state that once the site team contacted the engineers (1 hour call out), if the temperature did not show signs of stabilising or the DHU unit was not working at all and there was no temperature display, arrangements would be made to move the deceased immediately. From the decision to call out the engineer by the clinical site manager, any newly deceased patients would not be placed in the DHU but transferred directly to the undertaker. Following the inspection, a copy of the revised standard operating procedures and operational policy for the deceased holding unit was provided.

There were no signs throughout the hospital to direct visitors to the DHU which was located on the hospital site, the signage on the door was for the bereavement office. There were 12 spaces
available in the DHU, bariatric patients were not held in the DHU but transferred to the undertakers. The DHU was locked and keys were held securely.

The fridge used to hold babies up to 23 weeks and 6 days and foetuses was not lockable and had no external means of recording the temperature. Staff advised this fridge had been in use since the last inspection. This was raised with senior staff during the inspection and immediate action was taken to replace the fridge with another fridge which could be locked and had an external temperature display. Since the inspection the trust’s central pathology department has confirmed that the original fridge was adequate for its purpose.

Equipment was available to meet patient needs such as syringe drivers. The trust used nationally recommended syringe drivers to deliver consistent infusions of medication to support patients with complex symptoms. These were available through the equipment library. Syringe drivers were part of the planned maintenance programme and calibrated yearly. Syringe driver batteries were held on wards. At the time of the inspection none of the palliative care patients had a syringe driver.

Staff had access to all other equipment for patients at the end of their lives, including pressure relieving mattresses and air cushions. SPCT told us if equipment was required at people’s home they would arrange this to be in place before the patient was discharged.

Assessing and responding to patient risk

The hospital did not have an advance care plan in place for patients who were at risk of dying in the next few months, however in patient notes we saw that plans of care for patients who were under the SPCT were regularly reviewed and conversations with patients and relative were documented. There was no system in place to flag if a patient was under the care of the SPCT.

The trust had a compassionate care plan (CCP) for the dying patient which would be put in place when a patient was in their last days and hours. The CCP reflected the five prioritise of care for the dying person. During the inspection two of the patients were on a CCP, we saw that a CCP had been put in place and there was evidence of four hourly checks. The patient had improved so the CCP had been crossed through (cancelled).

The trust used the National Early Warning Score (NEWS) assessment tool for recording the observations of patients admitted to the hospital. This tool scored each aspect of patient’s observations to prompt staff to follow clear procedures documented on the form. This meant that there was a system in place to monitor patient risk, including those patients receiving end of life care.

Risk assessments were in patient’s notes. These related to moving and handling, risk of falls, and tissue viability. We saw that actions were documented to take place where risks were identified. For example; patients who were at risk of skin pressure damage were nursed on pressure relieving mattresses.

The SPCT team had access to the liaison psychiatry service provided by a neighbouring mental health trust. The team provided advice to staff as well as assessments for patients on wards when required.

The SPCT clinical nurse specialists held review meetings Monday to Friday. They discussed patients seen, allocated new referrals and reviewed their workload. Advice and support from the SPCT team concerning deteriorating patients was available on all wards. Staff on the wards informed us that the SPCT team responded quickly to requests for advice and support.
Nurse staffing

The specialist palliative care team consisted of one team lead band 8, (1.0 whole time equivalent), three band 7 clinical nurse specialists (CNS) (2.80 whole time equivalent) and one band 6 EoLC facilitator nurse (0.5 whole time equivalent). This met the ‘Helping to deliver commissioning objectives’ (Dec 2012) which recommends a minimum requirement of 1 whole time equivalent CNS in palliative medicine per 250 hospital beds. The specialist palliative care team told us that a social worker had been appointed to join the team shortly.

Care and treatment for patients who required end of life care was provided by the ward staff with support from SPCT and the EoLC facilitator nurse.

It was not clear if there was an expectation that all wards had nurse champions for EoLC. Staff either told us they did not have an EoLC champion nurse or they were not aware who they were on their wards. SPCT told us that the EoLC champion nurse programme was being redeveloped as wards found it difficult to release staff for training.

The trust did not provide planned vs actual staffing data for nursing staff within end of life care services.

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

From May 2017 to April 2018, Newham University Hospital reported a vacancy rate of 10% for nursing staff in end of life care, this was higher than the trust target of 6.3%.

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

The workforce turnover data provided by the trust did not identify staff working specifically in the SPCT.

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

The workforce sickness data provided by the trust did not identify staff working specifically in the SPCT.

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

From May 2017 to April 2018, Newham University Hospital reported no shifts filled by bank and agency staff within end of life care services.

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

Following the inspection, the trust provided the following information for nursing staff within end of life care services for the period October 2017 to September 2018:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Planned Staffing</th>
<th>Actual Staffing</th>
<th>Vacancy Rates</th>
<th>Turnover Rates</th>
<th>Sickness rates</th>
<th>Bank &amp; Agency Usage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing &amp; Midwifery Registered</td>
<td>4.5</td>
<td>3.5</td>
<td>22%</td>
<td>22%</td>
<td>2.06%</td>
<td>0</td>
</tr>
</tbody>
</table>

The trust advised in terms of turnover, the team had increased over the last year with the addition of two WTE CNSs and one 0.5 WTE EoLC Facilitator. The turnover rate is reflective of only one leaver in recent years.
Medical staffing

Medical staffing in the SPCT was 0.9 whole time consultants (WTE). This was an increase of 0.4WTE since the last inspection. The post was covered by three consultants who worked four days per week across the hospital. Senior medical staff felt this was appropriate as a staff could access EoLC consultants from the other trust sites. The trust recognised that consultant levels were still below the ‘Helping to deliver commissioning objectives’ (Dec 2012) which recommends a minimum requirement of 1 whole time equivalent consultant in palliative medicine per 250 hospital beds, where Newham had 344 beds.

The trust did not provide planned vs actual staffing data for medical staff within end of life care services.

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

The workforce vacancy data for medical staff provided by the trust did not identify the EoLC consultants.

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

The workforce turnover data for medical staff provided by the trust did not identify the EoLC consultants.

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

The trust did not provide sickness data for medical staff within end of life care services as the workforce data provided did not identify staff the EoLC consultants.

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

From May 2017 to April 2018 Newham Hospital reported no shifts filled by medical locum and agency staff within end of life care services.

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

Following the inspection, the trust provided the following information for medical staff for the period October 2017 to September 2018:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Vacancy Rates</th>
<th>Turnover Rates</th>
<th>Sickness rates</th>
<th>Bank &amp; Agency Usage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0</td>
</tr>
</tbody>
</table>

Records

The trust used both electronic and paper records. The hospital was moving towards electronic records we found that the SPCT would replicate their records in both the electronic and paper records that were held on the wards. In the paper records the SPCT plans of care were written up in the nursing notes and these were signed and dated. The compassionate care plan was in place for two patients and there was evidence of regular review.

Where ‘Do Not Attempt Cardio Pulmonary Resuscitation’ (DNACPR) forms were in place, these were found immediately at front of notes. We reviewed 28 DNACPR forms and found these had
been signed by a ST3 (doctors in speciality training year 3) or above. In some of the patients notes there was documented discussions with relatives.

In the DHU, a register was maintained which recorded when a deceased patient arrived and was transferred out of the hospital.

On wards, we found patient records stored in lockable cupboards and trolleys and staff were aware of the importance of maintaining the privacy of patient information.

**Medicines**

The trust had guidance on anticipatory prescribing / ‘just in case’ medication at end of life. Anticipatory medicines were prescribed to control key symptoms such as agitation, excessive respiratory secretions, nausea, vomiting and breathlessness, which may occur as an individual reaches the end of their life. Anticipatory medications refer to medication prescribed in anticipation of managing symptoms, such as pain and nausea, which are common near the end of a patient’s life so that these medicines can be given if required without unnecessary delay.

Medicines were readily available to patients requiring treatment for palliative and EoLC. The SPCT had one clinical nurse specialist (CNS) in palliative medicine who had trained as a non-medical prescriber and another palliative CNS was due to start the prescribing course. The SPCT worked closely with medical staff on the wards to support the prescription of anticipatory medicines.

There was a structured training course for the use of T34 syringe drivers which was led by the medical devices training team and staff competency was assessed at the end of the training. Training records were held by the PDNs, and a central register held with the medical devices training team. Each clinical area has a T34 advanced trainer whose responsibility is to update staff every 3 years. Most of the ward staff we spoke with had not received formal training in syringe drivers.

The trust’s policy for the use of syringe drivers requires all nursing staff to be ‘competent and accountable in the delivery of care they provide for a patient (NMC 2015; NPC 2010) this includes the safe delivery of medicines and the use and operation of the syringe driver’ and ‘It is the responsibility of the Registered Nurse to ensure continued competency in the use of the CME T34 syringe driver. This is required 3 yearly unless specified as an annual update by their Ward Manager.’

**Incidents**

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

From August 2017 to July 2018, the trust reported no incidents that were further classified as never events for end of life care at Newham University Hospital.

*(Source: NHS Improvement - STEIS)*

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents in end of life care at Newham University Hospital which met the reporting criteria set by NHS England from August 2017 to July 2018.

The trust used an electronic incident reporting system widely used in the NHS to report incidents including near misses. Since our last inspection a mandatory field had been included in the system that prompts staff to make the identification of whether a patient is considered to be at end of life.
Staff we spoke with were aware of how to report incidents. Staff told us learning from incidents was shared at ward safety huddles and handover.

The trust provided details of 18 incidents between October 2017 to July 2018 related to EoLC. None of the incidents had been reported by the SPCT. Three of the incidents reported related to children who had died. One incident reported in July and was still awaiting review. We looked at three NUH EoLC steering group minutes and saw that incidents that related to palliative or EoLC which occurred across the hospital were discussed.

In the DHU, we saw that incidents reported between July and September 2018 related to deceased patients coming from the wards who had not been cared for as detailed in the trusts Bereavement Policy. A further incident related to the DHU register not being completed fully when seven deceased patients were transferred to the undertaker following a problem with the DHU. Only four of the deceased patients had been signed out. None of the incidents reported by the DHU had been discussed by the EoLC steering group and it was not clear how learning was shared across the wider service.

The trust advised their policy for Responding to Deaths mandates initial review for all adult inpatients at first stage within one week of death and additional second stage review where significant sub-optimal care is highlighted.

The trust advised learning from deaths is shared monthly via the trust mortality review group, information from which is cascaded to services via clinical leads. Additional service level mortality review meetings take place locally across the trust and circulate to all members of the team.

Staff we spoke with were aware of the Duty of Candour under the Health and Social Care Act (Regulated Activities Regulations) 2014. The Duty of Candour is a legal duty on healthcare providers that sets out specific requirements on the principle of being open with patients when things go wrong. Staff knew what duty of candour meant and could describe their responsibilities and principles relating to it.

### Is the service effective?

**Evidence-based care and treatment**

The trust had a care plan tool called the compassionate care plan (CCP) for the dying patient which replaced the Liverpool pathway. The implementation of the tool began in 2016. The CCP was in line with the recommendations published in June 2014 by the Leadership Alliance for the Care of Dying People (LACDP 2014), National Institute for Health and Care Excellence (NICE) guidance NG31 ‘care of dying adults in the last few days of life’ December 2015.

The trusts End of life care strategy was first published in 2016. The trusts revised strategy ‘End of Life Care strategy 2017 – 2020 moving forward: Supporting our staff to care for our community’ was finalised in December 2017 and was based on the ‘Ambitions for palliative and end of life care: a national framework for local action 2015 – 2020’.

The trust undertook two separate case notes audits of EOLC at Newham, University Hospital (NUH). Audits were undertaken on the 1 February 2018 (43 case notes reviewed) and 14 May 2018 (20 case notes reviewed). The audit was based on the five priorities for the care of the dying. The audit showed that 86% (54) of the patients had CCP’s in place. The action plan highlighted the areas to be addressed which included the need for spiritual care to be documented and for care planning to be well documented.
Nutrition and hydration

Staff used Malnutrition Universal Screening Tool (MUST) when they assessed patients at risk of malnutrition. Nutrition and hydration risks were assessed and monitored on patients’ records. Fluid balance and nutritional intake charts were held and completed at the patient’s bedside.

Records showed evidence of speech and language therapist (SLT) and dietitian involvement for patients who were a feeding risk and needed a feeding tube.

Nutrition and hydration was accessed as part of the compassionate care plan (CCP).

Pain relief

Staff did not consistently assess and monitor patients regularly to see if they were in pain. Assessment tools were not in place to suitably support those unable to communicate. This was similar to what we found at the last inspection.

The relative of one patient who was not able to communicate verbally told us their relative was in consistent pain and when touched would grimace or blink. We found no pain chart in their patient notes or on the drug chart. Another patient had their pain assessed every two or three days and their pain score was zero, their relative told us they were in pain and they had to ask staff for pain relief. This meant that pain assessments and pain scores were not completed consistently.

The trust used the Abbey pain assessment tool for patients who had difficulty communicating. Staff told us they also relied on patients’ requesting pain relief or by their non-verbal behaviour or by observing their eyes to manage their pain.

The SPCT team worked closely with the hospital wide pain team for the management of chronic pain. Once patients came under the care of the SPCT their pain management was transferred from the pain team.

Patient outcomes

The trust participated in the End of life care Audit: Dying in Hospital (NCDAH) 2016 and performed better than the England average for two of the five clinical indicators. For the remaining three indicators the trust performed worse than the England average. These were:

- Is there documented evidence that the patient was given an opportunity to have Concerns listened to? The trust scored 79% yes, lower than the England average of 84% yes.
- Is there documented evidence that the needs of the person(s) important to the patient were asked about? The trust scored 44% yes, lower than the England average of 56% yes.
- Is there documented evidence in the last 24 hours of life of a holistic assessment of the patient’s needs regarding an individual plan of care? – The trust scored 36% yes lower than the England average of 66%.

The trust answered yes to one out of the eight organisational indicators.

(Source: Royal College of Physicians)

The trust provided details of the action plan that was put in place following the End of life care Audit: Dying in Hospital (NCDAH) 2016 which indicated most of the actions had been progressed...
and the audit was ongoing. Following the inspection, the trust advised NUH had also participated in the national care of the dying audit 2018. The results are due in early 2019.

During the inspection, the trust was unable to provide us with information about the percentage of people who were seen by the palliative care team within 24 hours and whether patients died at their preferred place of care. Following the inspection, the trust provided detail of the EOLC Audit Plan which provided details of the audit cycle currently being followed to inform areas for improvement within EoLC services. These included pain, opioid usage, use of Compassionate Care Plan, Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) and experience of care at end of life.

The trust advised that it was not implementing the gold standard framework accreditation for acute hospitals or the amber care bundle at NUH. However, the trust planned to introduce Treatment Escalation Plans (TEP), including DNACPR, instead of implementing the amber care bundle. The trust plan is for TEP to be introduced on electronic patient records. This is currently in the design phase before being built. The trust advised the TEP would be launched first at another of the trusts hospitals where electronic patient records are in use later this year. The amber care bundle is a communication and planning tool that supports a systematic approach for clinical teams to proactively manage the care of hospital patients who are facing an uncertain recovery and who are at risk of dying despite treatment.

**Competent staff**

One clinical nurse specialist (CNS) in palliative medicine had trained as a non-medical prescriber and another palliative CNS was due to start the prescribing course.

Advance communication skills training in palliative care had been undertaken by the lead EoLC consultants (100%) and the SPCT (75%). The trust EoLC education lead had also completed the training.

The trust had three EoLC facilitators working across the hospital sites with 0.5 whole time equivalent working at Newham University Hospital. The facilitators provided training sessions to health care assistances (HCA) and nursing staff and supported staff on wards.

Training and study days for band 5 and 6 nurses and HCA’s included EoLC training. However, a ward manager told us that it was not always possible to release staff to attend the training due to staffing levels on the wards. The trust had also planned an EoLC conference for November 2018 which was open for all staff to attend.

Senior staff told us that EoLC training was also provide to as part of the in house training programme for junior doctors.

There were plans to for EoLC to become part of the trust induction programme and EoLC training and study days which provided signposting information and contact details. The trust had a leaflet for staff about palliative and end of life care.

The trust provided information on the numbers of staff who have completed EoLC training in the last 12 months at NUH. This was as follows:

- 50% of medical and dental staff (10 Consultants and 157 doctors)
- 33.8% of nursing and health visitors (184 nurses)
- 13% of support to doctors and nurses (52 health care assistants).

Porters received training to ensure they were competent in aspects of EoLC related to their role. Training had been provided with 40% (16) porters completing the training.
The trust provided the following information for appraisal rates for the period October 2017 to September 2018. The trusts target was 90%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Appraisal Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing &amp; Midwifery</td>
<td>67%</td>
</tr>
<tr>
<td>Registered</td>
<td></td>
</tr>
<tr>
<td>Mortuary Attendant</td>
<td>100%</td>
</tr>
<tr>
<td>Bereavement Officer</td>
<td>0%</td>
</tr>
<tr>
<td>Chaplains</td>
<td>50%</td>
</tr>
</tbody>
</table>

The trust advised that a new CNS had currently being inducted into the trust and the outstanding appraisal had been booked for later this year.

**Multidisciplinary working**

The SPCT worked across the wards working alongside ward staff, doctors and other health care professional to support patients.

The service had weekly multidisciplinary team meetings which were attended by the HCPT, EoLC consultants, hospital social worker and chaplaincy. There was no community or hospice representation. All palliative and end of life patients who were under the care of the SPCT were discussed and their care plans were reviewed. This included discussing the patient preferred place of care and medications. The SPCT also attended the care of the elderly multidisciplinary team meetings.

A weekly end of life care ward round was undertaken to review patients who were approaching end of life across the hospital on different wards following the MDT meeting.

Ward staff communicated with community teams and GP’s concerning patients discharge.

Referrals to the SPCT came from the wards and the team worked closely with other specialist CNS’s in for example renal, lung and breast cancer. The SPCT also attended safety huddles across the medical wards to identify patients who were imminently dying.

**Seven-day services**

The hospital was not meeting the NICE guidelines (QS31) for ‘End of life care for adults’, which stated, “Palliative care services should ensure provision to visit and assess people approaching the end of life face-to-face in any setting from 9.00am to 5.00pm, seven days a week’. This had not changed since the last inspection in November 2016 as the SPCT was only available five days per week.

There was no on site cover from palliative care consultants out of hours, however staff had access to an out of hours consultant for telephone advice which operated across the trust.

The specialist palliative care team provided Monday to Friday face to face 8.30am to 4.30pm palliative care services. However, there were plans to increase the service to six days per week at the end of the year.

Deceased holding unit services were available 8.00am to 4.00pm Monday to Friday. Out of hours viewing were provided by the porters.

The bereavement office was available to assist families 8.00am to 4.00pm Monday to Friday to issue death certificates. Out of hours arrangements were in place to issue death certificates on religious or cultural grounds.
Chaplaincy services were multi-faith and provided a 24/7 service.

Health promotion

The trust did not have a system in place to identify people in the last 12 months of their lives and as such had not developed ways to identify the support they or their carers may need.

We did not see any information for palliative patients or relatives promoting healthy lifestyles.

We did observe a palliative care nurse discussing having oxygen at home with a patient and how this would fit with their life style.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms were not completed correctly. In 39% of the forms neither the patient, their relative or next of kin (NOK) had been involved in the discussion. Only one patient had a mental capacity assessment when 77% of records indicated that there were questions regarding the patient’s capacity. This was similar to what we found during the last inspection.

We reviewed 28 DNACPR forms and found the following:

- 100% of DNACPR records were found immediately at front of notes.
- 100% of the forms had been dated when signed.
- 100% of the forms clearly identified the rationale for clinical decisions.
- 77% (14) of patients were recorded as having questionable capacity.
- 5% (1) of patient was recorded as having Mental Capacity Assessment (MCA) or best interest decision.
- 39% (7) of the forms indicated neither the patient, their relative or NOK had been involved in the discussion.

The trust had a do not attempt cardiopulmonary resuscitation (DNACPR) policy. The trust provided details of two spot checks audits on DNRCPR records across the wards at NUH. The trust advised spot checks were undertaken on a quarterly basis. Between February and March 2018 25 DNRCPR records were ‘spot checked’ this showed that 40% (10) were found to be non-compliant and 60% (15) were compliant. The spot checks audits undertaken between May and July 2018 looked at 27 DNRCPR records, this showed that 48% were found to be non-compliant and 52% were compliant. Both spot checks had recommendations in place to improve compliance.

Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) training was included as part of the trusts mandatory safeguarding adults training programme. Staff were aware of policies regarding consent, mental capacity act and deprivation of liberty safeguards and had access to them through the intranet. Staff we spoke with demonstrated an understanding of the Mental Capacity Act (MCA) and DoLS.

Is the service caring?

Compassionate care

We saw staff treat people with dignity, respect and kindness. Staff were seen to be considerate and empathetic towards patients. Relatives we spoke with were very positive about the staff and
felt they could ask staff questions about their loved ones’ care and treatment. In patient records we saw that where the specialist palliative care team (SPCT) had been involved with the families this had been documented.

During the inspection two of the patients under the SPCT were in side rooms. A ward manager advised that patients were only prioritised when they were nearing their end of life and they would liaise with the site practitioners to identify suitable side rooms on other wards if necessary. However, during the SPCT multi-disciplinary meeting one patient was discussed where it was noted there was no side room available on the ward. The patient was receiving end of life care and staff on the ward did not want the patient moved to another ward.

There were no visiting time restrictions for family and friends visiting a patient in the last days or hours of life. This allowed family and friends unlimited time with the patient. Compassionate signage was used to identify patients who were end of life care. The signage was hung on bay curtains or outside side rooms with a message requesting staff and relatives speak to the nurse in charge before entering.

Compassionate care bags were provided to relatives for patient’s belongings and helped staff identify bereaved family members.

There was a bereavement care before, during and after death policy which described the care given to a body after death. The process demonstrated respect for the deceased and their religious and cultural beliefs, as well as health and safety and legal requirements.

The trust provided details of their annual bereavement survey which looked at 303 surveys that were received from across the trust. Information was not provided on the number of responses received for NUH, however across the trust 78% (237) carers rated their over experience of care either to be excellent or good.

**Emotional support**

The chaplaincy service was available 24/7 and were provided with a list of patients daily by the SPCT team and visited patients daily to provided support for patients and their relatives irrespective of their individual faith, or if they did not follow a faith. If patients were discharged the chaplaincy would contact the local parish priest or Iman.

The chaplaincy team held worship services in the hospital’s multi faith rooms which patients and or their relatives could attend.

The SPCT and ward staff could signpost relatives to third sector organisations who provided bereavement services. On the hospital site, the Macmillan Cancer information centre was available for people affected by cancer and they could access information, support and counselling services.

The trust held an annual service of remembrance for relatives who had lost loved ones in the preceding 12 months. People of all faiths were welcome to attend the service which included readings, music and poems from a variety of religions.

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

The SPCT team and chaplaincy team provided support for patients and those close to them at end of life. Relatives we spoke with told us that the staff communicated with them and their relative in a way that helped them understand their care, treatment and condition.
In records we reviewed, we saw that patients were involved in their own care and relatives were kept involved in the management of the patient with patient consent. We saw documented discussions with patients and their families regarding care and treatment.

**Is the service responsive?**

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

The last inspection in November 2016 found palliative care patients were not prioritised for side rooms and there was a lack of facilities for dying patients and their relative. We found this had improved.

End of life care was delivered in most wards by staff and were supported by the specialist palliative care team (SPCT) and the end of life care facilitator. The trust had a standard operating procedure (SOP) for the prioritisation of side rooms at NUH. This included prioritisation of side rooms for patients who were end of life care, infectious patients and patients with delirium and/or dementia. Staff told us they tried to allocate side rooms to patients who were receiving end of life care, to offer quiet and private surroundings for the patient and their families. Staff told us there was a demand on the availability of side rooms due to priority given to patients who required isolation which meant that end of life care patients were sometimes cared for on open wards.

The hospital did not have designated overnight accommodation facilities on site for relatives. Wards provided folding beds for those who wished to remain at their relative’s bedside. Comfort packs containing toiletries were also available for relatives on the wards if they wanted to stay overnight.

There were no visiting time restrictions for family and friends visiting a patient in the last days or hours of life. This allowed family and friends unlimited time with the patient. No parking fees for relatives of patients receiving end of life care could be arranged, to enable relatives to spend the maximum amount of time with their relative.

In patient notes, we saw that patients who were under the SPCT had plans of care which included the patients preferred place of care. Patient preferred place of care was also discussed at the weekly EoLC multidisciplinary meeting. Although it was not consistent during our inspection, the trust advised there were a number of flagging mechanisms for patients considered to be EoLC. These included identifying patients who were palliative on the wards white boards using a magnetic symbol of a dove (bird).

**Meeting people’s individual needs**

The hospital did not have a dedicated EoLC ward or dedicated beds. Patients who required end of life care were mostly nursed on general medical wards. Staff told us that due to staffing levels on the wards they were not always able to give the care as they wanted. The demand on siderooms meant that end of life care patients were sometimes cared for on open wards until a suitable sideroom was available.

Staff had access to the psychiatric liaison team which worked across the wards to support the needs of mental health patients. Following the inspection the trust advise us that the SPCT also had access to the dementia and delirium team and a specialist learning disability nurse who worked across the trust site. The trust advised they were working to be compliant with the Accessible Information legislation to ensure that all patients are identified on first contact and their needs are recorded. The trust had no specialist nurses for patients who are visually impaired or deaf.
The trust's bereavement policy took account of different faiths and cultures in how to deal with death. To respond to the local Muslim community’s beliefs, arrangements were in place to ensure documentation needed to help with the registration of death was handled swiftly to ensure burial could take place quickly for people who required funerals for cultural and religious reasons.

There were two multi-faith rooms on site, these were quiet spaces where people could pray or reflect. The multi-faith rooms were open 24 hours a day and were used by patients, relatives, carers and staff.

Information was available for patients about the chaplaincy services at NUH. Leaflets were also available for relatives on what to do when someone close to you dies, and coping with grief and loss.

**Access and flow**

There were 529 patient deaths at Newham University Hospital between April 2017 and March 2018.

The service did not collect data to evidence the number of patients who were supported to die at their preferred place of death. Staff we spoke with confirmed this. Without this information the trust could not assess if patients were being asked what their preference was. Although, we saw evidence that palliative and end of life care patients had plans of care which included the patients preferred place of death. This was also discussed in weekly MDT meetings. Following the inspection, the trust submitted data which evidenced that this information was now being collected.

The number of completed compassionate care plans was monitored as part of the SPCT performance dashboard. The trust provided information on the number of completed compassionate care plans (CCP) as percentage of expected deaths. The data highlighted that between January and September 2018 the number of completed CCP varied from between 32% (March 2018) to 68% (June 2018) of the patients that died each month.

Patients identified as requiring palliative care, such as symptom control, were referred to the SPCT by individual consultants or ward staff of following ward safety huddles which were attended by the SPCT. The trust provided information following the inspection on the number of patients referred to the SPCT. The data highlighted that between April and June 2018, 109 patients died at the hospital of which 90% (98) of patients were seen by the palliative care team.

At the time of the inspection there was no information on what percentage of patients were seen within 24 hours. Following the inspection, the trust provided data that highlighted that between April and June 2018 the SPCT saw 96% (130/136) of patients referred within one working day of receipt of referral.

The SPCT advised that continuing health care packages of care could be organised within 24 hours. Wards communicated with community teams and GP’s concerning patients discharge. The trust provided information following the inspection on the number of patients who had a rapid discharge. The data highlighted that between January and September 2018 a total of 97 patients were discharged with the majority being discharged within 2.5 days.

The trust submitted the data to CQC in March 2018 for the period January 2018 to March 2018. The data highlighted that all patients were seen within two days of being referred. The team carried bleeps for urgent referrals.

**Learning from complaints and concerns**
The trust had a complaints policy and procedure in place. Information on the trust’s complaints policy and procedure was available on the trust’s internet website. SPCT were aware of the trust’s complaints policy and of their responsibilities within the complaints process.

We saw Patient Advice and Liaison Service (PALS) leaflets available around the hospital.

From April 2017 to March 2018, there were no complaints about end of life services at Newham University Hospital.

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

From April 2017 to March 2018, there were 39 compliments given to Barts Health NHS Trust. No site or core service breakdown was available.

The trust provided various examples of compliments staff on the wards had received from relatives thanking them for looking after their loved ones.

Is the service well-led?

Leadership

Across the trust the chief medical officer (CMO) had specific responsibility for end of life care on the trust board. The named non-executive director on the trust board leading on end of life care usually chaired the quality assurance committee. The trusts End of Life Steering Group was chaired by the trust CMO which reported to the quality board which was co-chaired by the chief CMO and the chief nurse.

At Newham University Hospital (NUH) the End of Life Care Steering Group was chaired by the hospital Medical Director. This was attended by members of the hospital staff, the specialist palliative care team, members of the trust wide End of Life Care team, chaplaincy and the CCG. The NUH EoLC steering group was represented on the trust wide EoLC steering group which reported to the trust quality board.

The trust lead clinician had a job plan in place for their role in leading end of life care, however this had not been updated. This was dated 1st April 2014. A job plan is an annual prospective agreement between the trust and the consultant that describes the objectives to be achieved by the consultant and supported by the trust.

At site level, the specialist palliative care team (SPCT) was led by a team manager who was visible and worked alongside the SPCT. The team manager reported to the trusts nursing lead for end of life care who worked across sites and the NUH director of nursing. The deceased holding unit and bereavement service was overseen by the clinical site manager and chaplaincy services came under the trust lead for bereavement services.

Vision and strategy

The trust first published its ‘End of Life Care Strategy 2016 - 2019,’ in 2016. The ‘End of Life Care strategy 2017 – 2020 moving forward: Supporting our staff to care for our community’ was finalised in December 2017. The trust strategy was based on the ‘Ambitions for palliative and end of life care: a national framework for local action 2015 – 2020’.
Progress of delivery of the strategy was monitored by the trust's End of Life steering group. An action plan was in place to support delivery of the strategy which focused on the following six ambitions for the service:

1. Each person is cared for as an individual.
2. Each person gets fair access to care.
4. Care is co-ordinated.
5. All staff are prepared to care.
6. Each community is prepared to help.

The action plan was RAG (red, amber and green) rated to indicate if the action points had been completed, were in progress or overdue. The trust recognised that there remained areas that required further development and embedding.

**Culture**

The SPCT and the end of life care nurse facilitator were very motivated and passionate about providing good end of life care. They aimed to support palliative patients and staff on wards across the hospital and when appropriate, discharge the patients to their preferred place of dying. SPCT felt valued, supported and spoke highly of their jobs. Staff told us there was good team work and peer support.

Staff we spoke with told us the SPCT were very visible and accessible and worked collaboratively with staff on the wards in providing end of life care. Staff were positive about the support provided by the SPC team.

Staff we spoke with on the wards told us of their commitment to provide safe and caring services.

**Governance**

It was not clear how the EoLC steering group gained assurance about the quality of end of life care provided at ward level or by the SPCT. There were no arrangements in place to identify wards or services that provided 'good' end of life care.

The SPCT did not undertake regular case load audits; there was no routine collection of information of patients who died in their preferred place of care, or audit of responses times by the SPCT when a patient was referred.

The EoLC steering group meetings were held monthly, attended by the medical director, EoLC consultant, members of the SPCT, representatives from the clinical commissioning group (CCG)'s and chaplain. We looked at three sets of meeting minutes which demonstrated that complaints, incident and compliments were discussed; however, these did not include the incidents related to the deceased holding unit (DHU). This meant the EoLC steering group had no oversight of how end of life care was provided to the deceased. Two of the three sets of minutes had action logs which detailed the progress of actions points from previous meetings which were RAG (red, amber and green) rated to indicate if the action points were they needed escalation, were overdue or were in progress.

Morbidity and mortality review meeting for each specialty team reported to quality and safety meeting. The trust advised there was a plan to appoint medical examiners for each hospital to independently review all deaths.

**Management of risk, issues and performance**
The trust provided details of two risks related to EoLC. One which related to NUH regarding the DHU which related issued identified in during the inspection in 2016 in relation to staff cover, infection prevention and control standards, procedural standards and dignity in care of the deceased which required immediate remedial action. This had been added to the risk register in November 2016. The other related to the inability to move to seven day working for the specialist palliative care network service was added to the trust wide risk in July 2018. Both risk registers had been reviewed and updated within the last two months prior to the inspection. Whilst a risk registers were in place, they did not reflect some of the concerns we identified during the inspection. This included lack of mandatory training in EoLC, documentation of Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms, or consultant levels. It was not clear if the risk registers were discussed as part of the trust wide and NUH steering groups as there was no reference to the risk registers in the minutes of these meetings.

The work of the SPCT was monitored using a performance review dashboard. The dashboard was used to detail the number of expected deaths, the number of patients who had been fast tracked, the number of completed compassionate care plans (CCP) as a percentage of deaths, EoLC training delivered to staff, and number of Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms completed as a percentage of deaths. The dashboard did not have key performance indicators (KPI) or monitor if patients were supported to die at their preferred place of death. Without this information the trust could not assess how effective the SPCT were.

Information management

The service had not collated any specific information under each of the five domains e.g. safe, effective, caring, responsive and well-led for end of life care.

The trust did not have performance of measures for the SPCT to report on. Without this information, the trust was unable to monitor if the care they were offering patients was making a difference to patients and relatives experience of the service provided at end of life.

Specialist palliative care staff had secure access to the trust intranet which gave them access to trust news, policies and procedures and their training and personal development records.

Engagement

The trusts ‘End of Life Care strategy 2017 – 2020’ included an end of life care education strategy, ‘Moving forward: Educating our staff to support our community’. The education programme detailed the training programs and audience the training was aimed at. The training identified for all clinical staff included recognising dying, delivering EoLC with dementia, and palliative care study day. All staff were required to attend communication, sage and thyme training which was specific to end of life care. The trust provided details of the numbers of staff that attended the training (167 doctors and consultants, 184 nurses and 52 health care assistants) this was 34% of the clinical staff. However, details of the courses they had attended were not provided.

An end of life care link nurse programme had been introduced to support nursing staff on wards at the time of the last inspection, however as part of the strategy, link nurses had been rebranded as ‘EoLC champions’ so the training programme could include hospital social workers and allied health professionals. We found staff on wards either did not know if there was an EoLC champion or were not aware who they were on their wards. This was similar to what we found at the last inspection.

The trust bereaved carers survey was sent out to relatives six week after their relative’s death. The information gathered was incorporated in the trusts annual bereavement survey. The trust did not provide details of the number of responses received for NUH.
Learning, continuous improvement and innovation

Schwartz rounds were part of the EoLC education strategy for all staff. Schwartz rounds are an evidence-based forum for hospital staff from all backgrounds to come together to talk about the emotional and social challenges of caring for patients. The aim is to offer staff a safe environment in which to share their stories and offer support to one another.

The chaplaincy facilitated a grand round annually to co-inside with Ramadan to advise clinical staff about how to support Muslim patients during the month-long celebration. Grand rounds are an important teaching tool and help doctors and other healthcare professionals keep up to date in areas which may be outside of their core practice.

An end of life care conference had been planned for later in the year by the trust which was open for or all staff to attend.

Outpatients

Facts and data about this service

Outpatient services at Bart’s Health NHS Trust is provided at all five hospital sites: The Royal London Hospital, Whipps Cross Hospital, St Bartholomew’s Hospital, Mile End Hospital and Newham University Hospital. The trust saw around 1.48 million outpatient attendances in 2017/18.

Up until mid August 2018 there was a mixed operating model, however responsibility and management for outpatients was devolved to hospital sites from this time. This included central appointments, phlebotomy, clinic reception and out-patient nursing. Management of medical records was retained by Clinical Support Services (CSS).

St Bartholomew’s Hospital and Newham University Hospital manage most of their new patient bookings with CSS providing reception of clinics and medical records. This model is under review with an aim to offer a standardised site based operating model for outpatient services across the trust. A team manage outpatient services across the sites with around 500 front line booking, reception, nursing, phlebotomy and medical records staff, who are site based but managed by the central team.

While CSS manage large elements of the booking and reception functions, responsibility for referral to treatment time and income generation sits with the hospital sites. A key focus for 2018/19 is the national requirement for all trusts to stop accepting paper referrals from GPs, and instead accept bookings only via the Electronic Referral Service (ERS). The trust is due to go live with this process July-September 2018.

Source: (Provider Information Return RPIR Acute Context tab)

Total number of first and follow up appointments compared to England trusts:
The trust had 1,358,950 first and follow up outpatient appointments from April 2017 to March 2018. The graph below represents how this compares to other trusts.

(Source: Hospital Episode Statistics - HES Outpatients)

Number of appointments by site:

The following table shows the number of outpatient appointments by site, a total for the trust and the total for England, from April 2017 to March 2018.

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Number of Spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Royal London Hospital</td>
<td>765,685</td>
</tr>
<tr>
<td>Whipps Cross University Hospital</td>
<td>521,004</td>
</tr>
<tr>
<td>St Bartholomew's Hospital</td>
<td>316,882</td>
</tr>
<tr>
<td>Newham University Hospital</td>
<td>274,495</td>
</tr>
<tr>
<td>Barts and The London Outreach Clinics</td>
<td>42,432</td>
</tr>
<tr>
<td>This Trust</td>
<td>2,099,264</td>
</tr>
<tr>
<td>England</td>
<td>105,566,870</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics)

The chart below shows the percentage breakdown of the type of outpatient appointments from April 2017 to March 2018. The percentage of these appointments by type can be found in the chart below:
Is the service safe?

Mandatory training

Data provided by the trust showed that staff working in the outpatients department achieved an overall of 97% compliance for the completion of mandatory training against a trust target of 85%. Only nursing and administrative staff worked for the outpatient service, with virtually all medical staff employed at the trust attending as necessary, but were employed within the clinical services division, where their training compliance was managed. Compliance in Fire Safety Training was 92%, Information Governance was 88.5%, Investigation of Incidents at 100%, and Basic Life Support Training was at 94%. Out of the 32 training modules available for staff to complete, 22 of those modules showed 100% compliance, with only three of those modules falling outside of the trust target. These modules were Medicines Gas Safety, Medicines Management, and Infection, Prevention and Control – all of which achieved 83% compliance.

Mandatory training was completed electronically on a system called 'Wired'. We spoke with the matron for outpatients who informed us that all staff, with exception to one member of staff, were up-to-date with their mandatory training. The matron told us that staff were supported to complete their mandatory training when they entered an amber period (a period of three months before their mandatory training would expire) before the status turned red.

One person had failed their online module on VTE within their mandatory training but were told this had been due to a glitch in the online training system, which would not allow for a second attempt for that training to be completed. We were told by the matron and the staff member concerned, that they would subsequently have to complete a classroom based module on VTE. This member of staff had showed us their training log and it showed 100% compliance in all of their other trainings completed.

We looked at the training logs of other members of staff such as a HCA and Band 5 Nurse, which showed that all trainings were up-to-date with nothing outstanding.

Safeguarding

Staff were 100% compliant in Safeguarding Adults Level 1 and 2 training. Staff were also 100% compliant in Safeguarding Childrens Level 1 and 2, against a trust target of 85%. In data provided
to us by the trust, we were told that there was not a Safeguarding Adults Level 3 course provided. In additional data provided by the trust, we were told that there was only one registered nurse working primarily in paediatric outpatients and that they were fully compliant with Safeguarding Children Level 3, and had been compliant for the last year.

We spoke with a number of staff to test their understanding of what safeguarding was and generally we found that there was good understanding of what it meant and what their responsibilities would be in relation to safeguarding a patient. We did however speak to a HCA who appeared to lack understanding between what was meant by safeguarding and what was meant by the Mental Capacity Act. They demonstrated their understanding by saying that safeguarding was “About the mental capacity act”, “Making sure patients were looked after in their best interests, with no restrictions on their freedom”. We spoke with a Band 5 Staff nurse about safeguarding. She stated that her understanding of safeguarding was, “If there is anyone who is vulnerable, it is to ensure that they get the best care” / “What the patient wants if they were to make that decision themselves.”

A plaster technician gave us an example of when a child visited the department for plaster application. She described the patient as looking unkempt, displaying worrying body language. The staff member escalated her concerns to the consultant and a safeguarding was instigated and dealt with. The plaster technician was confident that she knew what to look for and what to do if a patient needed safeguarding.

Staff knew who to contact in the event of a patient needing safeguarding, informing us that they would follow trust safeguarding policy, which included identification of signs of potential abuse and the actions to take if such signs were observed.

**Cleanliness, infection control and hygiene**

We observed ‘I am clean’ stickers attached to surfaces and equipment in the treatment rooms in the Health Central Outpatients area and the Gateway area to show that they had been cleaned. Items cleaned included suction units, dressing trolleys, blood monitoring machines, skin prick trays and recliner chairs.

We looked at four disposable curtains used in the treatment and plaster rooms. They were all clean and had all been changed a month and two months prior.

We observed that there was personal protective equipment available to staff to use in the dirty utility room, plaster room and treatment room two in the Gateway Centre. Aprons and gloves were available in each of the rooms, and we saw ear defenders in the plaster room. We did however see that aprons and gloves were not stocked in wall mounted holders but were stocked on shelves.

We observed cleaning schedules in the main outpatient’s area of the Health Central that displayed who cleaned what and the schedule for cleaning. The hospital was responsible for cleaning toys and games, an external provider was responsible for daily cleaning of walls and surfaces, monthly for ceilings, and twelve monthly for a soft floor shampoo. We found that toy objects were clean, as with the surfaces and overall environment of the department.

We observed many waste streams. In the main reception of the Health Central, there were no bins in the waiting area and food containers were left on a table. In one of the sub-reception areas of the main reception area, black bins were available and no waste was left on tables. The two treatment rooms within Health Central were furnished with one yellow and one orange bin and one yellow, one white bin. The dirty utility and sluice room had two white bins and one orange bin. The
treatment rooms in the Gateway had one yellow and one black bin in each room. There were three recycling paper boxes in Area E (sub wait section of the main reception) of Health Central.

Over a fifteen-minute observation, we saw nine members of staff who conformed to bare below the elbows policy. The staff observed included HCAs, nurses, sisters, the matron and receptionist.

We saw training certificates for staff who had completed disinfectant product training. This was training in high-level and sporicidal disinfectant products that harness the biocidal power of chlorine dioxide. The following topics were covered during the training: explanation of the product chemistry; application of the system; pre-cleaning; high-level disinfection; and health and safety aspects of using the products.

An external provider audited the cleanliness of the environment of the outpatients department. We were told that one of the sisters would accompany the individual leading the audit. We were told that the common theme that came out of the external providers audit was chewing gum under seats.

Staff gave us results of hand hygiene audits that they undertook from the beginning of April 2018 to the end of August 2018, which showed 100% week-on-week compliance during this period, with exception to one week in April 2018 where there was 90% compliance and one week in August 2018 where results were not collected.

Environment and equipment

We looked at a resuscitation trolley in the Health Central Outpatients Department. All the contents within the drawers that had expiry dates were within date. The suction Unit on top of the resuscitation trolley had a service date of July 2019. The trolley was locked and the daily checklists of the trolley were completed for the two months prior to our visit in September 2018.

Staff we saw all wore ID cards and had a yellow name badge.

We looked at five sharps bins across the Health Central and Gateway. All were signed and dated but two out of five had not been closed when they had reached their maximum capacity.

We looked at 16 items of equipment across the outpatient areas of Health Central and Gateway. These included blood pressure machines, thermometers and otoscopes. Of the 16, 15 had all been PAT tested. However, the one manual blood pressure machine that had been kept in the store room of Health Central had not been PAT tested. We advised the sister in the department who thanked us and took out an action report to get the item PAT tested.

A yellow flammable storage cabinet used to house flammable items was locked and closed and was COSHH compliant.

Assessing and responding to patient risk

We spoke with the nurse manager for outpatients (OPD), who informed us that she had a background in looking after level 1 and 2 high dependency medical and surgical patients, so could identify how she would recognise a deteriorating patient in the outpatients department. We were told that because of the nature of the service, they hadn’t experienced any patients who had visited and had shown signs of deteriorating. However, if a patient showed signs of, or expressed that they were unwell, we were told that staff would respond very quickly by carrying out an assessment of the patient, with their observations taken such as blood pressure and weight, and escalate where appropriate.

Managers told us that all staff working in the outpatients department would prioritise stretcher patients so that they would be seen as early and as promptly as possible. Stretcher patients would
immediately be allocated a room (normally one of the larger treatment rooms which could accommodate a stretcher should this be needed), and the consultant would carry out the clinic for that patient within that room.

Frail and elderly patients were assisted by staff when visiting the department, with staff seating these patients where they were visible to them. Those patients who had visible mobility issues or who were using a walking stick were offered a wheelchair; one of which the department owned and was kept in the Health Central Outpatients department. If the department needed access to more wheelchairs, they would call the on-site provider who managed the portering service to bring additional wheelchairs, which were easily obtainable.

The senior sister told us that there was a link nurse for mental health who worked in A&E and the outpatients team could access them if necessary. There were also psychiatric doctors who visited the outpatients department every Friday afternoon, working in other areas of the hospital during the other days of the week. Whilst the psychiatric doctors did not see acutely unwell patients, we were given an example of where they would see a patient who was experiencing post-natal depression or depression. Non-urgent mental health support was requested via the patient’s GP. There were policies within the trust with various ways to escalate those patients with mental health concerns. Nurses said that if they suspected that a patient attending a clinic had mental health concerns, they would also inform the clinician before the start of the clinic and that the clinician would undertake an assessment of that patient.

The nurse manager told us that the service had a patient visit the department that had an air-borne infection, but if a patient did attend, and it emerged that they had MRSA, then a deep clean of the clinical room would take place straight after the patient’s visit.

We were given an example of where two visiting patients to the service had had an epileptic fit. We were told that in both cases, a screen was put around these patients to respect their privacy and dignity and that a staff member would secure the patients’ airways and ensure that they were in a safe position. A call would be put out to the cardiac arrest team and other staff members would help to move other patients away from the area so that the area could be kept secure.

**Nurse staffing**

Newham Hospital reported their staffing numbers below for the period December 2017 to August 2018. Nursing staff reached 75% of planned capacity as at August 2018.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Planned Staff</th>
<th>Number in post as at August 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newham Hospital</td>
<td>29.47</td>
<td>22.16</td>
</tr>
</tbody>
</table>

The staffing composition of those working in the Health Central was one Band 7, several Band 6s, with two posts due to recruit into as one of the Band 6s was due to leave. There were Band 5’s, Band 4’s, Band 2 (HCAs) and reception staff and Associate Practitioners in Health Central.

There were Clinical Assistant Practitioners (Band 4’s) and two plaster technicians working in the Gateway Centre.

The OPD matron told us that the service used bank staff, who were experienced, but did not use agency staff.

The HCA told us that previously there were staffing shortages, however the sister had been proactive in recruiting into those vacancies, with a few new starters due to join the team.
The matron showed us two rotas on the trust’s electronic system. Rotas were completed six weeks in advance. The matron explained to us that staff increased or decreased when correlated with the number of clinics that were booked on a week-by-week basis. A Band 7 would check the week in advance to see if any bank staff were required. Health Central (the main outpatients department) did not use agency staff and most bank was fulfilled by substantive staff, which minimised the risk of things going wrong because they were aware of the clinic area. The Band 7 would escalate any staffing deficiencies. If bank was not filled, they would explain to the doctors and offer support to the clinic, and the Band 7 would step in to do a clinic, as well as the matron if they were available and on-site. We were told this did not happen often.

Adhoc clinics were taking place on some weekends but were becoming more frequent. Staff in substantive posts were not covering these shifts, which were filled instead by bank staff. There was a plan to get more substantive staff to meet the demands of increased capacity.

Handovers took place during the daily safety huddle, which took place at 08:30 in the Health Central. All staff were required to attend, including the matron and often the general manager would be present. Topics discussed included: incidents, complaints, staffing issues, how to resolve problems and preventing re-occurrences of any issues that affected the service.

The trust did not provide vacancy data for nursing staff within outpatients services.

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

During the inspection, the matron told us that previously there had been two Band 2 vacancies, but they had recently recruited into these roles. We were told that they were currently recruiting for two Band 6’s, as there were two in post at the time of our inspection, however ordinarily there should have been three. One of the Band 6’s was due to leave soon and there was currently a vacancy. We were also told that 0.57 WTE Band 5 Nurse had been recruited, some weeks prior to our inspection, and that they were waiting for the recruitment checks to be completed.

The trust did not provide turnover data for nursing and midwifery staff within outpatients services.

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

The following breakdown of turnover rates was provided to us on inspection by the matron for the outpatients department: One Band 2 HCA had moved on to another department within the organisation. Three Band 5 staff had left the service. One HCA had also gone on to retire and one HCA had left the department to pursue other opportunities outside of the trust.

The trust did not provide sickness data for nursing and midwifery staff within outpatients services.

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

The matron told us that sickness had improved considerably and whatever sickness the service did have, were managed in line with the sickness absence policy. We were given details of two members of staff who were off sick, one of which was a planned sickness because they needed to have an operative procedure carried out.

Newham University Hospital did not provide bank and agency staff data for nursing and midwifery staff within outpatients services.
Medical staffing

The trust did not provide planned vs actual staffing data for medical and dental staff within outpatient services.

The trust did not provide vacancy data for medical and dental staff within outpatients services.

The trust did not provide turnover data for medical and dental staff within outpatients services.

The trust did not provide sickness data for medical and dental staff within outpatients services.

Newham University Hospital did not provide locum and agency staff data for medical and dental staff within outpatients services.

Records

Nursing documentation was no longer being recorded on the previous electronic patient record system but on a newer system. We were shown how nursing staff could update a patient record by first selecting a clinic within the electronic system and then selecting the consultant attributed to a specified patient. Outcomes were updated and closed before clinics ended for the day at each reception point. We were shown the electronic file of a patient and we saw where that patient’s readings for blood pressure, pulse, height and weight had been inputted to calculate that patient’s body mass index (BMI). The electronic system showed which member of staff had entered a patient’s observations.

We did not see any set of notes within Health Central and the Gateway (surgical centre) that were left unattended. Notes were always in a room that were with a member of staff or within a locked room.

A lockable confidential waste bin was stationed against a wall in the Outpatients waiting area next to the chairs.

We were told that there was a plan for the responsibility of medical records to sit under the new outpatients structure and that this had been discussed at the Outpatients Transformation Board.

The hospital was not undertaking medical records audits but we were told by the general manager that they planned to do this soon. This had been raised in our last inspection. Further to our inspection, we were provided with data to show that the service was monitoring notes availability, showing results of 95% and 94% in March and June respectively, against a target threshold of 95% - 98%.
Medicines

In Treatment Room 1 of the Health Centre, drug cupboards were locked and closed. There were blue drug wastage bins, which were closed, dated and signed. The drug fridge was closed and locked, with evidence checks that had been completed for September and three months prior. Ambient temperatures were taken, with daily checks recorded.

In Treatment Room 2 of the Health Central, we observed that fridge daily checks for September had been completed. A hyperglycaemia treatment box had been checked daily and completed in the same month. Ambient room temperature checks were completed. The drug fridge was closed and locked. A pharmacy returns box was available. Drug cupboards were also closed and locked. A blue drugs wastage bin was available, had been closed, dated and signed.

In Treatment Room 1 of the Gateway Centre, a blue drug wastage bin was closed, signed and dated. We observed that an oxygen cylinder was free standing and was not wall mounted and we raised this with the nurse in charge who later rectified.

Though rarely used by the department, we looked at the recording and storage of FP10 forms. Prescriptions for the pharmacy, which was operated by an external provider, were written within normal working hours 9am to 6pm Monday to Friday. Prescriptions were counted and checked twice a day and the key to the cupboard was kept by the person in charge, which was the nurse manager. Back up stock was also checked twice a day. If the service needed any more stock, they would order 50 from the pharmacy. There was a pharmacy policy.

Stock top-ups were completed by a technician every Wednesday who visited from the pharmacy. They would check expired stock and expiry dates. The nurse manager was a nurse prescriber but no nurse within outpatients was prescribing at Newham Hospital and there was no PGD (patient group directive) in use. All consultants would prescribe.

Incidents

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

Between August 2017 and July 2018, the trust did not report any incidents that were classified as never events for the outpatient services at Newham University Hospital.

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents in outpatient services at Newham University Hospital which met the reporting criteria set by NHS England between August 2017 and July 2018.

We spoke with a healthcare assistant (HCA) who told us step by step how she would report an incident using the electronic reporting system. She confirmed that she had not experienced any issues in relation to accessing a computer to report an incident. The HCA told us that she and other members of staff received feedback regarding incidents in the morning safety huddles, as well as at monthly meetings. A Band 5 Nurse told us that she received enough time to be able to complete incidents.

We were told that all incidents were submitted to the general manager for outpatients, but if an incident was being completed for the arrival of notes, then the datix would be submitted to the general manager within the medical records division. We were told that sometimes the service experienced issues in receiving medical records, for example, records did not always arrive with the patient’s referral letter, which were usually in the patient’s medical notes.
We spoke with a Band 5 Staff Nurse who told us that her understanding of Duty of Candour was about “Being open and honest with patients” – providing us with an example – “If we have late running clinics, we let patients know if there is going to be a delay. If they are not happy with the service, we explain to them where they can go to complain. Being forthright with the patients.” We spoke with a clinical assistant practitioner who told us what duty of candour meant to her and that it was about being honest where things had gone wrong. We asked a Band 7 if they could explain the principles of duty of candour. They understood Duty of Candour to be about being open and honest about any harms that had been caused. We were told that duty of candour was very rarely exercised in practice because of the nature of the service, with no moderate harm incidents (serious incidents or never events). The Band 7 said they felt confident to follow up and get support from matron and 2016 was the last time they had to enact it.

**Safety thermometer**

The service did not use a safety thermometer in outpatients, however they did have a Quality Board. The Quality Board in the Heath Central Outpatients Department, showed that there was 97.3% compliance with their environmental cleaning audit score in August and the hand hygiene score was 100%. There were no falls for September and there was over 98% medical records availability for September, with no incidents in the previous month. The quality board showed that there had been a shortage of staff members on 3 September and there was a shortage of staff on two days in the month of August.

**Is the service effective?**

**Evidence-based care and treatment**

NICE guidance was monitored by the clinical effectiveness unit. They would ensure that relevant NICE guidelines were sent to each clinical team to be reviewed at their governance meeting. They would check that the specific guidance applied to their service, and implement any necessary changes.

We asked the question around whether the service was compliant in using NatSSIPPS and LocSSIPPS (national and local safety standards for invasive procedures). We were told by a senior member of staff that the only service that was contemplating utilising locSSIPPS was Ophthalmology, and this was in the planning stage.

Staff told us that the service complied with NICE guidance on retractable needles. The clinical assistant practitioners working in the Gateway advised us that they were following new NICE guidance with gynaecological services and blood results for post-monitoring, advising that patients with haemoglobin levels of less than 12 would need an iron transfusion and follow-up appointment. We were told they advised teams of the patients’ results, keeping evidence of the results and advising the doctor and pre-assessment nurse as applicable. The team followed NICE guidance and this was discussed at monthly meetings.

Outpatient referrals for elderly patients to Newham Hospital were triaged by the consultant geriatricians. Those patients who required a purely medical assessment, were seen in the outpatients by a consultant geriatrician; those who had more complex needs and who may have required a multidisciplinary assessment were seen in the day hospital at the East Ham Care Centre, which was run by another neighbouring trust, with input from the Newham Hospital consultant geriatricians.
We were told that hard copies of policies and guidelines were kept in the sister's office, as well as on the intranet. However, we asked a HCA to show us how they would access the trust policies and guidelines. In showing us, they visited the internet and typed a search into google rather than the trust’s intranet. We were shown the Duty of Candour Policy, which had a review date of March 2018, However the policy had not been reviewed.

The service was carrying out medicines management and hand hygiene audits.

A HCA told us that since the new nurse manager had started, staff had been rotated for all clinics, so that they were not just limited to knowledge for one area.

**Nutrition and hydration**

We observed that there were water fountains available in all the outpatient areas for patients, carers and visitors to stay hydrated. The Health Central and Gateway outpatient areas both had cafes co-located to their reception areas, where patients could buy food and drinks if they required. We did not see staff monitoring patients for a lack of nutrition or hydration.

**Pain relief**

Paracetamol was available in the department's drug cupboard and could be given to patients if required, after being prescribed by a doctor.

In Health Central, staff would direct patients to the in-house pharmacy if in need of other over the counter pain relief, or arrange for them to be seen in the emergency department if the pain was severe.

**Patient outcomes**

The service was not measuring patient outcomes but we were told by the general manager that there was a plan to once the new structure of outpatients was fully embedded.

**Competent staff**

We were told by the matron that appraisals for staff had been completed, with an appraisal completion rate of 94%. One member of staff was due to have theirs carried out in mid-October.

We were told that the nurse manager would oversee supervision of staff, giving support to them and ensuring that they attended and completed all their mandatory training. If a member of staff expressed an interest to work in a particular area then the nurse manager accommodated this.

The nurse manager informed us that before her tenure in the role, learning objectives were not set for staff. However, she was now making sure that they were implemented, and objectives were measurable and achievable. The nurse manager told us that she helped staff improve on their work practice, helping them to achieve their objectives, with staff having to draw on evidence based examples of how they had met those objectives. We were given an example of where a staff member had not achieved their objectives and how the nurse manager supported that staff member to undertake additional training to ensure that future objectives were met.

The nurse manager took the view that staff doing their job went far beyond them greeting patients at the front desk, taking their observations and assisting the clinicians with their clinics. She encouraged staff to do as much training as possible and informed us of an upcoming ‘masterclass’ that she had subscribed her team to that was taking place around “pico” dressing, which is a training course for wound dressing for mainly breast patients but oncology patients too.

Staff were encouraged to complete continuous professional development (CPD) and we were given an example of where a staff member had expressed an interest in undertaking an ophthalmology course, which that member of staff had later gone on to successfully complete.
We looked at 10 completed local induction checklists for temporary workers, which had been signed and dated.

We were told that clinical nurse specialists ran clinics in the outpatient’s centre as follows: diabetes, breast, colorectal, gastroenterology, diabetes, haematology, rheumatology, stoma care and cardiac. The CNS’s were not under the management structure of the outpatient’s department, but were managed by their respective divisions. There was one associate practitioner.

**Multidisciplinary working**

We observed multidisciplinary working at both the Health Central and Gateway Outpatients Departments. At the Gateway, we saw a consultant, registrar, registered nurses, a Band 4 and plaster technicians all communicating with each other and patients about their patient journey.

At the Health Central Outpatients we observed nursing staff working with consultants in an ophthalmology clinic, with the doctor asking for chaperone support from the nurse-in-charge; a HCA then attended to assist in the clinic. We later observed the doctor thanking the nursing team at the end of the clinic.

One stop clinics were held in the following specialities: dementia, breast, transient ischaemic attacks and diabetes for new appointments.

**Seven-day services**

The service operated clinics between the hours of 9:30am and 5pm, with adhoc clinics taking place in the evenings between 5pm and 8pm, and also at the weekend. We were told that these additional clinics were part of a drive to give patients increased flexibility, as well as ensuring that clinics were made available to those patients who needed to have a follow up appointment within a certain timescale.

The Outpatients pharmacy was run by an external provider but was open between the hours of 9am to 6pm Monday to Friday only.

**Health promotion**

We saw several posters and leaflets within the outpatients department that encouraged patients and visitors to consider how they could keep themselves well and minimise the risk of contracting or spreading infections. On the entrance of the Health Central Department, we saw a poster for staff and patients about washing hands in-between patient contact, and patients thoroughly washing their hands with soap and water if they have symptoms of diarrhoea or vomiting.

We saw a leaflet produced by Public Health England about the potential implications of taking antibiotics when they were not needed, as it encouraged harmful bacteria living inside the human body to become resistant to the antibiotics.

We saw another patient information leaflet about how patients could look after their kidneys if they had diabetes, such as eating a healthy diet low in salt and fat and ensuring adequate measures of drinking water.

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

We were told by the matron that there had been a lot of training around DoLS and the Mental Capacity Act, as well as information being readily available on posters concerning the matter. We were shown the DoLS quiz that had been given to staff to complete. The department also carried out a DoLS quiz to get staff to understand more about the nature of DoLS because it had been identified that there had been a lack in staff knowledge on the subject. Most members of staff understood what was meant by DoLS and MCA.
MCA and DoLS training was included within safeguarding level 2, for which outpatient nurses and phlebotomists were 100% compliant. There were no medical staff assigned to outpatients; medical staff from all specialities work in outpatients and their training is recorded within their speciality.

**Is the service caring?**

**Compassionate care**

We spoke with 10 patients who all confirmed that all staff from clinicians to receptionists were all very nice and polite, with no real improvements needing to be made.

We saw that a clinical assistant practitioner had received a certificate of achievement for outstanding performance in the Friends and Family Test.

We observed an episode of good care where a nurse approached a patient in the waiting area to let them know that they would be the next patient to be seen.

We observed a member of the ambulance crew help a patient transfer from a wheelchair to a waiting area chair and in a separate episode, we observed another member of staff help a patient to mobilise to a chair.

In the Health Centre, we looked at 17 patient satisfaction surveys and of those 17, in the question ‘How likely are you to recommend our ward to friends and family if they needed similar care or treatment’, 14 responded as Extremely Likely and 3 responded with Likely. In the question ‘what was good about your care, and what could be improved?’, comments ranged from ‘I was seen almost immediately and the nurse was very nice and she communicated very well’ / ‘professional, extremely helpful, fast and friendly’ / ‘Was only here five minutes!’ / ‘Very quick and friendly staff and doctor is amazing’ / ‘Seen promptly. Friendly staff’ / ‘The nurses all went out of their way to help. Nothing was too much trouble’. Only one respondent commented on the waiting times being something that could be improved.

**Emotional support**

The outpatient manager and senior staff made themselves visible and accessible to staff and patients. They could direct patients towards the services to meet their needs including PALS, chaplaincy, social services, specialist nurses (e.g. cancer nurse specialists), health advocacy and the mental health team.

A chaplaincy team member was available to make sure that patients, staff, relatives and friends in the hospital could receive the support they needed from representatives of various faiths and beliefs. The team consisted of full-time, part-time and trained volunteering chaplains. The chaplaincy team could be reached via Switchboard or the chaplaincy office.

Registered nurses working in Health Central would offer support to patients when they had received bad news during a consultation. The registered nurses told us they would take patients to a separate room and offer support in the way of letting them express themselves, provide them with information about support groups where appropriate and contact numbers for specialist nurses for the relevant service.

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

We saw patients being given information and being supported to make decisions about the treatment they would like to receive. During our inspection, we witnessed good interactions with patients. Staff took time to reassure patients and explain to them why they were waiting or what the next stage of their treatment or care was.
All the patients and relatives we spoke with across the outpatient departments said they were actively involved in decisions about their care and treatment. Patients told us they had received enough information before their appointment to prepare them for clinic. We observed staff keeping patients updated when clinics ran late and explaining the cause of the delay.

We observed patient consultations in the outpatient services and saw each patient was treated with care and respect. Good explanations of procedures to be carried out were given and there was time for patients to ask questions.

Staff ensured privacy and dignity was maintained in clinics by ensuring clinic doors were closed during consultations. Patients’ information leaflets were available for people attending clinics and contact details were provided to patients to make contacts in an emergency.

We spoke with 33 patients about their views being listened to and acted upon and most of them were positive about this question. We spoke with patients who told us they felt encouraged to be involved in their care.

Is the service responsive?

Service delivery to meet the needs of local people

The hospital was participating in the Collaborative Pairs programme supported by the King’s Fund, which in the NHS’s five year forward view, talks about harnessing the ‘renewable energy represented by patients and communities’ and the need to ‘engage with communities and citizens in new ways, involving them directly in the decisions about the future of health and care services’.

The hospital had engaged with Healthwatch to access groups in the borough and the strategy for the coming year was for the service be to be out and about in the borough attending groups and forums to hear as wide a voice as possible from users and their families and friends.

Communication with the patient’s GP was by letter following every outpatient appointment. These letters were sent electronically and once the document was completed it was uploaded straight onto the spine and the GP could access it immediately. GPs would be contacted by clinicians if there was an urgent action required by a GP.

There was sufficient car parking available for visitors, though patients had to have the exact money if they were paying by cash. The parking machines were able to take contactless card and Ringgo payments. Parking was not paid for on exit but we were told that this is something that was being considered. There was not one price that patients could pay, especially in the event where clinics were running late.

There was no shuttlebus for distant car parks but all car parks were close to the hospital, and drop off points were available immediately outside the hospital entrances.

Meeting people’s individual needs

A transport service was provided for those patients who needed it, primarily for those with mobility difficulties. At the time of booking new appointments checks are made to identify those patients who meet the eligibility criteria.

The matron told us that they tried to keep patients updated verbally and through the whiteboard when it came to clinic waiting times but did not monitor waiting times formally. We were told that the whiteboard would be updated every 30 minutes. On the first day of our inspection, patients waiting for cardiac clinics were experiencing 45-minute waits and we were told that this was because patients first had to have their electrocardiograph (ECG) carried out and then be
weighed, which contributed to the wait times. We were told by the Junior Sister that a datix would be completed if waiting times ever exceeded 30 minutes. Despite this, we did see staff nurses actively informing patients about changes in waiting times, and we observed a nurse announce to waiting patients that there was a 15-minute delay in the vascular clinic. The service had plans to include monitoring waiting times in their quality improvement work in the near future.

In Health Central there were information leaflets in languages commonly spoken locally such as Urdu, Punjabi and Arabic. The service was also able to provide a face to face and telephone interpreting service for patients during their consultation. We were told that on average they would use face to face interpreting 150 times per month in Health Central. The service utilised a bilingual health service and the common languages were Bengali, Hindi, Spanish and Portuguese. The Bilingual Health Advocacy and Interpreting Service (BHAIS), provided language services to patients, relatives and carers who either do not have English as a first language or are users of British Sign Language (BSL). The service was available from 9am to 5pm Monday to Friday. We were told that most clinical rooms were furnished with hands-free phones for occasions where staff would need to utilise language line. Figures for telephone interpreting usage were not available.

There were over 90 chairs stationed within the Health Central Outpatients Department, so there were adequate numbers of seating for patients and their relatives or carers.

There was a TV in the waiting areas of the outpatients departments.

The senior sister told us that there was contingency planning for prison patients who were seen in the department. We were told that for the patient’s dignity and respect, that prison guards were told to conceal the patient’s hands from showing their handcuffs. Patients attending from prison were placed straight into a clinic room when they arrived for their appointment and were seen straight away.

Patients on a stretcher were brought straight into one of the treatment rooms to be seen by a consultant.

Healthcare assistants were always available to offer assistance to patients with mobility problems, for example taking them to radiology, helping them into rooms, taking forms to reception. A range of mobility aids were available in the department and similar assistance was available for those with visual impairments.

There was a dementia team in the trust that the Outpatients Department could access if they needed and outpatient staff would receive training. We were told that most patients who were either living with dementia or a learning disability would attend the department with a carer. We were told that the dementia team would visit the department frequently and would provide the outpatients staff with updates, as well as taking the time out to talk to patients. There was also a dementia champion within the department. We observed a ‘dementia box’ located in area c of the Health Central Outpatients department, and it was furnished with dominoes and cards. We were told that if a clinic was running late, once a vulnerable patient was identified, then staff would speak to the clinician and ensure that the patient was seen to as quickly as possible.

The West Wing, where women attended gynaecological clinics, was open Monday to Thursday from 9am to 5pm. The West Wing had not addressed some of our concerns from our previous inspection, whereby the clinic did not provide privacy for patients and there was insufficient space within the waiting area, given that more than twenty clinics ran a day. On our most recent visit, we found that there was no changing room for patients and there was no quiet area for staff to talk to patients. There was no signage in the reception area to show that it was a dedicated area for gynaecological services. We were told that the gynaecology service was managed by the
Women’s and Children’s Divisional team and that the provision of the reception function was managed solely by the outpatient team. Operational aspects of the procedural clinics (e.g. colposcopy), were provided by clinicians (including nursing support) within the Women’s and Children’s Division.

**Access and flow**

Between April 2017 and March 2018, the Newham University Hospital’s “did not attend” rate was higher than the England average.

The chart below shows the proportion of patients who did not attend appointment at the trust:

(Source: Hospital Episode Statistics)

The service had gone from being division based to site based, having previously been under Clinical Support Services (CCS). We were told that the site based structure meant that there had been more collaborative working, with services taking more ownership of issues that arise. Some of the more targeted work that had begun to reduce the DNA rate were as follows: having two receptionists sitting in the clinic areas who could book patients’ appointments immediately so that patients chose a suitable date and would leave the clinic with their follow up appointments. Receptionists communicated with clinicians and HCAs to ensure that outcome forms were completed correctly and that patients did not go home with their forms. Changes had also been made to the electronic record system, as previously the changes made to the patients’ address were not saved. The service had installed a ‘fix’ so that the new address could be saved. This meant staff had more assurance that the right address was on the system. There was also a text messaging service for appointment reminders and in some specialities, patients were telephoned by the patient pathway coordinator staff to remind them of their appointments and to ensure that if they needed transport or health advocacy, this was booked.
The trust was performing better than the 93% operational standard for people being seen within two weeks of an urgent GP referral (all cancers). The performance over time is shown in the graph below:

(Source: NHS England – Cancer Waits)

The trust was performing better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat). The performance over time is shown in the graph below.

(Source: NHS England – Cancer Waits)

The trust was performing better than the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral, except for quarter 1 in 2017/18. The performance over time is shown in the graph below.
The trust had only started reporting RTT again since April 2018 and data submitted to us was for incomplete pathways. The data set provided was for five months from April 2018 to August 2018. The performance for this period was around 85% with no discernible trend, neither getting worse or better. The trust target was 92%. The performance at speciality level was variable.

Choice of first appointment was achieved by use of the electronic referral service (ERS). The service was offering ‘hot’ clinics for the following conditions and services: transient ischaemic attacks, chest pain, ambulatory care for medicine, ambulatory care for surgery, ambulatory care for gynaecology and ambulatory care for paediatrics.

**Learning from complaints and concerns**

Between April 2017 and March 2018, there were 39 compliments given to Barts Health NHS Trust. No site or core service breakdown is available.

Between September 2017 and August 2018 there were 3 complaints which went through the formal complaints process. In addition, there were 20 complaints received through PALS. For the formal complaints, all were responded to within 25 days.

The general themes from the complaints were related to communication; healthcare records; advice and information, diagnosis/treatment.

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

The matron told us that the last complaint the service received was in April 2018 and was dealt with locally, eliminating the need for it to go through PALS. The details of the complaint were regarding the waiting times of a clinic; a clinic overran and a patient expressed his concern about not being kept updated about the clinic waiting times.

Immediate learning from complaints were always shared at the daily team huddles. This included all the staff members who were part of the outpatient service; nursing, receptionists and the phlebotomy team. More thematic discussions would occur at the outpatient service meeting which occurred every three months on audit mornings to ensure everyone was included in this discussion.

**Is the service well-led?**

**Leadership**

Under the new structure that Outpatients now sat under, the leadership of the Outpatients service was overseen by the Associate Director of Nursing for Outpatients, who is also the ADoN for Critical Care and Surgery. The matron reported to the General Manager, however we were told that the matron for Outpatients at Newham would be moving over into a matron role at Whipps Cross Hospital and as such, the service would be recruiting into the matron post at Newham. We did however see a poster on the Quality Board still hanging which described the composition of the leadership team for Outpatients under the old structure. Given the newly implemented site-specific structure, we were not able to appraise the new leadership of the service.
Vision and strategy

The matron told us that the vision for the service was to run an efficient and safe Outpatients service, so that patients have a safe, efficient and positive experience every time they visit the department. Staff working in the service also aspired to the ‘Golden Rules of Health Central’, which were to: welcome a patient to the department, introduce self in a friendly manner, address any concerns raised by a patient, keep white boards information updated, on arrival inform patients of current waiting times and ensure that notes are ready and prepared for clinic.

We were told by the senior managers that having the Outpatients Service as a site-based service, rather than sitting under the divisional structure of CSS was more efficient. The senior managers commented on striving to make improvements in DNA rates and clinic cancellations, looking at follow-up ratios and reducing in waiting times.

The General Manager told us that she was working towards implementing shared objectives with the specialities, having identified some issues since taking up her role. An example that was given was that staff working at clinics between different hospitals within the trust could often arrive late for clinics at Newham, either because of traffic or because of a clinic that overruns at Whipps Cross. The General Manager confirmed that she would be setting up an Outpatients Efficiency Group across all the specialities to iron out all the issues that would make for a better and efficient outpatients service.

Culture

The matron commented on how friendly people were, with the working environment being referred to as a “Family feel”. The matron said she was supported by her General Managers both at Newham Hospital and Whipps Cross Hospital.

A HCA we spoke with said she was supported by her Line Manager and by the senior managers. She stated that all staff support each other.

We spoke with a Band 5 Staff Nurse who told us that teamwork was very good and that the team was very cohesive. “The management is very supportive. The matron, line manager and general manager are very visible and very supportive. I have enjoyed working here and the support is there.”

Another HCA we spoke with stated that it was lovely working at the hospital, with colleagues being “amazing” to work with. They mentioned that the sister rotates staff so they get to see and be exposed to so many specialities, learning something new every day.

Governance

The new governance structure for outpatients was currently being developed.

We were told by the General Manager for Outpatients that as they were now working under a new structure, the service was trying to work out what the structure and agenda of governance meetings would look like because the department’s risks were so low. She confirmed that under the new site-based divisional structure, the new division would be allocated a governance support person and that the first governance meeting would take place in the month of October, which would feed into the wider trust governance meetings, which take place bi-monthly. At the trust-wide governance meetings, divisions were allocated a 15-minute slot and the General Manager confirmed her attendance at the most recent meeting, stating that she had also taken the Nurse Manager for OPD too.

We were told by a senior manager that for the first time she would be attending an ‘Outpatients Transformation Board’ meeting at one of the other hospital sites within the trust, where decisions...
about the new site-based structure, and any changes that were to take place such as medical records moving over from CSS and falling under the remit of Outpatients, would be discussed. At this meeting, the General Manager would find out about the timeframes and deadlines for when the medical records to come over to Outpatients would be achieved. This meeting was chaired by the Trust Director of Group Operations and other key priorities looked were: a paper Switch Off for GP referrals, which was completed in October 2018; 2018/19 CIP delivery; health records moving to site-based management rather than central trust management in 2019; and ‘Transforming Services Together’ – which is an East London-wide project including one workstream transforming delivery of outpatient services, for example instigating virtual clinics.

There were several meetings that were going to take place under the new structure that did not previously exist under the old structure, and we saw the General Manager’s diary invitations of the meetings she had accepted to attend. She confirmed that she would initially attend all the first meetings, but had put a plan together for meetings going forward that either her, the Associate Director of Nursing (ADoN), the Matron and the Nurse Manager for OPD would attend jointly or independently. The Quality and Safety Committee would continue to be attended by the ADoN; Medicines Management and the Nursing Workforce Assurance meetings would be attended by the Matron; the Patient Experience Group would be attended by the General Manager, and the Complaints and Serious Incidents meeting would be attended by the General Manager, the Nurse Manager for OPD and the governance support person. Other meetings that were taking place were the Infection, Prevention & Control Committee; Integrated Safeguarding Group; Risk Assurance Committee; Operational Performance and the Newham Hospital Finance Delivery Board. The meetings would feed into the monthly Hospital Management Board, which would then feed into the Bart’s Trust Board.

**Management of risk, issues and performance**

The matron reported that there was one risk on the risk register, which was children being seen in adult clinics (namely ENT and Ophthalmology) and this was reflected in our findings. The controls put in place were that any paediatric patients who were seen in a mixed list were to be prioritised to be seen at the start of clinics. In addition, other controls that were in place were to ensure provision of paediatric resuscitation equipment, staff being trained in how to manage a paediatric arrest, and all nurses in charge of clinics (Band 6 and above) must have Safeguarding Level 3 training.

Service performance amongst staff was managed and we were told by senior managers that if any changes were made to the service, then staff were informed and verbal confirmation would be sought from staff to demonstrate their understanding of the changes that had or were to take place.

If it was felt that there were lapses in staff members performance, then informally they would be put on training and offered opportunities to shadow other members of staff. Where there were more serious performance issues, staff would be taken down the more formal HR route.

The matron told us that the service was not communicating effectively with other specialities when clinics were cancelled.

**Information management**

Since the cyber-attack that took place in 2017, the trust had invested in a new computer system in trying to protect their computers.

Staff confirmed that they always had access to a computer, with all clinical rooms being furnished with a computer, as well as there being computers at the nurse’s station.
**Engagement**

We were told that there was a patient experience group at the hospital but it wasn’t specific to Outpatients. The service was in the development stages of creating one for outpatients.

Patient engagement activities were conducted on a site-wide basis, and outpatients were included in the Newham University Hospital Patient Forum, which met monthly just before the hospital’s Patient Experience Group meeting which they also attended. Each month there would be a different theme, which would include making visits to different departments.

The Friends & Family Test survey had been rolled out across the Trust, via text messages sent and paper forms. There was a dedicated central resource to upload paper information so that feedback could be provided to the individual services. This included feedback for the outpatients department.

More specific engagement of outpatients occurred by referral through the relevant specialist nurse for a patient’s specific condition. The department acted upon feedback from patients and put patients in touch with relevant support groups. Patient groups would also provide feedback.

**Learning, continuous improvement and innovation**

We were told by senior managers that one of the innovations in the service was having receptionists booking the follow-up appointments for the patients in the clinic areas, and that this had been introduced two weeks prior to our inspection visit.

The Outpatients Transformation Board was also doing work around reducing cancellation and DNA rates by using two-way text messaging to enable the service to fill empty appointment slots at short notice. In addition, the board was doing work around booking patient appointments in real time in the clinic receptions, ensuring that patients were given a choice of dates for their follow up appointment. They were looking at clinic templates to improve capacity, which would translate to improvements in the new to follow up ratio. The board was also looking at the use of electronic advice and guidance to triage GP referrals and offer the right type of care and support to the GPs and patients.
Diagnostic imaging

Facts and data about this service

Bart’s Health operates one of the largest imaging centres in the country, providing medical imaging and diagnostic services, ranging from routine x-rays to specialist imaging. Newham services are based at Newham University Hospital, Shrewsbury Road.

The imaging department at Newham University Hospital performs approximately 11,500 examinations per month, and provides a service to GPs, mental health, out-patients, in-patients and a 24/7 service to the emergency department, theatres and wards.

The trust provides clinical services for:

- Ultrasound
- Computed Tomography (CT)
- Magnetic Resonance Imaging (MRI)
- Plain Film X-ray
- Fluoroscopy
- Nuclear Medicine
- Endoscopic retrograde cholangio-pancreatography (ERCP)
- Mammography

Is the service safe?

Mandatory training

The service provided mandatory training in key skills to all staff.

Staff told us they accessed mandatory training in several ways, such as online modules and by trainer delivered sessions. Reminders were issued to staff by the intranet software platform when training was due to expire.

We saw examples of staff training records showing completed training. We also saw examples of the monitoring which showed that staff had undertaken all mandatory training, such as health and safety, infection prevention and control, moving and handling, safeguarding and basic life support.

There was some specific training, which was role specific. These, were included in the staff induction and the mandatory training updates for example basic life support level two which was for clinical staff.

Junior staff could tell us about their clear induction process with set out competencies and supervision from senior staff. Staff were observed liaising with supervisors and were well received in an inviting manner when questions arose. There was a six-month training period for new recruits, however staff did rotate at certain points.

Data submitted by the trust following the inspection showed levels of compliance with mandatory training where the trust standard was 85%.
### Performance

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and dental</td>
<td>91%</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>97%</td>
</tr>
<tr>
<td>Allied health professionals</td>
<td>95%</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>97%</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>92%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>94%</strong></td>
</tr>
</tbody>
</table>

Following inspection, the trust provided mandatory training compliance data by module.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/ No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consent</td>
<td>100%</td>
<td>85%</td>
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</tr>
<tr>
<td>Safeguarding Children Level 1</td>
<td>100%</td>
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</tr>
<tr>
<td>Complaints</td>
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<td>85%</td>
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</tr>
<tr>
<td>Blood Transfusion</td>
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<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 3</td>
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<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness</td>
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<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Working at Barts Health</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
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<td>85%</td>
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</tr>
<tr>
<td>Health and Safety</td>
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</tr>
<tr>
<td>Safeguarding Children Level 2</td>
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<tr>
<td>Conflict resolution</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling – Patient Handling Practical</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults – Level 1</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
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<tr>
<td>4 Harms - Slips, Trips, and Falls</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>(Patients)</td>
<td>Completion rate</td>
<td>Trust Target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>------------------------------------------------</td>
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<td>--------------</td>
<td>--------------</td>
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<tr>
<td>4 Harms – Pressure Ulcer Prevention</td>
<td>94%</td>
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<td>Nutritional Care</td>
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<td>4 Harms – Catheter Acquired Infections</td>
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<td>4 Harms - VTE</td>
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<td>85%</td>
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<tr>
<td>Security</td>
<td>94%</td>
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<tr>
<td>Fraud awareness</td>
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</tr>
<tr>
<td>Emergency planning</td>
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<tr>
<td>Moving and Handling – Patient Handling</td>
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<td>Low Risk</td>
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<td>Infection Prevention and Control – Non Clinical</td>
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<tr>
<td>Information Governance</td>
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<td>Fire Safety</td>
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<tr>
<td>Privacy and Dignity</td>
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<td>85%</td>
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<td>Clinical Documentation</td>
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<td>Corporate Induction</td>
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<tr>
<td>Early Warning Systems</td>
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<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation – Basic Life Support</td>
<td>87%</td>
<td>85%</td>
<td>Yes</td>
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<tr>
<td>Risk Assessment for Managers</td>
<td>86%</td>
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</table>

We noted the following low compliance.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical gas safety</td>
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</table>
### Investigation of Incidents

<table>
<thead>
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<th>Service</th>
<th>Information 1</th>
<th>Information 2</th>
<th>Result</th>
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</thead>
<tbody>
<tr>
<td>Investigation of incidents</td>
<td>81%</td>
<td>85%</td>
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<tr>
<td>Preventing radicalisation level 3</td>
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</tr>
<tr>
<td>Medicines Management</td>
<td>0%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

### Safeguarding

We spoke with staff about safeguarding. Staff were knowledgeable about the trust’s safeguarding policies and their role and responsibilities. Staff could give examples of what constituted a safeguarding concern and how they could raise an alert. Staff were aware of the dedicated safeguarding lead they could access for advice.

Patients and relatives we spoke with did not highlight any concerns about aspects of safeguarding. They said they were well looked after and they felt safe in the department.

The intercollegiate document ‘Safeguarding children – Roles and competencies for healthcare staff’ published by the Royal College of Paediatrics and Child Health 2014, stated that ‘all clinical staff working with children, young people and or their parents/carer and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding or child protection concerns should be trained in safeguarding for children level one, two and three.’

Staff in diagnostic imaging told us they had the appropriate level of safeguarding training to care for children. We could confirm this from data made available to us following inspection.

On all examinations we observed, patients were asked their name, date of birth and address. Pause and check processes (as recommended by the society of radiographers) were used to ensure that appropriate checks were carried out before the patient was exposed to radiation and ensured the completion of electronic process after the patient had left. Pause and check is a system to ensure staff stop what they are doing and ensure that all information presented in front of them is correct before making an exposure decreasing the risk of mistakes.

The safeguarding lead was available to provide support to staff regarding other specialist areas such as female genital mutilation. There were also policies established to further advise staff how to support women to ensure that appropriate referrals were made to the local authorities and other partner agencies. Staff we spoke with knew to discuss concerns with the safeguarding team.

### Cleanliness, Infection Control and Hygiene

We saw clinical rooms had facilities for the disposal of clinical waste and sharps. Waste management was handled appropriately, with separate colour coded arrangements for general waste, clinical waste and recycling. Clinical bins had foot pedal operated lids and were not overfilled. Sharps bins observed were assembled correctly, signed, dated and not overfilled.

Cleaning materials were stored securely in line with the Control of Substances Hazardous to Health Regulations (COSHH) 2002. COSHH is the legislation which requires employers to control substances which are hazardous to health.

Hand sanitising gel dispensers were available in corridors. We saw posters in waiting areas and other communal areas advising patients and visitors to gel their hands.
When treating patients who had a communicable infection such as tuberculosis or flu, staff said they prioritised the patient’s appointment to reduce time spent with other patients. Where possible, appointments were booked for quieter times within the department, usually at the beginning or end of the clinic. Patient times in treatment rooms were minimised to reduce the risks of cross infection.

Staff were aware of infection-control processes such as the use of personal protective equipment and hand hygiene. Staff observed the hand hygiene and ‘bare below the elbows’ policy of the hospital.

During inspection we saw completed up to date hand hygiene audits. Hand hygiene audits were completed monthly to assess compliance with National Institute of Health and Care Excellence (NICE) Quality Statement 61 (Statement 3). This states people should receive healthcare from workers who clean their hands immediately before and after every episode of direct contact or care. We saw 100% compliance was achieved for the six months prior to our inspection.

All areas within the department were visibly clean. We observed staff cleaning equipment after use. Staff completed daily cleaning logs of equipment. Appropriate level decontamination equipment was in place for transvaginal probes in ultrasound procedures.

There was a lack of storage space for equipment in some areas. During our unannounced inspection we saw the mobile x-ray arm stored within the corridor. Equipment used for ERCP was brought from another ward once a week to the department. This was left outside the clinical rooms within the corridor. Staff told us this was a regular occurrence as there was no room to place the equipment and it was a hazard within the corridors. Radiology areas also lacked space for waiting inpatient and outpatients.

**Environment and equipment**

There were two emergency trolleys within the diagnostic imaging department which were checked daily and tamper proofed. Equipment trolleys were clearly labelled. There were adequate stocks of equipment and we saw evidence of good stock rotation to ensure that equipment was used before its expiry date.

During inspection, we saw jugs of pre-prepared contrast and jugs of water stored next to each other within a patient preparation room. Both jugs contained clear liquid and both were unlabelled. There was a risk that a patient may be given the wrong fluid to drink. We escalated this to the department lead and the jugs of pre-prepared contrast were immediately removed. During the unannounced inspection, we saw that staff prepared contrast when and as it was needed.

Clear signage was visible for ‘controlled areas’ within the department. A controlled area is one designated to assist in controlling and restricting radiation exposures of patients and staff. Magnetic resonance imaging (MRI) equipment and devices were clearly labelled within the MRI environment. This was in accordance with Medicines and Healthcare Products Regulatory Agency (MHRA) (2015) recommendations.

The medical physics department of the trust supported diagnostic imaging staff by providing radiation protection services. This team included radiation protection advisors (as required under Ionising Radiation Regulations 1999 [IRR99]), medical physics experts (as required under Ionising Radiation (Medical Exposures) Regulations 2000 [IR(ME)R]) and radioactive waste advisors. The medical physics teams provided scientific support to diagnostic imaging departments in several areas. This included monitoring specialist radiology equipment, monitoring staff radiation doses and providing guidance on the various specialist regulations surrounding the use of imaging equipment. The RPA was on site once a month and available by phone at all times.
The department had five radiation protection supervisors (RPS). All were readily available as required by IRR99. The purpose of these roles was to ensure that staff followed local rules and adhered to radiation protection procedures in the department. The local rules summarised the key working instructions intended to restrict exposure in radiation areas. Staff we spoke with knew who their RPS was and could contact them for advice.

During inspection we spoke with RPS and saw evidence of training delivered in 2013. The RPS were given a half an hour training update session once, since initial training. We saw no evidence of yearly updates submitted to the RPA. Local radiation rules were available under IR17 and were signed and dated as required. There was knowledge of the new radiation legislation and changes in IR(ME)R17 that occurred in 2018, however, was not contained within the documentation as no training had been provided. Staff told us RPS training was unstructured and once initially trained attendance to ‘lunch time’ talks and updates were sporadic as no time was allocated.

Risk assessments were carried out on all imaging equipment and staff wore radiation badges to monitor any occupational doses. The radiation protection policy was regularly reviewed and we were told the radiation protection team carried out regular audits. However, we saw no evidence of this. Radiation warning signs were clearly displayed outside all appropriate rooms in the diagnostic imaging department.

Staff ensured there was ongoing equipment maintenance and they displayed service stickers to show when the next service was due.

There were fire risk assessments for the diagnostic imaging area. The fire safety policy also showed details of procedure to be followed if a fire was discovered.

The MRI and CT Department worked in tandem and although there were separate examination rooms their scanner consoles and workstations were within the same room working opposite each other. There was one double door entrance to the private scanning area which gave entrance and exit to MRI and CT patients. This shared area contained consoles, workstations, staff, equipment and paperwork. Patients entered separate doors within this area into the examination areas.

On inspection, we saw patients from the different modalities were in the scanning workstation area often together prior to examination. This led to issues regarding infection control, privacy and dignity, data protection, and patient and staff safety. We witnessed patients in this area awaiting scans in beds, one patient at this time had a clear view of the console of CT which still had on screen the examination of a previous patient.

Staff told us they transferred patients who were on trollies onto the MRI compatible bed within the console area and the small enclosed area meant they occasionally knocked themselves on surrounding walls and equipment. Staff told us they had raised these conditions previously with management.

We raised concerns we had about the CT and MRI area with the trust. The trust provided risk assessments of the area and sufficient mitigation. On our unannounced inspection, we saw a temporary screen placed between the CT and MRI work stations. This prevented patients being able to view the opposite console areas. Staff told us the screens did serve purpose, however, it made the area cramped and sometimes difficult to manoeuvre in.

Assessing and responding to patient risk

IR(ME)R requires a number of procedures to be in place within every department that uses ionising radiation. These cover a wide range of patient safety features such as patient ID, checking pregnancy and dose recording. During the inspection, we found that the staff had a good understanding of the regulations and were aware of where the procedures were kept.
There were clear signs in the diagnostic imaging department informing patients, visitors and staff where radiation exposures were taking place. There were additional signs on the doors which indicated to cleaning staff when the machine was off and they were permitted to enter and clean.

The diagnostic imaging department had guidelines to ensure that female patients and staff of childbearing age were asked if they were, or might be pregnant. There were signs in waiting areas and x-ray rooms reminding patients to inform staff if they may be pregnant. Staff we spoke with were aware of the importance of checking the pregnancy status of female patients.

Comprehensive risk assessments were carried out for patients who used services. Within the MRI service safety checklists were completed to ensure that the patient was safe to enter the magnetic setting.

Patients being cared for on wards were brought down to the department by porters. On inspection, we saw an elderly patient who was confused and displaying communication difficulties left within a holding area. The patient had a naso-gastric tube (NG) and had undergone an ultrasound examination. The patient was unaccompanied and a curtain was part drawn which restricted viewing by staff. Staff told us that patients were not sent to the department with qualified escorts. Porters told us this was normal practice and they had previously raised concerns of transporting patients without qualified escorts. In addition, staff stated that the department was unusually quiet due to the CQC visit. We escalated this situation to the department lead and other managers who agreed that the incident was unsafe and unacceptable and dealt with the situation immediately.

Staff told us of the action they would take if a patient became unwell or distressed while waiting for, or having a scan. They said this depended on the specific situation and gave us examples which indicated they would take appropriate action, for example, if a person fainted or panicked. We saw there was an agreed procedure to identify the actions to be taken in the event of a patient becoming unwell.

Radiographers were trained to examine referrals to ensure that there was an appropriate justification and rationale for performing the examination. We found that when patients were brought into the examination rooms they discussed symptoms to ensure the clinical justification was correct.

Radiographers did not have clear oversight of who or what types of examinations non-medical referrers were able to request. The radiation protection team had identified that there were a high number of non-medical referrers who didn’t have imaging referral as part of their scope of practice. There were staff requesting examinations which should not have been doing so. This increased risks to patients receiving an incorrect examination and radiation they did not need to be exposed too.

Following inspection, the service told us they had implemented a non-medical referrers policy. We were told that approved referrers lists would be held locally on each site and staff were told to challenge requestors who were not authorised to request.

Staff told us that adapted World Health Organisation (WHO) safer surgery checklists were not implemented for general biopsy procedures. We were told this was previously introduced to the department, however, actions had not been taken to fully implement the checklist forms.

The service did not have an effective process in place to monitor that plain film diagnostic imaging tests had been reported on appropriately on the computerised reporting system. During our examination of electronic records, we noted that several plain film scans appeared not to have
been reported on by a radiologist. Staff told us that scans were awaiting final review by a radiologist.

On review of imaging reports, we saw that the title and professional registration number of the reporter were not being routinely entered at the end of clinical radiology reports, as per Royal College of Radiology (RCR) standards. This was addressed and rectified at the time of inspection.

We did not find evidence that clinical audits were being undertaken within the service to ensure that the requesting referral of an x-ray or other radiation diagnostic test, for example by GPs or other clinicians, was made in accordance with IR(ME)R or (MHRA) safety recommendations.

The service planned for emergencies and staff understood their roles if one should happen. The trust had an updated major incident plan. There were effective arrangements in place in the event of a major incident occurring within the department, for example, a power failure. The service was also affected by the recent cyber-attack on the NHS in May 2017. Extra staff were brought in and manual processes were in place to mitigate risk. Staff we spoke with were aware of the hospital’s and department’s major incident plan and knew what they needed to do in the event of a major incident.

**Allied Healthcare Professional staffing**

The trust reported the following allied healthcare professional numbers for diagnostic imaging.

<table>
<thead>
<tr>
<th>Team</th>
<th>Actual WTE in post</th>
<th>Planned WTE</th>
<th>FTE vacancies</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHP staff</td>
<td>35.67</td>
<td>37.75</td>
<td>2.08</td>
</tr>
<tr>
<td>Ultrasound</td>
<td>15.76</td>
<td>18.20</td>
<td>2.44</td>
</tr>
</tbody>
</table>

Data showed the service was running with less staff than it was planned to do.

The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse, and to provide the right care and treatment.

Each area within the imaging department had lead radiographers. This was a senior practitioner who worked with the team to ensure completion of care, training, and competence management of staff.

Each clinical area within the diagnostic imaging department had an appointed radiation protection supervisor (RPS).

Staff we spoke with told us there were issues with retention of trained staff. Newly qualified staff would be trained up to a certain level and they would leave for positions at other Trusts. We were told there was a lack of career progression following recurring personal development plans.

Turnover rates within the allied healthcare professionals working in diagnostic imaging were better than the trust average. For clinical staff the average turnover rate in the trust was 10%. This was in turn lower than the trusts target which was 13%. This increased stability within the service and ensured retention of skills and experience.

Sickness rates within allied healthcare professionals working within diagnostic imaging were better than the trust average. For clinical staff the average sickness rate in the trust was 1.2% which was lower than the national average. This increased stability within the service and ensured retention of skills and experience.
Allied staff agency usage is information routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. Data provided after inspection showed an average use of four agency staff within the reporting period.

**Medical staffing**

During inspection, concerns were raised to us over limited access to consultant radiologists by staff. We were told this was attributed to failed recruitment rounds and a national shortage. As a consequence, report turnaround times were reported as being affected with delays particularly of two week wait outpatients CTs. Demand management measures were implemented within the last three to six months prior to inspection. This meant CTs and MRIs were outsourced to an external teleradiology company.

On-calls were undertaken by radiology trust doctors from five pm to nine am as first on call, this amounted to a 16-hour shift. A bank second on call consultant radiologist was also available. The Trust doctors were permitted to leave the site at 9pm and if necessary report from home.

Second on-call consultant radiologists were responsible for checking of overnight scans the following morning. However, on inspection we observed an incident where an overnight scan performed two days prior had not been checked by a consultant radiologist. We escalated this incident to the site manager by staff.

Staff told us there was significant under resourcing with 5.6 WTE consultant radiologists within the department following the departure of one consultant on a one-year sabbatical.

Turnover rates for medical staff were very low at 0% within the diagnostic imaging service. This increased stability within the service and ensured retention of skills and experience.

Data provided post inspection showed a 0% sickness rate for medical staff within the diagnostic imaging service. This increased stability in the services ability to provide a safe service.

Medical agency and locum staff usage information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data.

On inspection, we saw weekly timetables for the last month prior to our visit. We saw there was heavy utilisation of bank trust doctors, consultant radiologists and sonographers for ultrasound. This was seen during daytime and evening hours seven days a week.

**Records**

We looked at eight patient records and found them all to be complete and completed appropriately. Alongside patients’ physical health needs, records contained details of patients’ mental health needs, learning disability needs and dementia needs.

Radiology reports were generated electronically and stored using the Computerised Radiology Information System (CRIS) and Picture Archiving and Communication Systems (PACS). These systems could only be accessed by passwords which ensured the images could not be viewed by unauthorised personnel. This meant that patient appointments were not cancelled as electronic records were always available.

On review of imaging reports, we saw that the title and professional registration number of the reporter were not being routinely entered at the end of clinical radiology reports, as per Royal College of Radiology (RCR) standards.

We saw that patients transported to the radiology department from other wards had no official patient notes at hand in the case of potential emergency. Patients were transported into the
department without any relevant clinical information, infection risks, resus information or escort and portering requirements.

**Medicines**

Medicines were stored safely and securely with access only by authorised staff. This included appropriate storage of medication for serious allergic reactions. The medicines cupboards we inspected were locked and secure, all stock was within expiry date and there was evidence of stock rotation. We saw medicine storage temperatures were recorded daily within safe parameters.

On inspection we saw that the glucose monitor was kept in a locked room and was not readily accessible in the event of an emergency. Staff told us that one person was trained in its use and always had access to the monitor.

Staff told us patient group directives (PGDs) were available in MRI and CT and were in line with trust policy. A PGD is a written instruction for the sale, supply and/or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. The PGDs in place allowed trained radiographers to manage and administer low risk contrast. The trust provided requested documents regarding PGDs, all were appropriate and within date.

We were told by staff that most of radiographers in the service were unable to cannulate. There was reliance dependent on a single imaging department assistant who covered both CT and MRI. Staff reported limited opportunities to undertake cannulation training due to high intensity work patterns.

During inspection, we saw jugs of pre-prepared contrast and jugs of water stored next to each other within a patient preparation room. Both jugs contained clear liquid and both were unlabelled. There was a risk that a patient may be given the wrong fluid to drink. We escalated this to the department lead and the jugs of pre-prepared contrast were immediately removed. During the unannounced inspection, we saw that staff prepared contrast when and as it was needed.

**Incidents**

Staff were aware of their responsibilities and understood the need to raise concerns and report incidents. Staff described access to incident reporting as simple and intuitive. They were aware of the importance of changing practice as a result of investigative findings. Managers told us they gave feedback to all staff after investigating incidents to prevent them happening again.

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

From August 2017 to July 2018, the trust reported no incidents classified as never events for diagnostics at Newham General Hospital.

(Source: NHS Improvement - STEIS)
In accordance with the Serious Incident Framework 2015, the trust reported five serious incidents (SIs) in diagnostic imaging which met the reporting criteria set by NHS England from August 2017 to July 2018.

The types of incident reported were:

- Diagnostic incident including delay meeting SI criteria (including failure to act on test results): four incidents
- Confidential information leak/information governance breach meeting SI criteria: one incident

(Source: NHS Improvement - STEIS)

The Barts Health diagnostics service is part of the Clinical Support Services (CSS) division and covers all Barts Health hospital sites. It has its own management structure as if it were a hospital site and provides representation and reports to the Newham hospital (NUH) Quality and Safety Committee and Serious Incident (SI) panels. Incidents are reviewed both at CSS level and site level and the decision as to whether a case meets SI criteria is made jointly.

Diagnostic incidents were the second highest SI type reported by Barts Health Newham hospital over the course of the past three financial years.

Actions taken to minimise recurrence of the above included development of a variety of standard operating procedures (SOPs) to ensure significant findings were communicated, CT scans were carried out within required timeframes; formally reported, and review of escalation to on-call radiology consultant undertaken.

Meeting minutes reviewed from September 2018 stated that there had been nine new incidents. However, there was no clarification as to what the rating was. One incident described that breast biopsy samples were not sent to the lab.

Staff we spoke with from different areas in the diagnostic imaging department could not describe with confidence learning from a recent incident. Some staff referenced a radiation incident in 2015 involving overexposure. However, no more recent incidents could be described.

Staff described when the duty of candour applied and demonstrated an understanding of when it should be implemented. They informed patients when things went wrong and there was evidence of apology in incident investigations we reviewed. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service ensured they notified the Care Quality Commission under IR(ME)R regulations or to the Health and Safety Executive (HSE) under the ionising radiations regulations (IRR99) requirements when radiation exposure was 'much greater than intended' was notified.
Is the service effective?

Evidence-based care and treatment

All modalities worked to the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R) and guidelines from the National Institute of Health and Care Excellence (NICE), the Royal College of Radiologists, the College of Radiographers and other national bodies.

Policies and protocols were stored on the diagnostic imaging departments online document repository. Staff we spoke with could access the system and navigate it to key documents or policies.

We found that there were few documents stored on the system which were out of date, however, we found some protocols that did not have dates, signatures of authorisers and were not formatted in an easy to use layout. Therefore, some areas had printed copies of policies which may not be up to date.

All levels of radiographers could protocol CT examinations with protocols in place on how to conduct an examination. However, there was limited official guidance on how or why to protocol.

On inspection we saw that the CT examination protocol list was last reviewed by a consultant radiologist in 2015. We saw not all radiographers who protocolled CT examinations were named in the document. Consultant radiologists we spoke with were unaware that junior radiographers were tasked with this role.

The trust submitted data following this inspection which confirmed that an adult patient dose audit was carried out in August 2018 by the trust medical physics expert (MPE) as required under the Ionising Radiation (medical exposure) Regulations 2017. However, staff were unable to cite the audit during inspection.

National diagnostic reference levels (DRLs) were displayed in the Accident and Emergency (A & E) x-ray imaging area. However, they were not displayed within the CT and MRI area. DRLs are typical doses for examinations commonly performed in diagnostic imaging departments. They are set at a level so that roughly 75% of examinations will be lower than the relevant DRL. They are not designed to be directly compared to individual doses. However, they can be used as a signpost to indicate to staff when equipment is not operating correctly or when the technique is poor. The radiographers working in X-ray had a good working knowledge of the doses. However, staff within CT and MRI were unable to tell us why DRLs were important and were unable to recount national dose levels.

We saw a recent trauma audit of A & E CT heads showed good results with reports produced within one hour. However, except for A & E no guideline criteria had been set for report turnaround times across the imaging modalities.

Clinical audits were not being undertaken routinely to ensure that the requesting referral was made in accordance with IR(ME)R or The Medicines and Healthcare Products Regulatory Agency (MHRA) safety recommendations.

Following the inspection, we requested minutes of audit meetings. The trust was unable to provide this information.

Nutrition and hydration

Patients were offered food and drinks, if necessary. For example, if they had long delays while waiting for transport back to their home. We were told staff could request sandwiches 24 hours a
day for patients, for example, if a patient was diabetic. Hot food was also available from the hospital restaurant for patients during the day.

Patients were advised on whether they could eat or drink prior to their treatment in their appointment letters.

**Pain relief**

Pain relief was not routinely used in diagnostic imaging, except for when patients were attending for invasive procedures where local anaesthetic was used. Staff provided patients with pain-relieving medicine specific to the investigation being undertaken.

Staff ensured patient comfort before completing simple diagnostics, such as ultrasound scans, and X-rays. We saw that patients were helped to reposition themselves if they reported they were uncomfortable, and reassured during procedures of the time required in that position.

**Patient outcomes**

The head of radiology advised that the diagnostic imaging department was considering working towards the Imaging Services Accreditation Scheme (ISAS). ISAS is a patient-focused assessment and accreditation programme that is designed to help diagnostic imaging services ensure that their patients consistently receive high quality services, delivered by competent staff working in safe environments. The timescale for this work to be completed had not been set.

Staff told us discrepancy meetings were held every two months as set out in the royal colleges of radiologist (RCR) standards. The standards state the purpose of discrepancy meetings are to facilitate collective learning from radiology discrepancies and errors and thereby improve patient safety. It is essential that proper anonymised records are kept, learning points discussed and recorded and a blame culture avoided. Radiologists and reporting radiographers attended these meetings where discrepancies in reports were subject to discussion. Staff told us learning points and actions were discussed. We requested minutes from these meetings, however the trust was unable to provide evidence due to the meetings not being minuted. We were unable to view sufficient evidence for these meetings, therefore, were unable to confirm a 50% attendance rate as per requirement of the RCR ‘Standards for Learning from Discrepancies’.

Regular clinical audits in CT and ultrasound were not undertaken. However, audits against IR(ME)R procedures were done. We saw a recent radiation safety audit which stated audits were undertaken for lead aprons and the ‘red dot’ system.

The service was not using the National Safety Standards for Invasive Procedures (NatSSIPs) (2015). These standards set out the key steps necessary to deliver safe care for patients undergoing invasive procedures and allow organisations delivering NHS-funded care to standardise the processes that underpin patient safety.

**Competent staff**

New staff undertook a comprehensive induction programme. This ensured new staff gained competencies for their job role in diagnostic imaging and staff who had attended this programme felt it met their needs. We saw completed training workbooks that had been reviewed, dated and signed by senior staff.

Some staff told us they were concerned about staffing levels, they felt the skill mix was inappropriate with too many band 5s. Staff felt that some band 5 radiographers were working out of their scope of practice, and there was a distinct lack of experienced band 6 radiographers.
Staff told us there were no opportunities for career progression within the department. After limited training, band 5 radiographers were at times left on their own to complete examinations.

On inspection we saw band five radiographers were working outside their scope of practice regarding protocolling, working unsupervised and they were at times in charge of the department. We were told there was no possibility of promotion, little or no CPD time or ability of space to conduct feedback regarding the examinations they had completed. A majority of staff stated they rarely had contact with the consultant radiologists.

We saw the CT department staffed by three band five radiographers and one band seven who was the team lead. Junior radiographers discussed being left alone unsupervised and stated they received five weeks training which was not formally documented, followed by on the job learning.

There were two band seven team leaders and two band five radiographers present as a team in x-ray. Both team leaders were experienced members of staff and both were reporting radiographers.

We were told one of the band seven reporting radiographers was unable to report on imaging due to time constraints, lack of audit, and practice.

Opportunities for reporting appendicular plain radiographs were limited during working hours due to work intensity and work schedules with opportunities only available outside normal working hours and at a bank rate. As a consequence, reporting had not been undertaken for over 12 months.

Most of the staff we spoke with had undergone appraisals within the last year however, some sighted a lack of career progression following recurring personal development plans.

We saw evidence of CPD for radiographers, however this was not consistent in all areas and for all staff. Although training sessions and lunchtime learning events were held, staff told us they were not always supported to attend. These sessions included regular talks and presentations.

We were told by staff that there was reliance dependent on a single imaging department assistant who covered both CT and MRI to cannulate patients during the day. In the event of the imaging department assistant’s absence, this was completed by those radiographers who had been signed off as appropriately trained to cannulate.

Staff reported limited opportunities to undertake cannulation training due to high intensity work patterns. It was stated that no band 6 or below radiographers could cannulate.

From April 2017 to March 2018, 15 members of medical and dental staff were eligible to receive an appraisal, they achieved 87% completion rate against a trust target of 90%. (13 members of staff received an appraisal)

Managers appraised staff’s work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

The trust has not provided a core service breakdown for non-medical staff therefore we were unable to comment on completion rates.

**Multidisciplinary working**

We saw good working relationships between staff in the emergency department and the diagnostic imaging department. When there were queries or questions for patients requiring scans, staff had open conversations and discussions about treatment options and decisions regarding patient care.

Radiologists described good working between themselves and GP services to ensure that patients were managed appropriately. Staff gave examples where patients received a well-coordinated
patient-centred experience because of good communication between primary care (the day-to-day healthcare of patient, typically provided by a GP) and the hospital.

Radiologists described a good working relationship with other specialities in the hospital to ensure that safe and logical clinical decisions were made about patients care and welfare.

Some staff told us they rarely had contact with consultant radiologists and struggled to locate them when needed. However, MRI staff stated they had easy access to consultants and had a good rapport with them.

**Seven-day services**

There were inpatient services available 24 hours a day, seven days a week for plain film X-ray, CT and MRI. Outpatient services were available five days a week for plain film X-ray, CT, MRI, ultrasound and nuclear medicine.

Emergency services were available 24 hours a day, seven days a week for MRI, CT and plain X-ray. This included portable machines (such as plain film X-ray and ultrasound) for use in theatres.

**Health promotion**

There was limited opportunity within the diagnostic imaging service for staff to influence and encourage health promotion. However, there were posters displayed in the hospital to encourage patients to stop smoking.

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

The trust update programme contained an adult safeguarding module which covered training on the Mental Capacity Act and Deprivation of Liberty safeguards. The trust set a target of 95% for completion of this training. The diagnostic department achieved a 94% completion rate.

Staff understood the relevant consent and decision-making requirements required by legislation and guidance. There were consent forms for the use of contrast in MRI and CT which patients agreed and signed before being able to have their examination. Within plain film X-ray staff asked patients if they were happy to have an X-ray and asked the patient to discuss what they were having scanned and why. There was good consideration of patients’ rights to refuse an examination.

Staff had a good understanding of best interest decisions. Staff said if a patient was refusing to have a scan they would first discuss this with the doctor or the GP. If the doctor deemed it clinically urgent and they would need to have the scan they would detail this in the patient notes.

Staff encouraged carers to escort their relative to appointments to offer support.

We saw ten examples of accurately completed consent forms. Patients we spoke with told us they knew what procedure they were having and that staff always asked for consent before proceeding.

**Is the service caring?**

**Compassionate care**

During our inspection we spoke with 12 patients and observed several interactions between staff, patients and relatives. We saw staff communicate in a caring and supportive manner. Feedback from patients confirmed that staff were friendly, approachable and professional. We observed the staff answer patient and carer queries with clarity.
Changing facilities were provided for patients. The department could accommodate patients in wheelchairs or in beds, although patient dignity could not be maintained at all time. For example, during inspection within the a and e x-ray waiting area we observed a patient on a trolley part exposed waiting in the centre of the waiting room next to seated patients. No disposable cubicle curtains were available. Staff told us they were aware of this issue and had previously reported this to seniors.

Confidentiality was respected in staff discussions with patients and those close to them. We observed receptionist staff interacting in a positive and caring manner with patients. We saw that enquiries made at the reception desk were responded to in a polite and helpful way. We saw patients being directed to other clinic locations in a clear and reassuring style.

The co-location of MRI and CT meant that patients sometimes experienced lack of privacy. On inspection, we saw patients from the different modalities were in the scanning workstation area often together prior to examination. We witnessed patients in this area awaiting scans in beds, one patient at this time had a clear view of the console of CT which still had on screen the examination of a previous patient.

**Emotional support**

Patients we spoke with were positive about the support they received from staff throughout the diagnostic imaging department.

Staff provided emotional support to patients to minimise their distress. Staff spent time reassuring patients and explained the procedure in depth with reasoning. For example, we observed a radiographer reassuring a patient who was having a cannulation in preparation for a CT scan.

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

We observed that radiographers and medical staff took time to explain to patients and relatives the progress of their procedure. Patients and relatives told us they were kept informed of what was happening and understood what tests or scans they were waiting for.

Patients felt involved in planning their care, making choices and informed decisions about their care and treatment. We observed staff communicating in a way that people could understand and was appropriate and respectful.

Staff involved patients and those close to them in decisions about their care and treatment.

Posters were displayed only in English offering a chaperone service within the diagnostic imaging department. Staff we spoke with understood the importance of chaperones and provided them upon request. Staff told us where possible, a chaperone of the same gender as the service user was offered.

**Is the service responsive?**

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

Patients could access the service when they needed it. Waiting times from treatment were good and arrangements to admit, treat and discharge patients were in line with good practice. The service was currently performing better than the England average for the percentage of patients receiving their diagnostic imaging tests within six weeks.

All the diagnostic imaging areas had an established extended day, on-call and or a seven-day working pattern. This enabled patients to be seen at times to suit their needs.
The department offered a walk-in service for all plain film (x-ray) examinations requested by the person’s GP, which meant patients did not need to make appointments to attend.

Patients received clear appointment letters, explaining the purpose of their diagnostic test, what they needed to bring and how they needed to prepare. All the patients we spoke with told us they received useful information to help them plan their visit. We were also told that staff ensured they understood medical terminology and patients were given literature about their condition when required.

After being welcomed at the main reception patients were directed to specific waiting areas depending on the examination they were having. This meant that staff knew where to find patients. If patients were not waiting where they were asked to wait radiographers would look in other waiting areas or go and check with the receptionist where the patient may have gone.

The setting was appropriate and patient centred with comfortable seating and toilets. There were shops in the hospitals main entrance which allowed patients to get food and drink. During inspection we saw the children’s area at the back of the main waiting room seemed bare with little to entertain the children awaiting examination or accompanying their relatives.

There was sufficient parking available with pay as you leave systems in place. The department was clearly signposted and directions to waiting areas were clear.

Diagnostic imaging outpatient services ran during working hours. Because of this there were good public transport links to the main hospital. Buses and taxis could stop outside the main entrance which was near the diagnostic imaging department.

There were notifications for patients to let them know how long they may be waiting for their examination. This meant that patients knew how long they were going to be in the department for.

Following a patient’s appointment, we saw all staff explain what would happen next. This included when they will receive their test results. They also explained to patients how to contact the department after the procedure if they had any concerns or any worries regarding their condition or treatment.

**Meeting people’s individual needs**

We asked staff in the plain X-ray and CT/MRI department what they would do when seeing a patient with a learning disability or a diagnosis of a dementia to support them. Many staff we asked said they would give more time to the patient or if needed they would call the learning disabilities team available within the trust to provide additional support to the patient. Staff stated that double appointment slots would be given for these patients.

Senior management told us that translation services were available for patients whose first language was not English. Staff told us that patients were asked to bring somebody with them who could translate. This was usually a family member or friend. However, it is best practice for an independent interpreter to explain treatment and assist with consent, to minimise the risk of coercion and to ensure medical information is translated correctly.

We saw leaflets with information about scans and tests, drug treatments and patients guide to x-ray within the reception area. However, they were not available in any other language. Information sent out with appointment letters were only available in English. Information leaflets contained a number that patients could ring to request information in another language.

Posters with chaperone information was available for patients within the waiting areas, however this was only observed in English.
Some of the patient waiting areas were small and not particularly patient centred. For example, it was difficult to fully segregate male and female patients who had changed into hospital gowns while waiting for their examination. The waiting area for accident and emergency x-ray was particularly small with no designated area for paediatric patients (children) or patients in trollies to wait.

**Access and flow**

The monthly diagnostics waiting times and activity diagnostics collection (DM01) is the primary source for diagnostics waiting times and activity for 15 key diagnostics tests. It is used to measure performance against the operational standard, that less than 1% of patients should wait 6 weeks or more for a diagnostics test. DM01 data provided by the trust displayed consistent achievement of 100% at NUH from September 2017 to August 2018.

Between July 2017 and October 2017, the percentage of patients waiting more than six weeks to see a clinician was higher than the England average. The following eight months the trust’s performance was better than the average. The England average is the mean value from NHS Trusts, NHS Foundation Trusts and Independent Sector Providers in England. The chart below shows 6+ weeks percentages over time.

(SOURCE: NHS England – Diagnostic Waits)

Patients could access the service when they needed it. They were referred to diagnostic imaging services by their GPs, hospital consultants and other practitioners, for example nurse practitioners.

All appointments were made by the administration team on the department’s designated system. Patients could call and change the appointment if required.

The diagnostic imaging service did not monitor how long patients waited for examinations once they arrived in the department. However, during our inspection we saw patients did not wait long before they were called in for their appointment.

Patients with the most urgent needs had their care prioritised. The trust had set a target of 85% of patients to be seen within a set amount of time to ensure timely diagnosis. However, we were unable to confirm whether the department had met this target.
Learning from complaints and concerns

Management told us that the service treated concerns and complaints seriously, investigated them and learned lessons from the results.

We reviewed the trust policy on the management of complaints and concerns. The policy detailed how to make a complaint and the procedure the hospital would follow to respond to it.

Patients gave mixed feedback about making a complaint. Some of the patients we spoke with knew how they could raise a concern if they were unhappy with any aspect of the service they received. Several other patients said they would ask at reception or look up on the internet how to make a complaint if they were unhappy.

We were told complaints were reviewed and discussed at the monthly governance meetings. Staff told us that the complaints and compliments were shared at the staff meetings. However, we saw no consistent evidence of this in meeting minutes provided to us.

From April 2017 to March 2018 there were four complaints about diagnostic services at Newham University Hospital. The trust took an average of 24 days to investigate and close complaints, this is in line with their complaints policy, which states complaints should be completed between 10-60 days.

All four complaints related to poor staff attitude.

From April 2017 to March 2018 there were 39 compliments given to Barts Health NHS Trust. No site or core service breakdown was available.

Is the service well-led?

Leadership

The diagnostic imaging department was part of the trust's clinical support services. The leadership structure consisted of site based leadership (medical and radiographical managerial), modality site based leadership and site based imaging governance which reported to the imaging network governance.

The diagnostic imaging team was established with experienced staff that provided clinical and professional leadership by supporting and appraising junior staff. Staff were given identified roles on each shift and there were clear lines of accountability.

All staff we spoke with were positive about the diagnostic imaging site manager. Staff told us the site manager was very responsive and well respected. During inspection we saw the site lead working an extended day after an on-call session. We were told this was a regular occurrence as they were very passionate about their job and wished to have oversight of the department. On review, we saw the site lead held many roles within the department including RPS, safeguarding lead and infection control lead. Whilst very competent we were concerned about the amount of responsibility and lack of protected time the site lead had.

All staff reported that leadership within the department was very strong, with visible, supportive and approachable team leaders. Staff were motivated and described a supportive team-working environment. Staff commented that the head of imaging was not regularly visible within the department and was not available for advice. However, the trust head of imaging told us they were always available and visited each of the four sites once a week.
A radiographer said that the team leaders were very approachable and had a “can do” approach to problems. However, some staff cited they had not seen the imaging or governance leads of the trust prior to out inspection. Some staff were unable to name them.

Radiographer modality leads within the diagnostic imaging department discussed that because of “firefighting” every day clinical work took priority over management and governance priorities. None of the modality leads had scheduled time to perform their management duties and were considered as part of the imaging rota. Some radiographer modality leads were part of the on-call rota so could be away from work for several days during the week leaving their modalities without management to support more junior members of staff.

Because of added responsibility for the team leads, some described how they didn’t get time to perform audits or ensure quality within their service. One team lead described the service as “running to stand still” with regards to performing their management duties. Many team leads described to inspectors how their job roles were changing rapidly with a lack of support to allow them to achieve their roles.

Senior managers described how they were regularly pulled away from their managerial roles because of responding to things going on within the department. This meant they “cannot make what we discuss a reality” which they found frustrating. One senior manager described the demand on services as “total chaos” which meant that they could not forward plan effectively.

**Vision and strategy**

Staff were aware of the trust wide vision which was “WeCare”, and all staff spoken with knew what the trust values were.

We spoke with the senior team about the vision and strategy for the department. A formal strategy document had not been fully completed; however, we discussed some points with the head of radiology. The focus was on increasing band 6s, recruitment of consultants, retaining trained staff and replacing imaging equipment to make the service more efficient and able to cope with increasing demand. We were told there was business planning for a three-year equipment replacement programme to include a second CT and MRI. However, this was awaiting final approval before plans could be put in place.

The age of the x-ray imaging equipment was a concern to the department and this was reflected on the risk register. Initial feedback from a HEE (health education England) inspection in 2015 recommended the equipment be replaced as soon as finances become available. The equipment was stated as being over ten years old and obsolete. During the wait for replacement, some machines had a tolerance of use, this meant patient would have to be imaged on other machines. This created delays for some outpatient clinics and patients referred from a and e. Recent investments were evident within the department for CT and MRI scanners. The service told us remaining kit requiring replacement was considered and prioritised based on risk.

Managers felt that diagnostic imaging at NUH did not get sufficient priority within the wider trust to ensure the service they were providing was fit for purpose or in line with hospital wide developments. There was limited input from diagnostic imaging into the trusts quality account and they found that support from senior clinicians in other directorates was worsening.

**Culture**

Most staff we spoke with described an over-busy work setting that was not sustainable. However, during our inspection we observed the department as being quiet. Staff told us this was unusual and we were told prior to our inspection most outpatient appointments and outstanding reports had
been outsourced to an external company. Activity figures shown to us during inspection showed this was not typical.

When asked to describe the culture within the service one senior manager said that although staff were doing all they could to be caring and patient centred this came at a compromise to their own wellbeing. Managers were not aware of how staff felt in the department and were unaware of any concerns raised by staff regarding this issue.

Staff we spoke with discussed how because of being busy they had to perform tasks which were above their banding which made them feel uncomfortable. We were told that band five radiographers were “left to run the department” and authorised CT scans which radiologists deemed inappropriate due to lack of training and experience.

Staff described themselves as highly stressed in a hardworking environment. We were told that radiologists had moved to other hospitals or other hospitals within the trust due to the high unmanageable workload. Staff told us they had to complete administrative work at home within unpaid time.

During inspection, we observed excellent teamwork. Staff were patient orientated and were willing to assist each other to complete tasks. All staff spoke highly about their direct line manager and the department lead. However, there was no positive feedback or respect of the divisional lead and directors. This was due to lack of support for training, career progression and CPD time. Multiple staff told us they did not find the leadership of the clinical support services visible or approachable.

We noted there was a common theme of mistrust within staff to make an official complaint for fear of harassment. Staff were unwilling to elaborate further for fear of reprisal.

**Governance**

Not all levels of governance and management functioned effectively and interacted appropriately with each other.

There was a lack of process to ensure that all patient scans were being reported or in a timely manner. The systems in place did not fully record or highlight these patients effectively and there was a risk of patient harm due to the lack of processes.

During our examination of electronic records, we noted that some plain film scans appeared not to have been reported on by a radiologist. We had concerns that the systems in place did not record or highlight these patients effectively and there was a risk of patient harm due to the lack of processes. Radiologists described a stressful environment for reporting of on call studies and meeting demands of CT/MRI investigations, particularly outpatient two week wait patients.

After inspection we were told there was a standard operating procedure (SOP) to monitor unreported scans and a weekly report was produced to display patient level detail.

Due to the lack of CPD time, team leads held information sharing meetings. However, staff we spoke with said they did not have enough time for this meeting to be effective and they were regularly held during lunch breaks. Learning from incidents and complaints were not shared during this forum and was shared through the monthly radiological site meeting (Cogwheel). The agenda items of the monthly meeting included incidents, risk, complaints, patient feedback and closed DATIX actions. These fed into the divisional meeting and the monthly performance reviews with CSS. The CSS board met monthly and produced a clinical support services integrated report which reported on operating performance, risk registers, action log, quality and safety, staffing and finance.
There were radiation protection committee meetings which fed into the trust governance structure. The radiation safety committee met quarterly with representatives from the executive team, health and safety team, union representatives and service lines which use ionising radiation. This forum escalated concerns to the health and safety committee which is concerned with oversight of patient and staff safety. However, some staff felt that radiation protection was not the top priority of the board.

**Management of risk, issues and performance**

Staff wore whole body dose meters to monitor the occupational radiation exposure. This was reviewed on a quarterly basis. At the time of our inspection, no unusual results had been noted.

There were 19 risks on the diagnostic imaging risk register. One risk was considered to be ‘catastrophic’, eight risks were ‘major’ risks, seven were ‘moderate’ risk and the remaining three risks were ‘minor’ risk. The three highest risks identified were regarding the electronic referral system, staffing numbers, and capital cost of equipment replacement. We noted mitigating actions were in place for each risk.

A trust wide DRL (dose reference level) audit was done every three years. However, data was taken from a data management system and not from departmental DRL level audits. Staff we spoke with had limited knowledge of DRL levels and were unaware of recent audits or departmental standards.

The service had a systematic programme of clinical and internal audit to monitor quality, operational and financial processes and systems to identify where action should be taken.

There were plans in place for emergencies. For example, adverse weather, a flu outbreak or a disruption to business continuity. The trust had recently been affected by a cyber-attack on the computer systems in May 2017.

**Information management**

During inspection we found some specialty doctors were using personal laptops and desktop computers without official trust antivirus software installed when they reported from home. There was no schedule in place for quality assurance testing of the home computers. Furthermore, there was no assurance of Digital Imaging and Communications (DICOM) grey scale display function compliance.

Laptops cannot be used for primary reporting if they do not meet current Royal College of Radiologists (RCR) recommendations. They may impact patient safety during diagnostic reporting with pathology potentially missed due to inadequate equipment calibration or inadequate equipment. We raised this in a meeting with the trust head of imaging when on site. Following this inspection, the trust sent us a record of actions taken to address each matter.

One radiologist and two speciality doctors had non-compliant devices. The devices did not meet the minimum guideline for screen size and resolution or luminance contrast ratio. Mitigations were put in place to ensure the radiologist remained on site between 5:00pm and 9:00 pm to do their on-call reporting on trust compliant screens; after this time the on-call was outsourced to a third-party provider.

Home access at Barts Health NHS Trust was provided through a secure virtual private network (VPN) which used a digital token with two-factor authentication. This cannot be infected by viruses or malware as no data can be passed between the host personal computer and the virtual computing software. In this same way, no patient data can be transferred to the personal computer.
The trust acknowledged there was no schedule in place for quality assuring (QA) workstations used for home reporting. A monitor self-assessment quality check has since been deployed to the picture archiving and communication system (PACS); radiologists were expected to complete the quality check of their home reporting screens by 11 October 2018. The trust had plans to implement acceptance tested compliant self-calibrating monitors for home reporting by 28 October 2018.

The trust updated CQC following this inspection. We were told all radiologists completed a quality check of their home reporting screen and no issues were identified.

All imaging reviewed at home was via the full PACS client exactly as used when on site which provided full DICOM images and functionality. The trust acknowledged that it could not provide assurance of grey scale compliance for all home monitors. However, the trust planned to address this through the provision of acceptance tested compliant self-calibrating monitors for home reporting by 28 October 2018.

The trust updated CQC following inspection and confirmed diagnostic monitors were ordered and due for delivery 29 October 2018; acceptance testing and installation was planned to follow immediately.

The hospital introduced enhanced security in the IT system following the cyber-attack in 2017. This protected patient and staff data from unauthorised access and ensured staff had local access to records in the event of a server failure.

Engagement

Staff we spoke with did not feel their views were reflected in the planning and delivery of the service. They were unable to attend team meetings due to work pressures.

Staff told us they felt CQC was being misled to the true situation of the department as examinations were delayed and referred to others until CQC departure. We were told that 3000 outstanding reports were reduced to 300 by a management decision to outsource reports due to the impending CQC inspection. We were unable to corroborate this with evidence.

Learning, continuous improvement and innovation

Senior managers were frustrated that they were being asked to provide a safe service without enough resources. Staff members likened NUH as the “poor relation” of the trust, and stated NUH were not a priority in the provision of resources.

The trust-wide head of imaging advised the service was committed to improving services by promoting training, research and innovation. Training was to be supported to develop radiographers, sonographers and nurses to undertake tasks to relieve the pressures of the vacancies in radiology.

We were told the service had a three-year business plan which was still in its draft phase. Equipment replacement which was on the risk register was the main priority.
This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.
Barts Health NHS Trust has three emergency departments on three hospital sites; The Royal London Hospital, Newham University Hospital and Whipps Cross University Hospital. The hospital serves a diverse local population of more than 350,000 people from surrounding London boroughs including Waltham Forest, Redbridge and Epping Forest. The area has a wide variation in levels of deprivation and health needs, ranging from the most deprived five per cent to amongst the most affluent 30 per cent of electoral wards in England. Waltham Forest comes 15th out of 326 most deprived electoral wards with nearly 48% of the population from minority ethnic communities.

The Emergency Department (ED) is a 24 hour, seven days a week department that provides emergency medicine services for patients who require care for urgent or emergency conditions. There is a separate paediatric emergency department (PED), which is also 24 hours.

The emergency department treated people with serious and life-threatening emergencies. Adults and children with less urgent illnesses and minor injuries were treated in the urgent care centre. The urgent care centre (UCC) is managed by a neighbouring NHS Foundation Trust and includes qualified nurses and General Practitioners (GP). There were 135,765 attendances between August 2017 and August 2018. Of these, 102,239 (75%) were adults and 33,526 (25%) were children. Seventy per cent of adult attendees were over 70 years of age.

The majors area had 24 cubicles and two additional cubicles for sensitive examinations. Four cubicles were for patients who did not require a bay but were ‘fit to sit’ whilst waiting on test or x-ray results. The resuscitation area had six bays (one designated for use with children) with full facilities for resuscitating critically unwell patients, for example a patient with a serious injury or heart attack.

There was a seven-bed clinical decision unit where patients who were not ill enough for admission but required further observations or tests were placed in for up to 12 hours.

The paediatric emergency department had five individual cubicles, a separate ward with five bays for patients waiting for triage or to be seen by a doctor and a five-bedded clinical decision area.
From July 2017 to June 2018 there were 440,983 attendances across all of the trust’s urgent and emergency care services as indicated in the chart above.

(Source: NHS England)

The percentage of attendances to urgent and emergency care at this trust that resulted in an admission increased in the most recent year compared to previous year. In both years, the proportions were lower than the England averages.

(Source: NHS England)
Urgent and emergency care attendances by disposal method, from April 2017 to March 2018

<table>
<thead>
<tr>
<th>Disposal Method</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted to hospital</td>
<td>84,546</td>
</tr>
<tr>
<td>Discharged*</td>
<td>47,450</td>
</tr>
<tr>
<td>Referred*</td>
<td>26,770</td>
</tr>
<tr>
<td>Transferred to other provider</td>
<td>733</td>
</tr>
<tr>
<td>Died in department</td>
<td>15,300</td>
</tr>
<tr>
<td>Left department#</td>
<td>22,043</td>
</tr>
<tr>
<td>Other</td>
<td>25,098</td>
</tr>
</tbody>
</table>

* Admitted to hospital includes: no follow-up needed and follow-up treatment by GP
^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional
# Left department includes: left before treatment or having refused treatment

(Source: Hospital Episode Statistics)

Is the service safe?

Mandatory training

The trust set a target of 85% for completion of mandatory training which was a mix of classroom and face to face learning.

The trust provided a breakdown of compliance for mandatory training courses as of the 23 August 2018 for nursing and midwifery staff in urgent and emergency care as shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Trust completion %</th>
<th>Trust target %</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving and Handling - Patient Handling Low Risk</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness</td>
<td>88</td>
<td>89</td>
<td>99%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>88</td>
<td>89</td>
<td>99%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Working at Barts Health</td>
<td>88</td>
<td>89</td>
<td>99%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Harms (pressure ulcers; falls; urinary tract infections; VTE) Catheter Acquired Infections</td>
<td>87</td>
<td>89</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Harms (pressure ulcers; falls; urinary tract infections; VTE) Slips, Trips and Falls (Patients)</td>
<td>87</td>
<td>89</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Security</td>
<td>87</td>
<td>89</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Harms (pressure ulcers; falls; urinary tract infections; VTE) Pressure Ulcer Prevention</td>
<td>86</td>
<td>89</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Topic</td>
<td>Nurses</td>
<td>Total Staff</td>
<td>Compliance %</td>
<td>85%</td>
<td>Yes/No</td>
</tr>
<tr>
<td>-------</td>
<td>--------</td>
<td>-------------</td>
<td>---------------</td>
<td>-----</td>
<td>--------</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>86</td>
<td>89</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety</td>
<td>86</td>
<td>89</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Nutritional Care</td>
<td>86</td>
<td>89</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Harms (pressure ulcers; falls; urinary tract infections; VTE)</td>
<td>85</td>
<td>89</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>VTE</td>
<td>85</td>
<td>89</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Clinical Documentation</td>
<td>85</td>
<td>89</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>85</td>
<td>89</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Emergency Planning</td>
<td>85</td>
<td>89</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
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<tr>
<td>Early Warning Systems</td>
<td>84</td>
<td>89</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fraud Awareness</td>
<td>84</td>
<td>89</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
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<tr>
<td>Blood Transfusion</td>
<td>64</td>
<td>68</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Privacy and Dignity</td>
<td>83</td>
<td>89</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Complaints</td>
<td>82</td>
<td>89</td>
<td>92%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling - Patient Handling Practical</td>
<td>69</td>
<td>75</td>
<td>92%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Investigation of Incidents</td>
<td>20</td>
<td>22</td>
<td>91%</td>
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<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention and Control - Clinical</td>
<td>79</td>
<td>89</td>
<td>89%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation - Basic Life Support</td>
<td>77</td>
<td>87</td>
<td>89%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>78</td>
<td>89</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk Assessment for Managers</td>
<td>19</td>
<td>22</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical Gas Safety</td>
<td>74</td>
<td>86</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>69</td>
<td>84</td>
<td>82%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing and midwifery staff exceeded the 85% completion target for 27 of the 28 mandatory training modules. Following the inspection, the trust told us that between March and August 2018, 94% of shifts in the emergency department included nursing staff with paediatric life support training in line with Royal College of Emergency Medicine (RCEM) guidance. We were also told emergency department nursing staff were 93% compliant with sepsis training and paediatric nursing staff were 96% compliant.

The trust submitted life support data following the inspection: The data below related to intermediate life support (ILS) and advanced life support (ALS), as well as paediatric life support (PLS), paediatric intermediate life support (PILS) and advanced paediatric life support (APLS).

<table>
<thead>
<tr>
<th>ILS</th>
<th>ALS</th>
<th>PLS</th>
<th>PILS</th>
<th>APLS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses</td>
<td>31</td>
<td>16</td>
<td>Nurses</td>
<td>28</td>
</tr>
<tr>
<td>Total Staff</td>
<td>58</td>
<td>34</td>
<td>Total Staff</td>
<td>28</td>
</tr>
<tr>
<td>Compliance %</td>
<td>53</td>
<td>47</td>
<td>Compliance %</td>
<td>100</td>
</tr>
</tbody>
</table>
The trust provided a breakdown of compliance for mandatory training courses as of the 23 August 2018 for medical and dental staff in urgent and emergency care as shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Trust completion %</th>
<th>Trust target %</th>
<th>Target met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia Awareness</td>
<td>24</td>
<td>25</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Early Warning Systems</td>
<td>24</td>
<td>25</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>24</td>
<td>25</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety</td>
<td>24</td>
<td>25</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling - Patient Handling Low Risk</td>
<td>24</td>
<td>25</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>23</td>
<td>25</td>
<td>92%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fraud Awareness</td>
<td>23</td>
<td>25</td>
<td>92%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Consent</td>
<td>10</td>
<td>11</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Emergency Planning</td>
<td>10</td>
<td>11</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Security</td>
<td>10</td>
<td>11</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Harms – (pressure ulcers; falls; urinary tract infections; VTE)</td>
<td>22</td>
<td>25</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Clinical Documentation</td>
<td>22</td>
<td>25</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Nutritional Care</td>
<td>22</td>
<td>25</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Privacy and Dignity</td>
<td>22</td>
<td>25</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Working at Barts Health</td>
<td>22</td>
<td>25</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Harms (pressure ulcers; falls; urinary tract infections; VTE) Catheter Acquired Infections</td>
<td>21</td>
<td>25</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>4 Harms (pressure ulcers; falls; urinary tract infections; VTE) Pressure Ulcer Prevention</td>
<td>21</td>
<td>25</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>4 Harms (pressure ulcers; falls; urinary tract infections; VTE) Slips, Trips and Falls (Patients)</td>
<td>21</td>
<td>25</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>9</td>
<td>11</td>
<td>82%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation - Basic Life Support</td>
<td>19</td>
<td>25</td>
<td>76%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>18</td>
<td>25</td>
<td>72%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Medical Gas Safety</td>
<td>5</td>
<td>7</td>
<td>71%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>17</td>
<td>25</td>
<td>68%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention and Control - Clinical</td>
<td>14</td>
<td>25</td>
<td>56%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical and dental staff exceeded the 85% completion target for 15 out of 24 mandatory training modules.
(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)
Following this inspection, the trust told us statutory and mandatory training compliance were reviewed each week following the emergency department operational meetings. Members of staff who were non-compliant were contacted by their supervisor or line manager to set a date for completion.

Following the inspection, the trust told us junior doctors were 100% compliant with sepsis training as it was part of the trust induction. We saw the ED teaching programme for junior doctors and registrars included sepsis training repeated every 4 months.

After this inspection, the trust wrote to tell us Barts Health did not keep a comprehensive training log of all junior doctors’ resuscitation training. Training is often done in other hospitals and certification is valid for four years, during which time junior doctors rotate through Whipps Cross hospital.

Educational supervisors reviewed resuscitation course certification (ALS/ILS/APLS) appropriate to junior doctor’s current role as part of the Annual Review of Clinical Progress (ARCP). Appraisals were signed off only when current life support certification was submitted. Although this was recorded within their ARCP, the trust did not have a method of recording this in a central training record log.

**Safeguarding**

The trust set a target of 85% for completion of safeguarding training which was provided by the trust safeguarding team

The trust provided a breakdown of compliance for safeguarding training courses as of the 23 August 2018 for nursing and midwifery staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Trust completion %</th>
<th>Trust target %</th>
<th>Target met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Level 2</td>
<td>31</td>
<td>31</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 1</td>
<td>88</td>
<td>89</td>
<td>99%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>84</td>
<td>89</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>84</td>
<td>89</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 3</td>
<td>29</td>
<td>31</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Nursing and midwifery staff exceeded the 85% completion target for all five safeguarding training modules.

The trust provided a breakdown of compliance for safeguarding training courses as of the 23 August 2018 for medical and dental staff in urgent and emergency care as shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Trust completion %</th>
<th>Trust target %</th>
<th>Met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Level 3</td>
<td>7</td>
<td>7</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>24</td>
<td>25</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 1</td>
<td>24</td>
<td>25</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>23</td>
<td>25</td>
<td>92%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>23</td>
<td>25</td>
<td>92%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Medical and dental staff exceeded the 85% completion target for all five safeguarding training modules.

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

Members of medical and nursing staff told us they were confident in their knowledge of the trust safeguarding procedures and showed us them on the trust intranet. They told us the safeguarding team was accessible and on hand to support and advise.

Staff told us they would not hesitate to escalate any concerns about patient safety and demonstrated how to do this. They were aware of the signs of female genital mutilation and knew how to raise an alert. One told us of recent safeguarding referrals they made which included an elderly person about whom there were concerns of neglect in the home.

Staff members from the paediatric emergency department team attended a multidisciplinary safeguarding meeting each week, which included the local authority and child and adolescent mental health service. Safeguarding referrals were discussed and updates given; we were told that these meetings provided a good learning experience.

The trust was unable to supply data for the numbers of adult and child safeguarding alerts raised by the emergency department with the safeguarding team. The hospital safeguarding team did not record the individual departments which generated alerts.

**Cleanliness, infection control and hygiene**

There was easy access to personal protective equipment (PPE) such as aprons and gloves in all areas we inspected and all staff used PPE as required. There was also sufficient access to hand gel dispensers, handwashing and drying facilities. Hand washing basins had a plentiful supply of soap and paper towels. There was signage prompting people to wash their hands and gave guidance on good hand washing practice.

There were established systems in place for infection prevention and control, which were accessible to staff. These were based on the Department of Health’s code of practice on the prevention and control of infections, and included guidance on hand hygiene, use of personal protective equipment such as gloves and aprons and management of the spillage of body fluids. All the infection prevention and control standard operating procedures we reviewed were up to date and accessible by staff on the hospital intranet.

We saw that staff complied with local infection control policies throughout our inspection. Clinical, nursing and support staff were ‘bare below the elbow’ and adhered to infection control precautions. Hand gel was available in all areas and staff routinely decontaminated their hands before and after patient contact.

However, we saw that hand hygiene results were displayed on departmental whiteboards and currently showed 65% compliance. The matrons audited hand hygiene each month and told us that results were as low as 40% on occasion.

Matrons recognised this was a matter of concern and told us they were focussed on improving hand hygiene and made sure it was regularly discussed at staff safety briefings.
The trust submitted matron’s quality audits following inspection for 12 August which showed hand hygiene compliance was 75%; 28 August 2018 it was 40% and 31 August 2018 compliance 44%. The information in the table below was also submitted post inspection.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E WXH</td>
<td>100%</td>
<td>100%</td>
<td>95%</td>
<td>98%</td>
<td>100%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Patients and relatives spoke positively of the level of cleanliness in the department. There were housekeeping staff for cleaning all areas of the emergency department and all areas were maintained to a high standard of cleanliness. There were ‘I am clean’ stickers marked with the date the item was cleaned. Most areas we visited were tidy, clean and uncluttered. Cubicles had disposable curtains hung around examination beds that were clean and included a replacement date. We saw there was a cleaning schedule for the children’s play area in the paediatric emergency department, with signatures to denote toys and furniture were regularly cleaned.

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

Sharps bins were available in treatment areas where sharps may be used. This was in line with health and safety regulation 2013 (The sharps regulations, 5 (1) (d)). The regulation requires staff to place secure containers and instructions for safe disposal of medical sharps close to the work area. They were correctly labelled, were not over-full and were secured with a lid.

**Environment and equipment**

At the previous CQC inspection in July 2016, we found there was no dedicated place of safety room which could be used by patients detained under the Mental Health Act or with mental health conditions. This meant the ED environment was not suitable to meet needs of patients waiting to undergo mental health assessments. We found this was improved during this inspection and there was a designated psychiatric assessment room. This met most of the requirements of the Royal College of Psychiatrist guidance for mental health assessment rooms. The assessment room had no en-suite facilities however; staff said patients had supervised access to toilet facilities close to the room.

Patients could be observed safely and there were no ligature anchor points. The room was risk assessed and staff were aware of one small area that was a ‘blind spot’. There were actions to mitigate this risk; for example, patients were not left alone in the room and security staff observed the room via CCTV. The doors for the mental health assessment rooms had viewing panels to observe the patient. The room was visibly clean with appropriate alarms and furniture. However, the walls of the assessment room had no decoration, which did not make it calming or welcoming.
The ED also had an assessment room situated in the corner of the ED. This room was slightly quieter and the lighting could be subdued for patients who were over-stimulated by the environment, including those with autism or a learning disability. However, there was no dementia friendly decoration or equipment such as a clock in the emergency department.

We inspected the contents of the resuscitation trollies in the resuscitation area and clinical decision unit and confirmed that all equipment was present, sealed in sterile wrappers and in date. All equipment was present, including appropriately sized equipment for smaller or paediatric patients and there were no gaps in the daily checks record.

Staff told us they could access equipment required to care for patients. Spare consumables and other equipment were appropriately stored and labelled. Consumables including fluids were in date. Spare oxygen masks and nebulisers were stored in clear boxes and accessible.

Oxygen and suction were correctly set up in cubicles and were clean and ready for use. Call bells were accessible to patients.

The paediatric emergency department had a large waiting area that included a play area with toys, books and smaller sized seating. There was a central station where nursing and medical staff sat and had clear view of all cubicles and patients.

Some patients who waited in the triage (initial assessment) area complained about the environment. They sat on tightly packed chairs in a narrow corridor waiting for further treatment or tests. We discussed this with members of the departmental leadership team who acknowledged that the environment was not ideal. This was a recently created area and they acknowledged that more work was needed to make it a more conducive environment for patients.

The trust provided a spreadsheet of all the equipment in the department, along with the next service schedule date. Most service reviews of equipment items in the department were up-to-date. There were three pieces of equipment (two pressure support ventilators in ED and anaesthetic induction head in resuscitation) all rated as high risk which were overdue a service from March and November 2017. The trust subsequently told CQC that these pieces of equipment were prioritised for service by clinical engineering.

**Assessing and responding to patient risk**

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

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?</td>
<td>7.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>5.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?</td>
<td>6.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q33. In your opinion, how clean was the</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
Table

<table>
<thead>
<tr>
<th>emergency department?</th>
<th>trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?</td>
<td>9.1</td>
</tr>
</tbody>
</table>

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

The median time from arrival to initial assessment was worse than the overall England median over the 12-month period from July 2017 to June 2018. In the latest month June 2018, the median time to initial assessment was 11 minutes compared to the England average of 7 minutes. In order to address this, a doctor led triage system (‘pit stop’) began in July 2018 for patients who arrived by ambulance, which was being piloted at the time of this inspection. The expectation was that this would reduce the average length of time patients spent in the emergency department before a doctor reviewed them.

Ambulance – Time to initial assessment from July 2017 to June 2018 at Bart’s Health NHS Trust

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

Data submitted by the trust following the inspection showed that 10% of adult patients and 38% of paediatric patients who self-presented to the department between January and July 2018 were triaged within 15 minutes.

From June 2018 to June 2018, there was a stable trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Whipps Cross. In the latest month July 2018, 62% of ambulance journeys had turnaround times over 30 minutes.

Ambulance: Number of journeys with turnaround times over 30 minutes
A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff.

From April 2017 to March 2018, the trust reported 659 ‘black breaches’. Two different ambulance services served the trust and these black breaches are combined data from both. The way in which breaches were recorded was different for both.

The ED used a system of National Early Warning Score (NEWS) for adults and Paediatric Early Warning Score (PEWS) for children to alert staff to the deteriorating patient. Observations were electronically charted and scored and an escalation plan with prompts was in place.

Data submitted following inspection showed that between June 2018 and July 2018 showed NEWS was consistently recorded 97% of the time. However, data for three weeks in August 2018 showed that NEWS was recorded just 68% of the time.

There was a pressure ulcer risk assessment tool in place suited to the needs of patients in the emergency department. The matron’s audit showed this was inconsistently applied and varied between 40% and 74% in a 12-week period between June 2018 and August 2018.

Matron’s audit data submitted following the inspection showed that hourly vital signs were not always recorded and varied between 50% and 90% in the same period as above.

Sepsis screening was in place as part of the NEWS and PEWS records and staff told us that actions were escalated as appropriate and in line with guidance on the chart. The PEWS observation chart included a section for staff to record concerns about the child’s health.

We reviewed 10 adult patient records and saw regular recording of vital sign scores all of which were correctly calculated. Each record evidenced blood sampling and allergy notes. Two did not evidence review of pain management or include the emergency department checklist. We saw examples in patient records that the sepsis pathway was followed appropriately.

We also reviewed two sets of paediatric notes both of which evidenced the patient’s weight, height and any known allergies. Vital signs were regularly recorded and we saw that parents and carers consented to treatment on behalf of the child. Following this inspection, the trust confirmed there was no system in place to audit PEWS.

Patients who self-presented to the department between 8:00am and 8:00pm were first seen by a nurse from the trust or from the neighbouring foundation trust who operated the urgent care centre. Streaming between 8:00pm and 8:00am was the sole responsibility of the neighbouring foundation trust. Initial intervention for clinical assessment took place at point of streaming. Vital signs were taken and the patient had an electrocardiogram and urine analysis done. The streamer took patient details from which point their stay in the department was calculated.

Patients were streamed to a nurse, GP or to the trust initial assessment area to be triaged. Children were streamed to a GP who decided whether to treat; refer back to their own GP or,
where further treatment was required, they were streamed to the paediatric emergency department. There was a separate children’s waiting area for those children who waited to be seen in the UCC.

Patients identified at streaming and believed to need urgent attention were escorted by the streamer and handed over to assessment area (IA) staff. The IA was led by a qualified nurse with support from health care assistants. Patients were triaged in this area and if there was no cause for concern, they were assessed as ‘fit to sit’ awaiting further treatment or tests in ED majors. On occasion, the assessing nurse streamed the patient back to the UCC for treatment where this was more appropriate.

There was a standard operating procedure for the IA. There were escalation triggers at 30 minutes if clinical observations were not completed and 60 minutes if initial assessment has not taken place. A member of staff who covered the IA area described this process to us. Other control measures included two hourly departmental updates to identify risks and delays in the IA area, which we observed during inspection. We were unable to confirm whether IA training was included in the ED registrar teaching programme, which was another suggested control measure.

There were two patients with mental health issues waiting in the department on one of our inspection days. The department was very busy and all cubicles were full. A practice development nurse intervened and allocated an additional health care assistant to the patients to ensure they were safe and their physical needs were met.

ED staff arranged psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. ED staff told us they contacted the psychiatric liaison team where there were concerns that a patient may be at risk of self-harm or suicide. We looked at six sets of patient records for patients referred to the psychiatric liaison team. These records included a psychosocial assessment of the patient, which explained their current mental health needs and social circumstances. Records included a risk assessment and a management plan to ensure the safety of the patient.

ED staff told us some patients with mental health needs were nursed on a one to one basis by an agency mental health registered nurse or a healthcare assistant.

Staff said they followed a set procedure if a patient went missing from the ED which included a search of the immediate area by security staff. Descriptions of patients were routinely recorded at triage and available to security staff or police where appropriate.

**Nurse staffing**

Whipps Cross Hospital reported the following nurse staffing numbers for urgent care and emergency services in March and April 2018. The hospitals fill rate remained below 70% in March and April 2018.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care and Emergency Services</td>
<td>76.0</td>
<td>119.7</td>
<td>63.5%</td>
<td>77.5</td>
<td>123.9</td>
<td>62.6%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)
From May 2017 to April 2018, Whipps Cross Hospital reported a vacancy rate of 40.9% for nursing staff in urgent and emergency care services, this was higher than the trust target of 6.3%.

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

From May 2017 to April 2018, Whipps Cross Hospital reported a turnover rate of 32.9% for nursing staff in urgent and emergency care services, this was higher than the trusts target of 13%.

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

From May 2017 to April 2018, Whipps Cross Hospital reported a sickness rate of 2.3% for nursing and midwifery staff in urgent and emergency care services, this was lower than the trusts target of 3%.

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

From May 2017 to April 2018, Whipps Cross Hospital had a total of 9,280 nursing staff shifts. A breakdown of bank and agency usage and unfilled shifts is shown below:

A breakdown of bank and agency usage is shown below:

<table>
<thead>
<tr>
<th>Bank/ agency</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank</td>
<td>3,644 (35.6%)</td>
</tr>
<tr>
<td>Agency</td>
<td>4,633 (45.2%)</td>
</tr>
<tr>
<td>Not filled</td>
<td>1,003 (9.8%)</td>
</tr>
</tbody>
</table>

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

The staffing model used in urgent and emergency care was based on the Royal College of Nursing guidelines and matched surges in patient attendance. The ratio of staff to patients was 1:4 in cubicles. There was a band 7 nurse in charge 24 hours a day across the whole department and matron cover between 8:00am and 8:00pm Monday to Friday. Some staff expressed concerns about the high use of bank and agency staff but did not feel that the department was unsafe. Members of the departmental leadership team told us there was an on-going recruitment campaign to address the vacancy rate.

We observed daily handovers led by the matron. Full updates on patients were given and nurses coming on duty were allocated areas of responsibility. They were prompted to do patient skin assessments and transfer patients onto hospital beds if they were in the department for longer than four hours. The theme of the fortnight was discussed (alcohol related illness and injury) with a brief presentation on signs and symptoms.

The trust submitted data following the inspection which demonstrated that between January 2018 and July 2018 97% of shifts in the paediatric emergency department had a registered sick children’s nurse (RSCN). The data showed that all day shifts were covered by an RSCN up until 2:00am. Shifts not fully covered by an RSCN had two experienced registered nurses rostered to work solely in the paediatric area. These nurses were trained in aspects of paediatric care.
including recognition of the sick child, paediatric life support and safeguarding. The trust also submitted fill rates for paediatric nursing staff which showed there was 91% fill rate for band 7, 54% band 6, 92% band 5 and 82% for unregistered staff.

**Medical staffing**

Whipps Cross Hospital reported the following medical staffing numbers for urgent care and emergency services in March and April 2018.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care and Emergency Services</td>
<td>35.7</td>
<td>50.4</td>
<td>70.8%</td>
<td>36.8</td>
<td>50.4</td>
<td>73.0%</td>
</tr>
</tbody>
</table>

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

The vacancy rate from May 2017 to April 2018 was 32.2% for medical and dental staff in urgent and emergency care services; this was higher than the trust target of 6.3%.

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

From May 2017 to April 2018, Whipps Cross Hospital reported a turnover rate of 13.5% for medical and dental staff in urgent and emergency care services, this was lower than the trusts target of 13%.

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

We received the following data during the inspection, which reflected the medical staffing level in September 2018:

<table>
<thead>
<tr>
<th></th>
<th>Planned</th>
<th>Actual</th>
<th>Fill rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultants</td>
<td>13.4</td>
<td>9.25</td>
<td>69%</td>
</tr>
<tr>
<td>Tier A (ST4 registrars)</td>
<td>13</td>
<td>6.5</td>
<td>50%</td>
</tr>
<tr>
<td>Tier B (ST3 junior registrars and senior house officers)</td>
<td>8</td>
<td>13</td>
<td>163%</td>
</tr>
<tr>
<td>Tier C (FY2 junior doctors)</td>
<td>16</td>
<td>15</td>
<td>94%</td>
</tr>
</tbody>
</table>

The sickness rate from May 2017 to April 2018 was 1.6% for medical and dental staff in urgent and emergency care services; this was lower than the trusts target of 3%.

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

From May 2017 to April 2018, Whipps Cross Hospital had a total of 3,710 medical staff shifts. A breakdown of locum and agency usage and unfilled shifts is shown below:
<table>
<thead>
<tr>
<th>Locum/ agency</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Locum</td>
<td>1,248 (29.9%)</td>
</tr>
<tr>
<td>Agency</td>
<td>1,998 (47.9%)</td>
</tr>
<tr>
<td>Not filled</td>
<td>464 (11.1%)</td>
</tr>
</tbody>
</table>

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

From March 2017 to March 2018, the proportion of consultant staff reported to be working at the trust was the same as the England average and the proportion of junior (foundation year 1-2) staff was lower.

**Staffing skill mix for the 176 whole time equivalent staff working in urgent and emergency care at Bart's Health NHS Trust**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>0%</td>
<td>15%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>48%</td>
<td>33%</td>
</tr>
<tr>
<td>Junior*</td>
<td>22%</td>
<td>23%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

The Royal College of Emergency Medicine (RCEM) recommendation is that there is consultant presence in the emergency department 16 hours a day, seven days per week as a minimum in all emergency departments. Whipps Cross ED had consultant cover on site 14 hours per day, between 08.00 and 22.00 seven days a week, with on-call cover from home between 22.00 hours to 08.00. We were told that there were no plans to increase this to 16 hours per day. We reviewed consultant rotas and were satisfied that risks were mitigated by the provision of senior doctor presence (ST4) 24 hours a day, seven days per week in accordance with RCEM guidance.

There was a paediatric emergency medicine (PEM) consultant based in the paediatric emergency department (PED) Monday to Friday between 9:00am and 5:00pm. The current weekend PEM cover in the department was eight hours on Saturday and Sunday on one weekend in eight due to staff shortages; this was expected to improve in January 2019 when an established consultant returns to their role in the department. There was an on-call consultant paediatrician between 8:00am and 10:00pm seven days a week.

We observed a consultant led daily handover during which all patients were discussed and required actions allocated.
Records
We reviewed 14 patient records in the adult emergency department and two in the paediatric emergency department. We found most information, including clinical data, was written and managed in a way that kept patients safe. Allergies and pain scores were completed and recorded in all patient notes. Administered medicines were recorded electronically and evidenced the medicine and dose given.

However, the two most recent matron’s audits of recording on patient records indicated that certain areas were below the trust standard of 90%. The lowest were falls risks assessment (between 40% and 70%), pressure area risk assessment (between 50% and 70%) and hourly observations (between 20% and 40%). To mitigate patient risk and improve assessment levels, the trust introduced a nurse in charge (NiC) booklet to monitor hourly checks as well as a matron’s audit every two hours. A Situation Report was held every two hours which updated nursing staff on the current state of the department. This included numbers of patients, waits and confirmed that all aspects of patient’s care were carried out, including relevant risk assessments.

Medicines
Some prescription medicines are controlled under the Misuse of Drugs Act 1971 (and subsequent amendments). These medicines are known as controlled medicines or controlled drugs and their storage and dispensing are regulated by legislation. Controlled drugs should be kept in a separate locked cupboard with those keys kept separately from the main cupboard keys; counted twice daily and when dispensed, signed by two members of staff in a separate controlled drugs register. We checked the controlled drugs cabinet and confirmed that this procedure was followed in accordance with safety guidelines.

The psychiatric liaison team advised ED clinical staff in relation to the safe use of medicines including rapid tranquilisation by injection. The trust had a rapid tranquilisation policy and flow-chart in place that included the physical healthcare observations required in relation to administration of rapid tranquilisation.

Incidents
Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. From August 2017 to July 2018, the trust reported no incidents classified as never events for urgent and emergency care at Whipps Cross Hospital.

(Source: NHS Improvement STEIS)

In accordance with the Serious Incident Framework 2015, the trust reported 11 serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from August 2017 to July 2018.

The types of incident reported were:

- Diagnostic incident including delay meeting SI criteria (including failure to act on test results): four incidents
- Adverse media coverage or public concern about the organisation or the wider NHS: two incidents
• Abuse/alleged abuse of adult patient by third party: one incident
• Abuse/alleged abuse of child patient by third party: one incident
• Medication incident meeting SI criteria: one incident
• Sub-optimal care of the deteriorating patient meeting SI criteria: one incident
• Surgical/invasive procedure incident meeting SI criteria: one incident

(Source: NHS Improvement STEIS)

We saw that 72-hour reports and root cause analyses of serious incidents were carried out and action plans drawn up. Staff told us they were encouraged to report all incidents and gave recent examples. They said they received feedback and for certain incidents were updated on progress and outcome. We found staff were aware of some but not all the SIs and learning from them in the department.

Serious incident details and learning were e-mailed out to all staff and included in the emergency department newsletter. In addition, there was a theme of the fortnight where learning from incidents discussed in safety huddles.

Each member of staff we spoke with told us they were encouraged to report incidents even if they were not sure whether it constituted an incident. Staff told us there was no sense of blame attached and each incident was seen as a learning experience.

The two moderate harm incidents related to treatment and one to medication. The three most reported low harm incidents related to equipment (non-medical), infection control and pathology/specimen. The one severe harm - permanent or long-term harm related to equipment. We noted that the date by which the trust should submit a report about this incident to the Strategic Executive Information System (StEIS) was overdue.

The emergency department reported an average of 170 incidents per month. The trust submitted data that identified the severity of all incidents between January and July 2018.

<table>
<thead>
<tr>
<th>No Harm</th>
<th>Low Harm</th>
<th>Moderate Harm</th>
<th>Severe Harm</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1119</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1119</td>
</tr>
<tr>
<td>0</td>
<td>61</td>
<td>0</td>
<td>0</td>
<td>61</td>
</tr>
<tr>
<td>0</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>1119</td>
<td>61</td>
<td>3</td>
<td>1</td>
<td>1184</td>
</tr>
</tbody>
</table>

Safety thermometer

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

Data collection takes place one day each month. A suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of the suggested data collection date.
Data from the Patient Safety Thermometer showed that the trust reported five new pressure ulcers, 32 falls with harm and two new urinary tract infections in patients with a catheter from June 2017 to June 2018 within urgent and emergency care.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Bart’s Health NHS Trust

1 Total pressure ulcers (5)

2 Total falls (32)

3 Total CUTIs (2)

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

(Source: NHS Digital - Safety Thermometer)

Is the service effective?

Evidence-based care and treatment

The emergency department used a combination of National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine (RCEM) guidelines to determine the treatment provided. We reviewed rosters and confirmed that the paediatric emergency department met Royal College of Paediatrics and Child Health standards. Guidance was discussed at team meetings, and regular audits were completed and learning opportunities shared with staff.

A range of clinical care pathways and proforma were developed in accordance with national guidelines. Pathways included frailty, stroke, sepsis, and asthma; fractured neck of femur, suspected pulmonary embolism and management of patients with mental health issues. There were additional pathways for the paediatric patient which included lower abdominal pain, accident/minor injury pathway and emergency/illness pathway. We found staff understood and
used pathways effectively to manage patients’ care. They told us pathways were accessible on the intranet.

We reviewed a number of clinical policies and guidelines during the inspection within the emergency department (ED) and on the trust intranet. Policies were in date, regularly updated and based on NICE and best practice guidelines. These were easily accessible to staff on the trust intranet.

We saw examples of care pathways completed for patients who had presented with specific conditions such as fractured neck of femur and frequent falls which followed evidence based guidance.

The department undertook regular audits which included national audits requested by the RCEM. Others were based on NICE guidance and included pain score in adults. There were 11 audits completed during the last audit year (2017-2018).

There was a clinical audit programme in place for 2018-2019 and audits were already assigned to doctors to lead on. There were 12 audits which included the RCEM procedural sedation in adults; RCEM fractured neck of femur; elderly trauma; feverish children and VTE in lower limb immobilisation.

A re-audit of paediatric pain assessment and management in Emergency Department showed deteriorated results from the initial audit. Forty one percent of patients had their pain score documented at triage (compared with original audit result of 62%). Forty-four per cent did not have their pain reassessed in 60 minutes (compared with original audit result of 80%); the explanation offered for this was because a doctor saw them within 60 minutes.

Recommended actions identified the need to improve pain assessment in triage and reassessment and to teach all nurses about how to assess pain scores. The emergency department practice development nurses planned to include pain reassessment and pain scoring in training for all paediatric ED nurses. This was not yet in progress; the deadline was November 2018 and re-audit November 2019.

**Nutrition and hydration**

In the CQC Emergency Department Survey, the trust scored 5.5 for the question “Were you able to get suitable food or drinks when you were in the emergency department?” This was worse than other trusts.

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

Staff offered patients refreshments from the refreshments trolley located in the emergency department. We saw patients were offered drinks and light snacks by nurses and healthcare assistants on a regular basis. One patient told us that whilst they were given water to drink, this was in a bottle, which they were unable to open due to their medical condition. They had to ask another nurse for a straw.

**Pain relief**

In the CQC Emergency Department Survey, the trust scored 5.6 for the question “How many minutes after you requested pain relief medication did it take before you got it?” This was the same as other trusts.

The trust scored 7.4 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was the same as other trusts.
The Royal College of Emergency Medicine (RCEM) best practice guidance states that ‘patients in severe pain should have the effectiveness of analgesia re-evaluated within 30 minutes of receiving the first dose of analgesia’. We saw results from a recent emergency department Quality, Innovation, Productivity and Prevention (QIPP) study of pain score in adults. These showed the 64% of patients had their pain re-evaluated compared with the initial score of 54%.

A visual pain score chart for adults to indicate levels of pain was developed. These were in each cubicle and used by nurses and doctors. Patients told us they were given pain relief when required.

Patients with suspected neck of femur fracture were fast tracked into the ED and a fascia-iliaca pain block (FIB) was administered. This method of pain management was particularly valuable in the case of patients living with dementia as regular analgesia was known to lead to increased confusion and exacerbation of behaviours as well as an increased tendency to fall. A recent audit showed that 49% of patients were administered FIBs in November 2017 compared with 75% in February 2018.

**Patient outcomes**

The CQC inspection in July 2016 found that just 6% of people over 75 were screened for dementia in accordance with RCEM audit of Older People in ED 2014/15. Following this inspection, the trust told us of measures introduced to address this and heighten awareness of dementia. These included incorporation into the trust induction programme, into junior doctor training and mandatory training. In addition, elderly patients identified as being at risk prior to discharge were referred to the admission avoidance team who screened for dementia. Dementia screening data was applied to admitted patients rather than to patient attendance to the emergency department. The trust submitted data which showed that there was a steady increase in dementia screening from 67% in September 2017 to 99% in August 2018.

In the 2016/17 RCEM Moderate and acute severe asthma audit, Whipps Cross Hospital emergency department failed to meet six of the national standards. The department was in the upper UK quartile for one standard:

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

  This department: 81.6%; UK: 52%.

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

- **Standard 2a (fundamental):** As per RCEM standards, vital signs should be measured and recorded on arrival at the emergency department. This department: 14%; UK: 26%.

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)
• Standard 3 (fundamental): High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the emergency department. This department: 5%; UK: 25%. The department’s results for the remaining four standards were all between the upper and lower UK quartiles.

• Standard 1a (fundamental): O2 should be given on arrival to maintain sats 94-98%. This department: 21%; UK: 19%.

• Standard 4 (fundamental): Add nebulised Ipratropium Bromide if there is a poor response to nebulised β2 agonist bronchodilator therapy. This department: 80%; UK: 77%.

• Standard 5a (fundamental): within 60 minutes of arrival (acute severe). This department: 19.2%; UK: 19%.

• Standard 5b (fundamental): within 4 hours (moderate). This department: 42.5%; UK: 28%.

(Source: Royal College of Emergency Medicine)

There was no re-audit done of the lower performing standards.

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

The department’s result for one standard was in the lower UK quartiles:

• Standard 4 (developmental): Consultant reviewed: abdominal pain in patients aged 70 years and over. This department: 0%; UK: 10%.

The department’s results for three standards were between the upper and lower UK quartiles:

• Standard 1 (developmental): Consultant reviewed: atraumatic chest pain in patients aged 30 years and over. This department: 6%; England: 11%.

• Standard 2 (developmental): Consultant reviewed: fever in children under 1 year of age. This department: 16.7%; UK: 8%.

• Standard 3 (fundamental): Consultant reviewed: patients making an unscheduled return to the emergency department with the same condition within 72 hours of discharge. This department: 6.7%; UK: 12%.

(Source: Royal College of Emergency Medicine)

There was no re-audit done of the lower performing standards.

In the 2016/17 Severe sepsis and septic shock audit, Whipps Cross Hospital emergency department failed to meet three of the national standards.

The department’s results for five standards were in the upper UK quartiles.
• Standard 1: Respiratory rate, oxygen saturations (SaO2), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival. This department: 100%; UK: 69.1%.
• Standard 2: Review by a senior (ST4+ or equivalent) emergency department medic or involvement of critical care medic (including the outreach team or equivalent) before leaving the emergency department. This department: 88.9%; UK: 64.6%.
• Standard 4: Serum lactate measured within one hour of arrival. This department: 77.8%; UK: 60%.
• Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given within one hour of arrival. This department: 83.3%; UK: 43.2%.
• Standard 7: Antibiotics administered: Within one hour of arrival. This department: 72.2%; UK: 44.4%.

The department was in the lower UK quartile for two standards:
• Standard 3: O2 was initiated to maintain SaO2>94% (unless there is a documented reason not to) within one hour of arrival. This department: 0%; UK: 30.4%.
• Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival. This department: 5.6%; UK: 18.4%.

The department’s result for one standard was between the upper and lower UK quartiles.
• Standard 5: Blood cultures obtained within one hour of arrival. This department: 38.9%; UK: 44.9%.

(Source: Royal College of Emergency Medicine)

The emergency department regularly undertook audits to monitor antibiotic administration. Following inspection, the trust submitted the data below:

<table>
<thead>
<tr>
<th></th>
<th>January 2018</th>
<th>February 2018</th>
<th>March 2018</th>
<th>April 2018</th>
<th>May 2018</th>
<th>June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>cases screened</td>
<td>52</td>
<td>50</td>
<td>53</td>
<td>132</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>cases of sepsis</td>
<td>19</td>
<td>35</td>
<td>14</td>
<td>27</td>
<td>31</td>
<td>21</td>
</tr>
<tr>
<td>antibiotics within 1 hour</td>
<td>16</td>
<td>25</td>
<td>13</td>
<td>17</td>
<td>29</td>
<td>20</td>
</tr>
<tr>
<td>% within 1 hour</td>
<td>84%</td>
<td>71%</td>
<td>92%</td>
<td>67%</td>
<td>94%</td>
<td>95%</td>
</tr>
</tbody>
</table>

From July 2017 to June 2018, the trust’s unplanned re-attendance rate within seven days to the emergency department was worse than the national standard of 5% and worse than the England average.
The trust submitted trust wide data following the inspection that showed performance between January and July 2018 was 8.8% compared to an England average of 7.9%.

**Unplanned re-attendance rate within seven days - Bart’s Health NHS Trust**

(Source: National Episode Statistics)

**Competent staff**

From April 2017 to March 2018, 113 members of medical and dental staff were eligible to receive an appraisal, and they achieved a 96% completion rate against a trust target of 90% (108 members of staff received an appraisal).

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

Data submitted following the inspection showed the appraisal rate for registered nursing staff was 97% and 95% for non-registered support staff.

The table below shows the appraisal compliance rate for medical staff. There were three doctors in substantive posts in the ED whose appraisal was overdue.

<table>
<thead>
<tr>
<th>Grades</th>
<th>Compliance%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>100.00%</td>
</tr>
<tr>
<td>Staff grade</td>
<td>0.00%</td>
</tr>
<tr>
<td>Specialty doctor</td>
<td>100%</td>
</tr>
<tr>
<td>Trust grade</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>84.00%</strong></td>
</tr>
</tbody>
</table>

We spoke with practice development nurses (PDN) who told us of ways in which learning development took place. This included sepsis training for all nursing staff on the team study days around the early recognition and treatment of sepsis. We saw that sepsis was a recently scheduled theme of the fortnight and discussed at the safety huddle with doctors and nurses each day for two weeks. It was also included in the junior doctor induction programme.
The PDNs told us they linked with other areas of the hospital and shared learning between areas and specialties. Specialist nurses including from critical care, learning disability and dementia were booked to provide training on their area of expertise.

Newly qualified nursing staff spoke positively of the support they received to enhance their clinical skills. They described the range of training they completed or were about to complete. These included intravenous cannulation, venepuncture and plastering. They met with a ‘buddy’ nurse each month and evidenced their competencies and training done to date.

We observed a simulation training session on paediatric resuscitation held in the resuscitation area and attended by eight nurses and two doctors.

It was world sepsis awareness day on one of our inspection days. Staff from the emergency department did a presentation for all staff in the canteen. This included question and answer opportunities as well as information and recent trust sepsis audit results.

ED clinical staff received mandatory training on how to recognise and provide a first response to patients with mental health needs, learning disabilities, autism or dementia. Trust induction training included how to meet the diverse needs of patients and included training on mental health, learning disabilities and dementia. It also included information on the psychiatric liaison team and how to make a referral. Members of nursing and medical staff told us their induction was relevant to their jobs.

Consultant psychiatrists from the psychiatric liaison team provided regular training to junior doctors starting rotation in the ED. This included rapid tranquilisation and how to make referrals to the mental health liaison team

**Multidisciplinary working**

We reported in the previous CQC report that multidisciplinary working was poor. On this inspection, we found this was no longer the case and staff spoke of much improved multidisciplinary team (MDT) working. They described the interface between nursing and medical staff as effective. There was close working with allied health professionals as well as geriatricians.

Joint training took place with different specialties including orthopaedics and anaesthetics for fascia-iliaica pain block (FIB) administration. Medical staff told us this was very valuable learning and had many benefits for patient safety and comfort.

Staff members from the paediatric medical and nursing team attended a weekly multidisciplinary safeguarding meeting. This included the local authority safeguarding children team, child and adolescent mental health team (CAMHS), Early Help and Prevention Service (part of children’s social care) and substance misuse service.

The psychiatric liaison service had regular MDT meetings and handovers twice a day at shift changeover.

**Seven-day services**

All areas of the department provided care to adults and children 24 hours a day, 365 days a year. There was consultant cover between the hours of 8:00am and 10:00am seven days a week. There was a full seven-day diagnostic imaging and reporting service in the ED department, as well as a pathology service. The pharmacy was available 9:00am to 5:00pm Monday to Friday and 10:00am to 2:00pm Saturday and Sunday.
Clinical staff had 24-hour access to the neighbouring foundation trust and the local authority's psychiatric liaison service. Social workers were available on site from 7:00am to 6:00pm seven days per week.

**Health promotion**

Posters to raise awareness of sepsis were displayed throughout the department and there were patient leaflets available that gave information on the signs and symptoms of sepsis.

The emergency department participated in Commissioning for Quality and Innovation (CQUIN) ‘Preventing ill health by risky behaviours – alcohol and tobacco’. An alcohol users screening tool (AUDIT C) was devised and training took place on how to use it. Patients were screened for alcohol when they arrive to ED. The score determined whether a member of the psychiatric liaison team was called to do a further assessment.

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

Staff we spoke with had a good working knowledge of the law around consent. The nature of emergency medicine was such that there were few occasions when written consent was required and consent was implied. Staff were therefore focused on patients giving them verbal or implied consent. We observed verbal consent taking and appropriate recording, including consent for inspectors and specialist advisors to observe aspects of care. We saw consent documented in patient records and, in the case of a child; we saw the parent or guardian signed their consent.

There was no stand-alone training on Deprivation of Liberty Safeguards (DoLS) of patients; it was incorporated into safeguarding adults level1 for all members of staff. We were told a DoLS was usually completed on the ward rather than in the ED. However, staff could describe to us the implications of DoLS for patients and professional practice.

ED staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 (MCA). Staff we spoke with understood their responsibilities in relation to patients who lacked the mental capacity to make decisions about their care and treatment and the key principles of the MCA. They understood their duty to act in the patient’s best interests. We found a care record where a capacity assessment was completed in accordance with the MCA.

Nursing and medical staff told us there were few occasions when restraint was necessary with patients. Staff did not have training in restraint and had a zero tolerance to violence and aggression from patients. When restraint was necessary, police support was called upon. Security staff did not restrain patients. The psychiatric liaison team was staffed 24 hours a day and managed patients presenting with a mental health condition well.

**Is the service caring?**

**Compassionate care**

The trust urgent and emergency care Friends and Family Test performance indicated that the percentage of patients who recommended the department was generally better than the England average for the first four months of the reporting period. However, trust performance was worse than the England average from December 2017 to July 2018. There was no available data for November 2017.
Friends and Family feedback was gathered through a trust wide text service and the emergency department received 8% of feedback for August 2018 in this way. Members of staff told us they believed the text service did not reach a wide enough range of patients and paper copies were reintroduced. Feedback was also gathered when the matron did their audit; they used the feedback form to speak with patients about their experience of the emergency department (ED). The target was to improve the response rate from 8% to 15% by the end of December 2018.

Following the inspection, the trust submitted data for August 2018 based on 172 responses for the whole emergency department. Results showed that of 23 responses in ED majors, 18 (78%) were extremely likely or likely and three (13%) were unlikely or extremely unlikely to recommend. Results for the initial assessment area showed that of 198 responses, 132 (67%) were extremely likely or likely and 46 (23%) were unlikely or extremely unlikely to recommend. The trust did not submit any action plan that may be in place to address these results.

We spoke with eight patients and two relatives, most of whom praised the staff for their kindness. Patients told us they were treated with dignity and respect at all times. Those in the general waiting area told us “the nurses are all very professional” and “they all do a very tough job marvellously well.”

Staff used curtains around the bed spaces to provide privacy when assessing and treating patients, and ensured patients’ dignity was maintained when curtains were opened. Patients were covered up at all times when in public areas. We observed how staff took care during handover to anonymise patients and refer to them by their cubicle number. They spoke in low voices when discussing patient related information.

We heard staff introduce themselves when they entered patient cubicles and asked the patient what their preferred name was. We observed several instances of staff being caring towards patients. For example, we saw a nurse offering emotional support to the elderly relative of a patient who found the situation in the emergency department difficult to deal with. We also saw sensitivity shown towards the relatives of a recently deceased patient. They were given time to be with their relative’s body and then taken to the relative’s room where they were comforted and their immediate questions answered.
Staff supported patients who became distressed in an open environment, and helped them maintain their privacy and dignity. For example, ED staff told us that the lights could be dimmed in the bay area to manage patient’s hypersensitivity to light.

**Emotional support**

Staff we spoke with showed understanding and a non-judgmental attitude when talking about patients with mental health needs, learning disabilities, autism or dementia.

Emotional support was provided to patients and relatives. There was a relative’s room in ED where family members could go to when their relative was gravely ill or had died. This enabled them to have confidential discussions with the medical and nursing team away from the general busyness of the department. The room had comfortable seating, was tidy and had tea and coffee making facilities.

Staff told us there was a team debrief whenever there was a traumatic death in the department. The whole team involved with the patient was part of this led by senior doctors. Counselling was available to staff through the trust occupational health department.

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

The trust scored about the same as other trusts for 22 out of the 24 Emergency Department Survey questions relevant to the caring domain. The trust scored worse than other trusts for the remaining two questions.

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you told how long you would have to wait to be examined?</td>
<td>3.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>7.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q17. Did doctors or nurses talk to each other about you as if you weren't there?</td>
<td>8.4</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>7.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>7.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</td>
<td>7.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?</td>
<td>6.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q26. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q27. Before you left the emergency department, did you get the results of your tests?</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q28. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?</td>
<td>9.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q39. Did a member of staff tell you about medication side effects to watch out for?</td>
<td>5.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?</td>
<td>5.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department?</td>
<td>4.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?</td>
<td>5.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?</td>
<td>6.0</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q45. Overall... (please circle a number)</td>
<td>7.7</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

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

Most patients and their relatives we spoke with told us they received regular communications and were kept informed about their care, treatment and condition. Staff made sure patients and relatives understood the assessments being done and the likely diagnosis and treatment plan. We observed patients and relatives were given opportunities to ask questions and spoke with family...
members of a very sick patient. They said they were made fully aware of their relative's care plan, treatment and possible outcomes.

Is the service responsive?

Service delivery to meet the needs of local people

The service had arrangements, known to all staff on duty, to meet patients’ urgent or emergency mental health care needs at all times, including outside office hours and in an emergency. The service ensured emergency department (ED) staff were made aware of the role of the psychiatric liaison team at their induction and how to refer patients.

Staff and the care systems they followed helped to provide good care to patients in need of additional support. ED staff made referrals to the psychiatric liaison team or the learning disability lead nurse for advice and support.

Appropriate discharge arrangements were used for people with complex health and social care needs. Where patients were returning home their follow up needs were addressed. Staff communicated with the patient, their family, the GP and other agencies as necessary. Where patients were transferred to another health setting such as an in-patient mental health ward, staff ensured that the receiving ward had appropriate referral and background information.

Patients were streamed to a number of areas for their safe treatment when they arrived at the hospital. The emergency department treated people with serious and life-threatening emergencies and the paediatric emergency department treated children up to the age of 16. Adults and children with less urgent illnesses and minor injuries were treated in the urgent care centre or streamed to the initial assessment area (IA).

The clinical champion for frequent attenders was a consultant who reviewed data on this group between January and April 2017, in accordance with NHS CQUIN (Commissioning for Quality and Innovation) 2017-19: Indicator 4 (Improving services for people with mental health needs who present to A&E) with the aim of reducing overall emergency department attendances.

The top 50 attenders (27 female, 23 male) identified made between 16 and 58 attendances in this period. An action plan was devised and continuing work with this group of patients included weekly multidisciplinary meetings with the admission avoidance team and liaison with outpatient department and community based services. Staff told us a flag on the patient electronic system alerted them when a frequent attender was in the department.

Bart’s Health NHS Trust staff worked with the neighbouring foundation trust to support frequent attenders with mental health issues to the ED. Staff from the ED and the psychiatric liaison team met every two weeks to discuss cases. Staff could refer frequent attenders to a psychologist.

Meeting people’s individual needs

The trust scored about the same as other trusts for all three Emergency Department Survey questions relevant to the responsive domain.

<table>
<thead>
<tr>
<th>Question – Responsive</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency department last?</td>
<td>6.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
Patients with needs related to disability, impairment or sensory loss were identified on the hospital electronic system when the patient record was accessed in accordance with the NHS Accessible Information Standard requirement. The trust told us information was made available to support communication needs including British Sign Language and braille. Staff told us they could access a translation service if required by patients for whom English was their second language.

Staff were aware of nurse specialists for patients with a learning disability and for those living with dementia. There was also a dementia and learning difficulty champion who offered advice and support to staff. ED staff told us that they had easy access to specialist staff for advice and support on patients with learning disability or autism. A learning disabilities team and lead nurse were available for consultation.

Patients identified as vulnerable or with a special need were fast-tracked to triage. Reception staff told us they alerted the triage nurse to these patients so they did not have to be in the department any longer than was necessary.

Most patients with a learning difficulty had a hospital passport. This is a resource for people with a learning difficulty or autism who might need hospital treatment. The passport is designed to help people to communicate their needs to doctors, nurses and other healthcare professionals. If patients did not have one, a temporary document was created for use when in the hospital. The emergency department followed the trust wide pathway for patients with learning difficulties. This included guidance on reasonable adjustments to be made to minimise distress for the patient or their carer. Staff told us they spoke with patients and their carers and relatives to identify their likes and preferences, which helped to reduce their distress.

The service had a pathway in place for cognitive impairment, delirium and dementia. Doctors completed a dementia screening on the electronic records system for all patients aged 75 years or older and for those younger than 75 years where a cognitive impairment or dementia might be suspected. Referrals to specialist support services such as to a local memory services were completed where appropriate.

Patients at risk of falling were placed into cubicles where they could be easily observed. An alarm was positioned under their mattress to alert staff when the patient moved off the mattress. There was a noticeboard in the ED which identified dementia champions as well as information on dementia and delirium.

Patients who required a longer period of recovery time but were not sick enough to be admitted were transferred to the clinical decision unit (CDU) which had seven beds with single sex areas and shower facilities. There were four chairs for patients assessed as ‘fit to sit’, some of whom waited for tests or test results. The aim of the CDU was to provide effective care for patients who needed to stay within a hospital setting for less than 24 hours, where it is appropriate and clinically safe for them to be managed within the CDU setting. The decision to admit was consultant led between 8:00am and 10:00pm Monday to Friday and between 2:00pm and 10:00pm weekends and bank holidays and by a senior doctor at all other times.

There was a doctor in the unit between 8:00am and 5:00pm after which medical cover was by doctors in the ED majors area; there were two qualified nurses on duty at all times. We saw there were patient pathways and operational guidelines. Staff we spoke with understood that beds in the CDU were not used to avoid departmental breaches. We observed this was the case during the inspection. The four-hour performance target was breached on a number of occasions and at the
same time; there were unoccupied beds in the CDU. No patients were transferred to these unoccupied beds to avoid a breach.

The psychiatric liaison service provided assessments of patients aged 17 or over presenting to the ED with mental health needs and/or drugs and alcohol needs. The local authority’s psychiatric liaison service also provided advice, assessment and brief psychological interventions for adults, including older people, on acute inpatient wards at the hospital. This team recently employed a psychologist to offer short term psychological therapy to patients who repeatedly presented to ED with a mental health diagnosis/condition. These sessions were provided on a short term basis to try to improve the outcome for patients and prevent re-admission or frequent presentation to the ED.

There was a CQUIN in place for alcohol use and this meant that every patient was screened for alcohol use and referrals made accordingly. There were alcohol champions in the ED who made referrals to the drugs and alcohol practitioner.

**Access and flow**

The Royal College of Emergency Medicine (RCEM) recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust did not meet the standard for five months over the 12-month period from July 2017 to June 2018.

From July 2017 to June 2018, the trust’s performance generally followed the national trend although in December 2017 the median time to treatment was 55 minutes, which was better than the England average of 62 minutes.

**Median time from arrival to treatment from July 2017 to June 2018 at Bart’s Health NHS Trust**

![Graph showing median time from arrival to treatment](Source: NHS Digital - A&E quality indicators)

The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department.

From August 2017 to July 2018, the trust failed to meet the standard and performed worse than the England average. The trust submitted data following the inspection which showed that between January and July 2018, the average performance was 86%. 
Four hour target performance - Bart's Health NHS Trust

From August 2017 to July 2018, the trust’s monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was generally worse than the England average.

Percentage of patients waiting more than four hours from the decision to admit until being admitted - Bart’s Health NHS Trust

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

(Source: NHS England - A&E SitReps).
Over the 12 months from August 2017 to July 2018, one patient waited more than 12 hours from the decision to admit until being admitted. The highest numbers of patients waiting over four hours were in March 2018 (1,759), January 2018 (1,721) and October 2017 (1,645).

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients waiting more than four hours to admission</th>
<th>Number of patients waiting more than 12 hours to admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aug-17</td>
<td>1,056</td>
<td>0</td>
</tr>
<tr>
<td>Sep-17</td>
<td>1,191</td>
<td>0</td>
</tr>
<tr>
<td>Oct-17</td>
<td>1,645</td>
<td>0</td>
</tr>
<tr>
<td>Nov-17</td>
<td>1,484</td>
<td>0</td>
</tr>
<tr>
<td>Dec-17</td>
<td>1,570</td>
<td>0</td>
</tr>
<tr>
<td>Jan-18</td>
<td>1,721</td>
<td>0</td>
</tr>
<tr>
<td>Feb-18</td>
<td>1,351</td>
<td>1</td>
</tr>
<tr>
<td>Mar-18</td>
<td>1,759</td>
<td>0</td>
</tr>
<tr>
<td>Apr-18</td>
<td>1,227</td>
<td>0</td>
</tr>
<tr>
<td>May-18</td>
<td>1,217</td>
<td>0</td>
</tr>
<tr>
<td>Jun-18</td>
<td>828</td>
<td>0</td>
</tr>
<tr>
<td>Jul-18</td>
<td>499</td>
<td>0</td>
</tr>
</tbody>
</table>

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

From July 2017 to June 2018, the monthly percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment was similar to the England average. In the latest month June 2018, the percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment was 2.5%, compared to the England average which was 2.4%.

Percentage of patient that left the trust’s urgent and emergency care services without being seen - Bart’s Health NHS Trust

(Source: NHS Digital - A&E quality indicators)
The emergency department (ED) had a full capacity protocol (FCP) developed to respond to extreme and sustained overcrowding. The purpose was to ensure the safety of patients and staff whilst maintaining the service. When there were 10 or more unplaced adult patients in the ED at 10:00am, activation of the FCP was considered. This command and control plan had clearly defined trigger points as well as roles and responsibilities. Certain wards were identified to accept patients on transfer as part of the FCP. Only one additional patient would be placed on a ward and a ward nurse identified to look after the patient in a suitable area whilst awaiting a bed.

Data submitted by the trust following the inspection showed that the FCP was activated on 49 occasions between August 2017 and July 2018, with a spike of 13 in March 2018.

The department introduced a doctor led triage system (‘pit stop’) in July 2018 for patients who arrived by ambulance, which was being piloted at the time of this inspection. Ambulance crew handed over patients to the doctor in charge, always a consultant or senior doctor which ensured early senior clinician review and treatment. The trust told us early indicators showed there were significant improvements to the average length of time patients spent in the emergency department before a doctor reviewed them. Data submitted by the trust following the inspection showed there was a reduction from 105 minutes for time to medical review to 26 minutes between July and August 2018 during the pilot period. We were told the expectation was to continue with this doctor led triage system whilst it was acknowledged that staffing of this system required further planning.

We attended a daily bed meeting led by the chief operational officer and attended by all departmental leads. The current ED status was discussed, including wait times, resuscitation status, longest patient waits and general safety of the department.

We inspected the emergency department at night and whilst busy, staff managed to maintain safety and order. All bays in the ED majors were full and there was one patient in the corridor during this time. A senior doctor managed the shop floor and there was consultant oversight. We noted that doctors regularly spoke with the patient in the corridor and nurses carried out regular observations. This patient told us they felt safe and well looked after.

Allied health professionals (AHP) conducted a six-week pilot study April 2018 in response to the high proportion of patients over 70 years of age who attended the emergency department. This meant there was physiotherapy and occupational therapy presence in the ‘pit stop’ area to assess patients who arrived by ambulance Monday to Friday 9:00am to 5:00pm. The view was that early intervention in the patient pathway increased the patient’s functional levels and independence.

The expectation was that more patients would be discharged from the ED or if admitted, their length of stay in hospital would be reduced. Results from this pilot study showed that of the 172 patients seen, 41% (71) were discharged and 26% (44) were admitted for medical reasons only; the remaining 32% (55) required longer term medical and therapy input.

AHPs told us intervention at such an early stage had significant benefits for patients, as well as improve patient flow. They said AHPs continued to attend the pit stop, although there were challenges to staffing resources, which made it difficult to provide a full 9:00am to 5:00pm service.

Staff in the emergency department worked closely with the admissions avoidance team (AAT) and frailty assessment unit (FAU) to provide a safe and effective service to frail elderly patients. A clearly defined pathway was initiated when a patient over 65 years old came into the emergency department and displayed at least one geriatric syndrome.

They were referred to the AAT, members of which were based in ED between 8:00 to 8:00pm. They used a frailty score tool as part of their assessment to determine any input required by the
patient from community or acute services. Where a patient was not fit for discharge but required a longer period of assessment, they were transferred to the FAU where the average length of stay was 48 hours.

We saw data between May and August 2018 which highlighted the numbers of patients seen by the AAT and the number of those patients for whom admission was avoided:

<table>
<thead>
<tr>
<th></th>
<th>May 2018</th>
<th>June 2018</th>
<th>July 2018</th>
<th>August</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients seen</td>
<td>153</td>
<td>149</td>
<td>145</td>
<td>109</td>
</tr>
<tr>
<td>Admission avoided</td>
<td>119</td>
<td>113</td>
<td>124</td>
<td>90</td>
</tr>
<tr>
<td>% avoided</td>
<td>78%</td>
<td>76%</td>
<td>86%</td>
<td>83%</td>
</tr>
</tbody>
</table>

From August 2017 to July 2018, the trust’s monthly median total time in A&E for all patients was higher than the England average. In the latest month June 2018, the trust’s monthly median total time in A&E for all patients was 187 minutes compared with the England average of 148 minutes.

**Median total time in A&E per patient - Bart’s Health NHS Trust**

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

The psychiatric liaison service had a current operational policy, due for review in September 2019. The policy set out the target times for the team to respond to referrals. The target response time for patients in the emergency department was one hour. For assessment units such as the clinical decision unit it was four hours and for the wards it was 24 hours. ED staff told us that the psychiatric liaison team responded to referrals very promptly and care records we looked at confirmed that patients were seen within the one-hour target time. There were established arrangements for obtaining mental health assessments for patients aged 16 years or under.

Staff were aware of delayed discharges and told us these were often due to the patient coming from another area which meant an out of area placement had to be located.

Patients who required a bed in a mental health unit were frequently delayed in the emergency department until one was identified. For example, one patient we saw on inspection waited 12 hours for transfer and staff escalated their concerns about this delay. The psychiatric liaison team
developed a model of “parallel processing” in an effort to reduce any delay for a patient who was medically fit to be discharged. Any breaches of target times for referral to assessment and assessment to discharge were analysed and recorded by the psychiatric liaison team.

Learning from complaints and concerns

From April 2017 to March 2018, there were 92 complaints about urgent and emergency services at the hospital, from which 53 complaints related to diagnosis/treatment. The trust took an average of 53 days to investigate and close complaints, this was in line with their complaints policy, which states complaints should be completed between 10 and 60 days.

The general themes from all complaints related to poor patient care, staff attitude and multiple instances of mis-diagnosis which resulted in delays of treatment.

The top three departments with the highest number of complaints were:

- A&E majors – 35 complaints
- Acute assessment unit – 25 complaints
- A&E paediatric – 12 complaints

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

From April 2017 to March 2018, there were 39 compliments given to Bart’s Health NHS Trust.

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

Minutes of the emergency department recovery board recorded complaints and compliments specific to the department. In certain cases, clinical staff met with complainants in order to reach a resolution. Learning was shared with staff in the ED newsletter and displayed on the staff room noticeboard. We noticed several thank you cards on the staff room wall in addition to learning from complaints.

Following the inspection, the trust submitted data between September 2017 and August 2018. The emergency department received 109 complaints, 73 (67%) which were closed within the agreed date; 26 (19%) were closed after the agreed date was exceeded and there were currently 10 (4%) open and within date. We saw examples of responses to patient complaints which were comprehensive. Some responses outlined how the cause for complaint might have been avoided if staff took different actions and all included an apology.

Is the service well-led?

Leadership

Since the last CQC inspection in July 2016, the emergency department (ED) became part of the emergency care and trauma clinical board. A new site based leadership team for the ED was formed which had direct contact with the medical director. The emergency department leadership team included a clinical director, an associate director of nursing and associate general manager. They told us the strengthened leadership meant there was better communication at board level and more autonomy over decision making at a local level.

Most staff members told us they were familiar with all the team, who were very visible and were often around the department. The emergency department senior leadership team were aware of the challenges and barriers to improving the safety and quality of care for patients, including those with known or suspected mental health symptoms.
Vision and strategy

At the last CQC inspection in July 2016, we found there was no clear long-term strategy for the emergency department (ED). During this inspection, members of the leadership team shared the ED strategy which included workforce development and improved performance.

Most staff understood and shared the trust vision, which was to provide safe, high quality and timely care to patients. Staff told us they were proud of the way in which the emergency department upheld this vision. Staff were also aware of the trust ambition to become a centre of excellence for the health and well-being of elderly people. This would best reflect most adult attendees, 70% of whom were over 70 years of age. The trust values ‘WeCare’ (welcoming, engaging, collaborative, accountable, respectful and equitable) were widely displayed in all the areas we visited.

Priorities for the emergency care and trauma clinical board 2018-19 included sustainable improvement of 4 hours performance, development of new workforce models to deliver a high quality, sustainable clinical workforce and address recruitment issues. Other priorities included improved staff recruitment and retention as well as admission avoidance and attendance.

Culture

There was a general sense amongst staff that they were an integral part of the overall continuous improvement of the department. However, a range of staff, clinical and non-clinical and with varying lengths of service told us they felt bullied at times. In most cases, they said this was due to the ways in which line managers pushed the pressure to achieve set targets downwards. They said they experienced rudeness and general poor behaviour from some line managers.

We raised this with the trust during the inspection and found there was a lack of awareness of bullying behaviours within the emergency department. Following the inspection, the trust submitted an action plan drawn up in response to this matter. This included engagement with staff groups to listen to concerns and the impact on individuals and team and identify support required. Formal action would be taken as necessary and a monitoring process put in place. The trust also proposed to engage the organisational development team and set up focus groups to work with the teams and individuals on trust values.

Governance

A new divisional governance framework was introduced as part of the trust action plan following the previous CQC inspection in July 2016. This included monthly departmental multidisciplinary morbidity and mortality (M&M) meetings, monthly clinical governance meetings and monthly breach meetings. There was also a weekly complaints meeting and quarterly clinical faculty meetings, as well as a variety of leadership and operational team meetings. Staff told us that the governance systems in place helped them to work efficiently and made the environment a safer place to work.

All deaths in the department were discussed at the M&M meetings. We looked at a selection of minutes between April 2018 and August 2018 and saw that attendance included emergency medicine consultants as well as a representative from the patient panel. The meeting rated patient care according to the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) classifications of care. Learning was documented; for example, it was noted that ‘Do Not Assist Resuscitation’ (DNAR) and resuscitation booklets were not completed for all patients. The recorded action was to make this a ‘theme of the fortnight’, which was then discussed with doctors and nurses at the daily safety huddle each day for two weeks.
The emergency department recovery board met weekly and included senior clinical and nursing staff, improvement coordinator, ED general manager, heads of therapies and business planning and director of operations. The function of this board was to have oversight of all aspects of performance and management of the emergency care, including the urgent care centre. We saw that agreed actions included a relationship owner. There was a progress update at each meeting and actions closed as appropriate.

Emergency department managers, medical lead and the psychiatric liaison team met each month to review security issues, clinical governance issues and the clinical pathways for patients.

**Management of risk, issues and performance**

The emergency department clinical governance group met each month and reviewed risks, incidents and progress on serious incident analyses. Attendees included doctors and nurses from adult and paediatric emergency departments, patient experience lead and representatives from the neighbouring foundation trust who managed the urgent care centre and patient panel.

There was a set agenda each month and minutes from the May 2018 meeting recorded that 31% of incidents were overdue and required action to close. The trust sent data following the inspection, which showed the number of overdue incidents reduced to 6%. Complaints and compliments were also shared during this meeting.

The paediatric emergency department (PED) did not hold a separate risk register from the main emergency department (ED). There were no current PED related risks on the emergency department risk register.

There were nine risks on the ED risk register; one of the highest was failure to achieve ED performance targets. This presented a risk to patient experience, safety and quality. Members of the departmental leadership team told us about risk reduction measures which included closer working with the provider of the urgent care centre (UCC). The clinical lead told us meetings were planned to standardise pathways and agree a shared protocol on how to increase the level of patients streamed to the UCC. Other measures currently in place to improve performance included the recently established consultant or senior doctor led ‘pit stop’ for rapid assessment and treatment of patients who arrived by ambulance.

Other risks on the risk register included low numbers of junior doctors at registrar level within the ED; crowding within ED and risk of delay in patient treatment due to unchecked diagnostic results.

We noted that the Initial Assessment area of ED was added as a medium risk to the risk register following this inspection. It was included in the overall risk ‘failure to achieve the 15-minute time to initial assessment’. Reasons cited included crowded environment, poor visibility, inadequate IT and staffing sometimes not able to match demand due to recruitment issues in the ED medical staffing provision.

We found that clinical and nursing staff we spoke with were aware of the top departmental risks as listed by the leadership team and told us the risk most relevant to them was staffing. They understood that there was a recruitment campaign but were realistic about how quickly vacancies could be filled.

We discussed planning for winter pressures with the divisional leadership team. They told us there were plans made to reconfigure wards to receive patients. They also said it was important to retain the presence of the admission avoidance team and frailty team in the ED; as well as develop the work done in the ‘pit-stop’ area on admission avoidance work piloted by members of the allied health professionals. However, we understood that finance was not yet secured for this at the time of the inspection.
**Information management**

The department could monitor performance of accident and emergency performance against the four-hour target on a daily basis. This information was shared during bed management meetings each day. The emergency department was part of the divisional quality meeting which fed into the trusts quality board. Key quality indicators such as four-hour waits were discussed here and any concerns in the department were escalated to the trust.

The hospital introduced enhanced security in the IT system following a malicious cyberattack in 2017. This protected patient and staff data from unauthorised access and ensured staff had local access to records in the event of a server failure.

**Engagement**

Although the 2017 staff survey results showed an improved response rate of 38.9% in comparison with 30.1% in 2016, this was below the trust average response rate of 47.8%. Responses in the emergency department and emergency medicine were above the trust average for the following: 92% of staff thought their job made a difference to patients; 96% of staff said they knew how to report unsafe practice and 92% of staff reported training helped them stay up to date with professional requirements.

Responses were below the trust average in the following: 66% felt able to make suggestions and improvements that improve where they work; below 50% felt involved in deciding changes that affected their work; 25% believed there were sufficient numbers of staff; 40% did not have shared team objectives and just over 50% were satisfied with support from their line manager.

Responses were also below the trust average for the following: health, wellbeing and safety at work in terms of experiencing bullying, harassment and abuse from patients / service users, relatives and members of the public, as well as colleagues and managers. Just 50% felt the organisation would address concerns about unsafe clinical practice; 30% did not believe the organisation acted fairly in terms of career progression and 53% would recommend the hospital as a place to work.

We spoke with members of the senior leadership team who shared with us their recently formulated action plan, which focussed on the poorer staff survey results. They told us their initial focus was on four areas, which included management team working; health and well-being; bullying and harassment and staff safety.

The department engaged with the public in a number of ways which included having a patient’s panel representative at governance meetings and offering face to face engagement with complainants.

An emergency department newsletter launched in July 2018 provided information on governance, performance and staff well-being in addition to general updates on compliments and complaints.

**Learning, continuous improvement and innovation**

Members of the leadership team told us how the introduction of the ‘pit stop’ area in the emergency department helped to improve the patient experience. Other improvements included the proactive early assessments of patients over 65 years of age with at least one geriatric indicator which led to increased admission avoidance.

There was on-going learning for staff through themes of the week and fortnight, which reinforced learning. Practice development nurses held regular daily teaching sessions in the department for all available staff. We observed one of these, which was simulated training on paediatric resuscitation in the paediatric bay of the resuscitation area. This was attended by eight medical
and nursing staff and was interactive. Each attendee demonstrated resuscitation techniques on the model in what was a good learning environment.

Medical care (including older people’s care)

Facts and data about this service

Acute medical care provision at Whipps Cross Hospital is provided by a dedicated acute physician team, including acute geriatricians, and delivers medical care to a 60 bedded Acute Assessment Unit (AAU) and provides acute medical cover for the Emergency Department (ED). Out of hours medical cover is provided via an on-call system. Weekend ward rounds and discharge rounds are undertaken by an acute/medical consultant team. The acute medical referrals are supported by a 10-bedded frail elderly unit called Forest Assessment Unit (FAU), with a dedicated team, admission avoidance service and acutely-run ambulatory care unit (ACU) seven days per week. Inpatient medical and elderly ward base comprises of six speciality medical wards, with a total of 107 beds.

Specialty medicine inpatient care is delivered by specialty teams such as respiratory, gastroenterology, stroke care, diabetes and endocrine and cardiology, as well as rheumatology and neurology providing inpatient care by referral.

Elderly care is delivered by a dedicated team of geriatricians (five elderly wards with a total of 102 beds). The elderly medical team also support the inpatient rehabilitation ward with 19 beds. The acute stroke unit (Peace ward) has 19 inpatient beds and a dedicated stroke team. An orthogeriatrician also supports orthopaedic wards. Elderly patients, if required post discharge, are followed up by multi-disciplinary team at Connaught Day Hospital for on-going assessment and treatment. All medical and elderly wards have dedicated consultant-led ward/board rounds on a daily basis.

(20180517 RPIR Acute - NUH Documents – Context)

The trust had 87,427 medical admissions from April 2017 to March 2018. Emergency admissions accounted for 42,691 (48.8%), 5,040 (5.7%) were elective, and the remaining 39,696 (45.4%) were day case.

Admissions for the top three medical specialties across the trust were:

- General medicine: 24,413
- Gastroenterology: 22,946
- Cardiology: 11,059

(Source: Hospital Episode Statistics)

Care and treatment was provided by 16 medical specialties or services and we included the endoscopy service in our inspection.
Is the service safe?

Mandatory training

The trust set a target of 85% for completion of mandatory training. Data provided by the trust were split between the acute assessment unit (AAU) acute medicine wards/acute medicine and the other medical specialties and services.

A breakdown of compliance for mandatory courses as of the 4 June 2018 for nursing staff in medical care (cancer services, cardiology, electrophysiology, gastroenterology, dermatology, rheumatology, older people’s services, stroke services, renal, diabetes and respiratory medicine) is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving and Handling - Patient Handling Low Risk</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>253</td>
<td>256</td>
<td>99%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness</td>
<td>252</td>
<td>256</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Working at Barts Health</td>
<td>252</td>
<td>256</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fraud Awareness</td>
<td>248</td>
<td>256</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>247</td>
<td>256</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety</td>
<td>246</td>
<td>256</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Security</td>
<td>246</td>
<td>256</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Investigation of Incidents</td>
<td>44</td>
<td>46</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk Assessment for Managers</td>
<td>44</td>
<td>46</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Harms - Catheter Acquired Infections</td>
<td>244</td>
<td>256</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Harms - Pressure Ulcer Prevention</td>
<td>244</td>
<td>256</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Harms - VTE</td>
<td>244</td>
<td>256</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Harms - Slips, Trips and Falls (Patients)</td>
<td>243</td>
<td>256</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Nutritional Care</td>
<td>243</td>
<td>256</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>219</td>
<td>231</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Early Warning Systems</td>
<td>242</td>
<td>256</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Privacy and Dignity</td>
<td>241</td>
<td>256</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Nursing staff exceeded the trust's 85% completion rate target for 26 out of 28 mandatory training modules.

The trust provided a breakdown of compliance for mandatory courses as of the 23 August 2018 for nursing staff in medical care (the AAU acute medicine wards/acute medicine) as shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Documentation</td>
<td>240</td>
<td>256</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Complaints</td>
<td>240</td>
<td>256</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Emergency Planning</td>
<td>240</td>
<td>256</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling - Patient Handling Practical</td>
<td>232</td>
<td>254</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>233</td>
<td>256</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention and Control - Clinical</td>
<td>227</td>
<td>256</td>
<td>89%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>222</td>
<td>256</td>
<td>87%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical Gas Safety</td>
<td>219</td>
<td>254</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>211</td>
<td>256</td>
<td>82%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation - Basic Life Support</td>
<td>208</td>
<td>256</td>
<td>81%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing staff exceeded the trust's 85% completion rate target for 26 out of 28 mandatory training modules.

The trust provided a breakdown of compliance for mandatory courses as of the 23 August 2018 for nursing staff in medical care (the AAU acute medicine wards/acute medicine) as shown below:
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes / No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Prevention and Control - Clinical</td>
<td>45</td>
<td>45</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>45</td>
<td>45</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Investigation of Incidents</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical Gas Safety</td>
<td>45</td>
<td>45</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling - Inanimate Loads</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling - Patient Handling Practical</td>
<td>44</td>
<td>44</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Nutritional Care</td>
<td>45</td>
<td>45</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation - Basic Life Support</td>
<td>45</td>
<td>45</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk Assessment for Managers</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Security</td>
<td>45</td>
<td>45</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Clinical Documentation</td>
<td>44</td>
<td>45</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>44</td>
<td>45</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>43</td>
<td>45</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness</td>
<td>43</td>
<td>45</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Emergency Planning</td>
<td>43</td>
<td>45</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>43</td>
<td>45</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety</td>
<td>43</td>
<td>45</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Privacy and Dignity</td>
<td>43</td>
<td>45</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Working at Barts Health</td>
<td>43</td>
<td>45</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Complaints</td>
<td>42</td>
<td>45</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Nursing staff exceeded the trust’s 85% completion rate target for all 28 mandatory training modules.

The trust provided a breakdown of compliance for mandatory courses as of the 4 June 2018 for medical staff in medical care (cancer services, cardiology, electrophysiology, gastroenterology, dermatology, rheumatology, older people’s services, stroke services, renal, diabetes and respiratory medicine) as shown below:
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Safety</td>
<td>55</td>
<td>60</td>
<td>92%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Harms - VTE</td>
<td>54</td>
<td>60</td>
<td>90%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Clinical Documentation</td>
<td>54</td>
<td>60</td>
<td>90%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness</td>
<td>54</td>
<td>60</td>
<td>90%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>54</td>
<td>60</td>
<td>90%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling - Patient Handling Low Risk</td>
<td>54</td>
<td>60</td>
<td>90%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>51</td>
<td>57</td>
<td>89%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Harms - Catheter Acquired Infections</td>
<td>53</td>
<td>60</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Harms - Pressure Ulcer Prevention</td>
<td>53</td>
<td>60</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Harms - Slips, Trips and Falls (Patients)</td>
<td>53</td>
<td>60</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>53</td>
<td>60</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Consent</td>
<td>53</td>
<td>60</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Early Warning Systems</td>
<td>53</td>
<td>60</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Emergency Planning</td>
<td>53</td>
<td>60</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention and Control - Clinical</td>
<td>53</td>
<td>60</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Nutritional Care</td>
<td>53</td>
<td>60</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fraud Awareness</td>
<td>52</td>
<td>60</td>
<td>87%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>52</td>
<td>60</td>
<td>87%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Privacy and Dignity</td>
<td>52</td>
<td>60</td>
<td>87%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical Gas Safety</td>
<td>16</td>
<td>19</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>50</td>
<td>60</td>
<td>83%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Working at Barts Health</td>
<td>50</td>
<td>60</td>
<td>83%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Security</td>
<td>48</td>
<td>60</td>
<td>80%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation - Basic Life Support</td>
<td>44</td>
<td>60</td>
<td>73%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical staff exceeded the trust's 85% completion rate target for 19 out of 24 mandatory training modules.

The trust provided a breakdown of compliance for mandatory courses as of the 23 August 2018 for medical staff in medical care (AAU acute medicine wards and acute medicine) as shown below:

Medical (AAU acute medicine wards and acute medicine)
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 Harms - Catheter Acquired Infections</td>
<td>11</td>
<td>11</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Harms - Pressure Ulcer Prevention</td>
<td>11</td>
<td>11</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Harms - Slips, Trips and Falls (Patients)</td>
<td>11</td>
<td>11</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Harms - VTE</td>
<td>11</td>
<td>11</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Clinical Documentation</td>
<td>11</td>
<td>11</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>11</td>
<td>11</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Consent</td>
<td>4</td>
<td>4</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness</td>
<td>11</td>
<td>11</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Early Warning Systems</td>
<td>11</td>
<td>11</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Emergency Planning</td>
<td>4</td>
<td>4</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>11</td>
<td>11</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fraud Awareness</td>
<td>11</td>
<td>11</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety</td>
<td>11</td>
<td>11</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical Gas Safety</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling - Patient Handling Low Risk</td>
<td>11</td>
<td>11</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Nutritional Care</td>
<td>11</td>
<td>11</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Security</td>
<td>4</td>
<td>4</td>
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<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Working at Barts Health</td>
<td>11</td>
<td>11</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Privacy and Dignity</td>
<td>10</td>
<td>11</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>9</td>
<td>11</td>
<td>82%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention and Control - Clinical</td>
<td>9</td>
<td>11</td>
<td>82%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>9</td>
<td>11</td>
<td>82%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation - Basic Life Support</td>
<td>9</td>
<td>11</td>
<td>82%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical staff exceeded the trust’s 85% completion rate target for 20 out of 24 mandatory training modules.
Staff received protected time to complete mandatory training and told us their managers were supportive of this. The nurse education team had a key role in facilitating the completion of mandatory training and worked with all staff groups to maximise the benefit of this. A dedicated education centre was based on site and staff could readily access this for training sessions in addition to self-planned e-learning.

Each ward manager maintained a record of mandatory training and planned for staff to complete refresher courses and ensure they remained up to date. We saw eight examples of this in a sample of wards we inspected.

Fire safety training had recently been extended to include practical training in evacuation equipment and fire extinguishers. The fire safety officer delivered this in small groups to ward teams, who were required to demonstrate competency in using the equipment. As of September 2018, 83% of staff had completed the new practical training.

Safeguarding

The trust set a target of 85% for completion of safeguarding training. Data provided by the trust were split between the AAU acute medicine wards/acute medicine and the other medical specialties and services.

The trust provided a breakdown of compliance for safeguarding courses as of the 4 June 2018 for nursing staff in medical care (cancer services, cardiology, electrophysiology, gastroenterology, dermatology, rheumatology, older people’s services, stroke services, renal, diabetes and respiratory medicine) as shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Level 1</td>
<td>254</td>
<td>256</td>
<td>99%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>248</td>
<td>256</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>244</td>
<td>256</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>142</td>
<td>154</td>
<td>92%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Nursing staff exceeded the trust’s 85% completion rate target for all four safeguarding training modules.

A breakdown of compliance for safeguarding courses as of the 23 August 2018 for nursing staff medical care (AAU acute medicine wards and acute medicine) is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>45</td>
<td>45</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>45</td>
<td>45</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 1</td>
<td>43</td>
<td>45</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Nursing staff exceeded the trust's 85% completion rate target for all four safeguarding training modules.

The trust provided a breakdown of compliance for safeguarding courses as of the 4 June 2018 for medical staff in medical care (cancer services, cardiology, electrophysiology, gastroenterology, dermatology, rheumatology, older people's services, stroke services, renal, diabetes and respiratory medicine) as shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes / No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Level 3</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>58</td>
<td>60</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 1</td>
<td>55</td>
<td>60</td>
<td>92%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>52</td>
<td>60</td>
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<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>37</td>
<td>43</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Medical staff exceeded the trust's 85% completion rate target for all of the five safeguarding training modules.

The trust provided a breakdown of compliance for safeguarding courses as of the 23 August 2018 for medical in medical care (AAU acute medicine wards and acute medicine) as shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes / No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>11</td>
<td>11</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
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<tr>
<td>Safeguarding Children Level 1</td>
<td>11</td>
<td>11</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>11</td>
<td>11</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>10</td>
<td>11</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Medical staff exceeded the trust's 85% completion rate target for all four safeguarding training modules.

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

Safeguarding training was mandatory for all staff based on wards and we spoke with 13 ward managers and senior nurses about this. The teams on Syringa ward, Birch ward and Bracken ward were fully up to date with safeguarding training levels 1 and 2 for relevant staff. The
Completion rate in the AAU was 97%, in Peace ward it was 96% and in B3 ward it was 94%, which reflected persistent short staffing on that ward.

We spoke with an agency nurse working on AAU about their knowledge of safeguarding. They demonstrated a detailed understanding of trust policies and local procedures as well as the principles of safeguarding. We were assured from our conversations that the induction process for temporary staff included an appropriate establishment of safeguarding knowledge.

A safeguarding lead was in post and all staff we spoke with knew how to reach them, including how to make referrals out of hours.

Staff assessed patients for safeguarding risk on admission to a ward if they presented with complex needs or where staff were concerned about issues such as coercion or abuse. Ward teams and the safeguarding and mental health teams arranged for enhanced care in instances where they were concerned about a patient, which included the provision of one-to-one care.

Ward staff worked to established risk thresholds for referring patients to the safeguarding lead. For example, if a patient was admitted with two or more pressure ulcers that were acquired in the community, the ward team would refer them to the safeguarding team in addition to the tissue viability nurse.

The team on Peace ward had developed new practice and understanding as part of the learning outcomes from a safeguarding investigation. This involved allegations against staff that were found to be false and the director of nursing worked with the ward team to identify opportunities to improve their work as a result of the investigation. This resulted in enhanced safeguarding training, planned discussions, one-to-one staff supervisions and structured discussions of safeguarding during appraisals.

A safeguarding lead and three safeguarding coordinators provided a dedicated safeguarding service and an additional member of staff had been recruited. A learning disability clinical nurse specialist and three administrators formed a learning disability team. Both teams worked across all five hospital sites operated by the trust. Staff told us they were accessible and easy to contact despite not always being on site.

The safeguarding lead was reviewing key trust policies in relation to safeguarding practice, the Mental Capacity Act (2005) as it related to safeguarding and staff training and competence. This was part of a strategy to increase the overall skill and knowledge base of staff and ensure they accessed and implemented guidelines in the correct context, in patients’ best interest and in line with their legal duties. This project followed feedback from the local authority safeguarding teams that referrals from wards were not always completed correctly, which caused a delay in the process. The safeguarding lead included contracted staff in the project and was working with the security team to ensure they were trained in safeguarding practice.

The safeguarding team monitored a safety dashboard that tracked referrals and Deprivation of Liberty Safeguards (DoLS) applications. This ensured specialist staff maintained oversight of processes and enabled them to provide support and guidance to staff as needed.

There was a demonstrable focus on ensuring safeguarding was a key focus of every member of staff and of all care delivered in the hospital. This was evident from the highly visible, proactive work of the safeguarding team to increase training and discussions and to update the trust policy in a way that would be useful to staff.

Multidisciplinary care teams considered patient’s safeguarding needs and social vulnerabilities during reviews. We saw from attending multidisciplinary meetings that safeguarding was a key
priority and staff from a range of professional roles considered each patient’s needs in relation to home support, social situation, social isolation risks and family relationships.

The safeguarding lead attended the daily site safety huddle to identify the most immediate needs amongst admitted patients and the areas in which staff needed most support. The safeguarding lead had worked to encourage staff to make more proactive referrals when they were concerned about a patient. They said referrals had significantly increased as a result and they carried out daily visits to each inpatient ward to proactively identify patients for review.

The safeguarding team was reviewing the trust safeguarding policy to ensure it fully complied with the Care Act (2014) and to embed the Royal College of Paediatrics Intercollegiate Document on safeguarding children and young people.

**Cleanliness, infection control and hygiene**

During our inspection staff demonstrated good standards of hand hygiene and adherence to the ‘bare below the elbow’ policy. Staff used brightly coloured ‘I am clean’ stickers to denote when an item of equipment had been cleaned, decontaminated and was ready for use. For example, clinical staff followed handwashing guidelines before and after contact with patients and used antibacterial hand gel when entering clinical areas. Personal protective equipment (PPE) was readily available and staff readily used this. Ward staff arranged for on-demand deep cleans to be carried out whenever a patient with an infection risk was transferred out or discharged. We spoke with a member of the domestic team who carried this out. They demonstrated skills in enhanced infection control and explained that only members of the team with additional training were able to carry out deep cleaning.

A dedicated infection control team provided oversight, benchmarked standards and supported staff across the hospital. A nurse consultant led this team with two nurse practitioners and six nurses. The team carried out an annual whole-site audit of every medical inpatient area to maintain consistent standards and practice. The team had identified 21 cases of avoidable *Clostridium difficile* (C.Diff) in 2018 and carried out multidisciplinary team meetings with ward managers and junior doctors to identify contributing factors. The team identified late sampling and late transfer of patients to side rooms as key factors and worked with ward teams to address them. The team also reviewed two cases of meticillin resistant Staphylococcus aureus (MRSA) and subsequent decolonisation therapy. The team found standards of documentation were consistently good and identified the speed at which antimicrobial treatment was started as a key area of focus.

Ward managers tracked their ward’s performance in the identification of hospital-acquired infections including meticillin-resistant Staphylococcus aureus (MRSA) and *Clostridium difficile* (C.Diff). Hospital-acquired infections were rare. For example, there had been no instances of MRSA on Acacia ward for over two years and no instances of C.Diff for 197 days.

The infection control team identified colonisation of *Escherichia coli* (E.coli) and extended spectrum Beta-Lactamases (ESBLs) as significant risks in the hospital. This was due to the age of the estate and the lack of en-suite facilities in side rooms. To manage and monitor the risk the team followed the NHS Improvement plan for E.coli control, carried out focused audits of catheter care and provided printed information for risk management to patients.

We reviewed the compliance of each inpatient ward with the Department of Health (DH) Health Building Note (HBN) 00-10 in relation to infection control in the built environment. In most areas we found full compliance with effective cleaning processes in place. However, there were balls of dust on high level surfaces on Acacia ward, which presented a risk to patients, particularly those with compromised immune systems or respiratory needs. Cobwebs were visible on lighting on
Peace ward. This was above dispensers for PPE, which presented a risk of contamination. We discussed this with the ward manager who said they would address it with the cleaning team.

Each ward had a dedicated domestic cleaning and housekeeping team that was responsible for completing cleaning and disinfection duties in line with trust risk assessments for each area. Each area included a cleaning schedule and checklist that the team completed to document their work. These were present in all areas we inspected and staff had completed them consistently. Where an area was closed at the weekend, staff had noted this as the reason for not carrying out cleaning duties.

Each inpatient ward had a kitchen for the preparation of meals and snacks for patients. We looked at six kitchens and found each to be visibly clean and tidy with fully completed and up to date cleaning schedules and checklists. Staff had maintained consistent temperature recording for fridges and taken appropriate action when temperatures fell outside of the manufacturer’s safe range.

The age of the building presented specific challenges to staff in managing infection control. Staff noted Acacia ward as a high-risk area due to the environment and a microbiologist carried out a weekly ward round to monitor all patients for infections. To mitigate the risks, the facilities contractor had separated the roles of staff into dedicated cleaning and catering teams. This reduced the risk of cross-infection and the spread of infections. Since the implementation of the segregated roles in March 2017 there had been no infections related to the environment.

Fabric chairs were in use in two clinical areas; the discharge lounge and Peace ward. Fabric chairs present an increased risk of infection as bacteria can grow in them easily and they are difficult to disinfect. The chairs were damaged and stained. The armrest covering on two chairs had split and the internal form was visible and dirty. We spoke with senior staff on both wards about the chairs who said they would be discarded when the wards moved or were refurbished. However, they had not identified this as an infection control risk previously. We saw during our return to the hospital the fabric chairs in the discharge lounge had been removed when it had moved location.

Thirteen patients we spoke with across nine wards and clinical areas made unprompted, positive comments about the cleanliness of the environment. Patients said cleaning staff were visible in the ward and were, “constantly cleaning.”

Staff on Acacia ward had implemented new standards for the cleaning of commodes following learning from past audit results, which meant they cleaned and disinfected commodes within two hours.

The infection control team carried out a monthly audit of hand hygiene practices in each ward to benchmark practice against trust policy and a target of 90% compliance. Between June 2018 and August 2018 wards achieved a 95% compliance rate. This was an overall average and reflected two months on Chestnut ward in which the audit result was 0% and inconsistent scores on Mary ward; which achieved an average of 91%. Ten wards achieved the maximum 100% compliance score for all three months in this audit period, which reflected the standards of practice we observed during our inspection.

Inpatient wards performed consistently well in the annual patient-led assessment of the care environment (PLACE), with an average 99% scored for four consecutive years leading to 2018.
Environment and equipment

We reviewed the compliance of each ward with DH HBN 00-10 in relation to the standard and condition of flooring. Most areas were fully compliant, with curved edges of flooring to allow for cleaning and disinfection. The floor covering in some areas on Curie ward was lifting, which presented a risk for bacteria growth. Most hand wash sinks complied with DH HBN 00-09. However, two sinks on Peace ward were not compliant due to the number of overflow holes fitted, which presented an increased risk of the build-up of bacteria.

Inpatient wards were secured and access was granted by key code or visual identification only and we saw staff proactively checked the identity of each person trying to enter a ward. During our inspection we were challenged in numerous areas for identification when staff did not recognise us or expect our presence.

In most areas staff managed sharps bins in line with the requirements of the Sharps Instruments in Healthcare Regulations 2013 and the Department of Health (DH) Health Technical Memorandum (HTM) 07/01 in relation to the safe management and disposal of healthcare waste. For example, all sharps bins were labelled, signed and dated. However, it was common practice for staff to leave the temporary lid apertures open, which presented a risk to children or people with unauthorised access. We saw several examples of this on Acacia ward. One sharps bin in Peace ward was overfilled with used clinical, hazardous items protruding from the lid in the sluice room. The room had controlled access, which reduced the risk of unauthorised access but the condition of the bin was not in line with safety guidance.

The trust had adopted the use of a safer sharps needle-less system, which was compliant with EU Legislation 2010/32/EU in relation to the prevention of sharps injuries in hospitals. Staff followed this practice during all our observations.

In some areas we found chemical products not stored in line with the Control of Substances Hazardous to Health Regulations (2002). On Acacia ward chlorine tablets were left on a bench in the utility room. Although access to this room was restricted, chemical products should be locked in a cupboard when not being used. We spoke with a member of the ward team about this who addressed it immediately.

The discharge lounge provided two patient areas, one with seats and one with bed spaces. The team maintained seven prepared, dressed beds ready to swap with the beds patients arrived on from the ward. This ensured beds sent back to wards were free from infection risks.

Acacia ward was the designated infectious diseases ward. However, the ward had no negative pressure rooms to carry out high risk infective bronchoscopies. This meant patients who had been admitted for tuberculosis (TB) treatment needed to be transferred to another hospital for some procedures. This resulted in patients who were vulnerable or frail being transferred. The acute assessment unit 2 (AAU2) had two negative pressure side rooms and staff prioritised these for patients with infectious conditions such as TB. The AAU was equipped to care for four patients receiving non-invasive ventilation (NIV) at any given time, with space available to separate female and male patients.

Emergency escape routes from the upper floors of the main hospital building involved using uncovered walkways that connected buildings. Although these areas were usually secured we observed during our inspection it was a regular occurrence for the emergency door release system to be activated. We also observed large quantities of discarded cigarette butts and empty cans of alcoholic drinks littering these areas. This presented a security breach and a fire safety risk if people accessed the areas to smoke. This included immediately outside of the external fire
escape door from Cedar ward. We spoke with a security officer about this who said the team carried out continuous sweeps of the hospital to address unauthorised access or smoking. The security team used an escalation process for people caught smoking and the officer we spoke with said this was effective and taken seriously by the site management team. During our weekend unannounced inspection, we observed the security team carried out continuous patrols of the site.

The fire escape on Faraday ward was cluttered with plywood from previous repairs, which partially blocked the exit and would delay an evacuation. Staff told us they had reported this some time ago but it had not been removed. On Cedar ward we found the external fire doors and escape route were partially blocked by equipment, some of which was plugged into electrical sockets. The fire exit had a sign reminding staff not to store any equipment in this area. Two evacuation sheets and two evacuation mattresses were stored adjacent to the fire exit and were completely blocked by equipment. Staff told us they had nowhere else to store it. Scaffolding had partially obstructed one of the escape routes from Peace ward. The fire safety officer had taken this fire exit out of use but there was no sign in place to note visitors of this. The ward manager told us all staff had been briefed that in an evacuation they could not use that door. However, three nurses we spoke with said they did not think it was out of service and would have used it in an emergency.

Staff in the endoscopy unit said lists were rarely cancelled due to equipment failure. The team prepared additional scoping instruments for each clinic to ensure there was a surplus of equipment to act as a back-up. The last system failure related to the reverse osmosis water purifying system. This was repaired and there were plans for replacement or duplication of the water purifying system. Technicians operated and monitored drying cabinets and there was a contingency plan in place for unexpected failure.

Most inpatient wards consisted of a single large room in ‘nightingale’ style that could accommodate up to 16 patients. To make the best use of space, staff partitioned areas to provide space dedicated for specific treatment or to separate patients by gender in line with national guidance. For example, Elizabeth ward was semi-partitioned midway to create an eight-bed cardiac care unit and a cardiology stepdown ward with 10 telemetry (for monitoring patient’s vital signs) beds. Both sections were nominally separated to provide accommodation by gender.

We spoke with the assistant director of operations, the fire safety advisor and the fire safety officer for the hospital about fire safety and emergency planning on site. The hospital was in the process of a major redevelopment programme that would move wards to new locations and reconfigure some areas. To ensure the safety of the physical environment, the team carried out impact assessments with clinical ward teams before starting a new project. The team provided resources and initiated temporary plans when development work might have an impact on staff. For example, evacuation chairs were installed in the discharge lounge when scaffolding work outside impacted the usual emergency exit route.

A fire response team provided the first response in an emergency or alarm activation. The team included security staff, porters, the estates team and the site manager and they undertook regular training to be able to carry out this enhanced role. The training was comprehensive and included attention to detail, such as the most common deficiencies found in specific types of fire extinguisher.

We reviewed fire risk assessments carried out for 14 inpatient wards between February 2018 and September 2018. The fire risk assessor found significant risks in each ward, including poor staff knowledge of escape routes and challenges presented by the age and design of the building. The assessor found faults with fire doors, emergency lighting and fire alarms. In each case an action plan for improvement was in place, with each action assigned to an accountable person. This
reflected good practice and we were assured on site that senior staff had the skills and resources to continue improving fire safety. However, most action plans had no tracked completion date, which meant it was not possible to confirm progress against specific risks.

Each ward had a resuscitation trolley with a defibrillator, emergency oxygen and masks in a variety of sizes. Staff had documented daily and weekly safety checks on the equipment in each area we inspected, with no gaps in recording in the three months leading to our inspection.

The hospital performed similarly to the national average in the 2018 PLACE score in relation to condition, appearance and maintenance, with a 93% score.

**Assessing and responding to patient risk**

The hospital had introduced an acute response team (ART) to provide care and treatment overnight to patients who deteriorated. The team had five key roles provided by a medical registrar, a medical SHO, an intensive care registrar, an anaesthetic practitioner and an advanced nurse practitioner from the hospital at night team. Four out of five of the team each night held advanced life support (ALS) training and the remaining individual held immediate life support (ILS) as a minimum. In the hospital at night team 100% of nurses had up to date ALS training.

The trust was rolling out specialised recognising and responding to deteriorating patients (REACT) training to nursing staff to help them manager clinical emergencies in wards. Nurses on Nightingale ward spoke highly of this training and said it had already improved their practice.

The hospital used the national early warning scores (NEWS) system or chronic respiratory early warning scores system (CREWS) to identify patients whose condition was deteriorating and alert appropriate staff such as duty doctors and the critical care outreach team. We looked at 13 examples of the NEWS score in four different wards and found staff used clear parameter setting and escalated care appropriately and without delay.

The ward manager on Elizabeth ward had led a programme to integrate NEWS with the ward’s electronic records system for the first time. This improved patient safety as it meant staff could assess their condition alongside live information on test results and diagnostics. The trust had recognised the manager with an award for their contribution to this work.

The senior nurse for the fundamentals of care monitored compliance with NEWS and CREWS on each ward using a monthly audit, which assessed staff against the trust’s 90% standard. From November 2017 to August 2018 there were 43 instances in which data were not submitted. Performance in the months in which data were submitted was highly variable, from 25% compliance in Mary ward in November 2017 to 49 instances of 100% compliance. B3, Syringa and Elizabeth wards met or exceeded the trust’s 90% standard in each month during this period.

Nurses used risk assessment bundles to document patient risk assessments. This included a bed rails assessment, falls risk assessment and a skin care/integrity assessment.

The ambulatory care unit (ACU) had a seated waiting area and patients could be safely accommodated there while receiving intravenous fluids or mobile monitoring equipment. The unit had an escalation policy in the event the waiting area became crowded and standing-room only, which included prioritising patients most in need of medical attention. This was a rare occurrence and the nurse in charge told us it had happened twice in the previous two years. On both occasions the team had used the escalation policy to secure more rapid triaging and review of patients, to identify those most at risk.

The ACU was restricted with space and did not have a resuscitation trolley. The nearest trolley was in the adjacent Forest Assessment Unit, which was directly by accessible staff. The
The resuscitation team had risk assessed this arrangement and found it to be appropriate with no impact on patient safety.

We reviewed the notes of two medical patients who were cared for as outliers on Sycamore ward, an orthopedic trauma ward. Medical consultants had documented regular reviews of each patient, including two reviews on the same day on two occasions.

The multidisciplinary team used weekly meetings and daily board rounds to identify patients who may have been at increased clinical risk due to their location, such as when they were cared for as an outlier. For example, during a meeting on Curie ward the team discussed the needs of a patient under the care of the respiratory team but accommodated on an endocrinology ward. The team ensured additional safeguards were in place and planned the patient’s care to ensure they received continual oversight from the respiratory team.

We looked at the medical notes of six patients who presented with clinical risks, such as with a diabetic ulcer and with dementia. In all cases staff had completed and maintained comprehensive risk assessments in line with trust policy and additionally where required by the patient. This included use of the national five-step ‘SSKIN’ care bundle, a falls risk assessment and visual infusion phlebitis (VIP) review. SSKIN is an acronym that stands for each step of assessment process.

The discharge lounge had criteria for accepting patients to ensure the team could safely provide care and risks to patients were minimised. For example, the team could not accept patients living with dementia or patients with an elevated NEWS score or mental health needs. However, if a patient deteriorated whilst they were in the discharge lounge the team was able to respond to their needs.

During our last inspection in July 2016, we found staff carried out venous thromboembolism (VTE) sporadically and inconsistently. On this inspection, we found practice had improved as staff had documented risk assessments for venous thromboembolism (VTE) in all 19 records we looked at. Nurses we spoke with said they always carried out VTE assessments as part of each patient’s initial care bundle at admission.

The hospital monitored completion of VTE risk assessments through the monthly well-run ward quality and safety assurance audit programme. This included a sample of five patients on each ward and the audit checked whether staff had completed a VTE risk assessment and administered prophylaxis appropriately. The audit results for July 2018 and August 2018 for all inpatient wards indicated practice was consistently in line with trust standards in most areas. During this period staff had completed VTE risk assessments in 91% of cases and administered prophylaxis in 96% of cases. Most wards performed consistently well, although Mary ward demonstrated a deterioration of standards in this period. In July 2018 the audit found 80% of patients had a VTE risk assessment, which decreased to 60% in August 2018. Staff in the AAU improved their performance during this period. In July 2018 0% of patients had a VTE risk assessment in the audit sample, which increased to 100% in August 2018. The administration of prophylaxis improved from 67% to 80% in the same period.

Completion rates for life support training amongst nurses was variable. As of September 2018, 53% of nurses had up to date ILS training and 47% had up to date ALS training. Education supervisors ensured junior doctors maintained a standard of life support training appropriate to their level of responsibility and reviewed this annually.

There were 19 sepsis champions across medical care and 83 members of staff fully trained in sepsis screening. The sepsis lead audited each ward for screening and antibiotic prescribing rates as part of an ongoing programme to embed the national Sepsis 6 standard. Audit results from
October 2017 to July 2018 identified a need to improve use of the Sepsis 6 proforma as staff had completed this fully in only 48% of cases. The audit found the ART carried out 33% of sepsis screens and identified a need for more proactive action from junior doctors, nurses and HCAs. In the same period staff initiated antibiotics following a positive sepsis screen within one hour in only 60% of cases, reflecting highly inconsistent practice. The sepsis lead was working with the practice development nurse to implement more frequent training on sepsis and related use of NEWS.

An emergency therapy team provided services at weekends for patients admitted through the emergency department and for those at risk of deterioration on the frailty pathway. This was an expanding service and medical occupational therapists were undertaking advanced training to be able to join the team.

The hospital had significantly improved consultant recruitment and level of cover since 2016, which had resulted in a 60% reduction in the number of cardiac arrests that took place on inpatient wards in the year to April 2018.

A nurse on Cedar ward had led a project and pilot scheme to improve the use of the situation, background, assessment, recommendation (SBAR) tool used to assess patient status and identify possible deterioration. The nurse, supported by the ward manager, had trialed new ways of using the SBAR tool and identified a method that decreased risk and improved response times. As a result, this was being rolled out across the hospital to all inpatient services.

**Nurse staffing**

Whipps Cross Hospital reported the following nurse staffing numbers for medical care in March and April 2018. The staff fill rate remained the same for both reporting periods.

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</thead>
<tbody>
<tr>
<td>Medical Care</td>
<td>298.8</td>
<td>375.2</td>
<td>79.6%</td>
<td>299.0</td>
<td>375.8</td>
<td>79.5%</td>
</tr>
</tbody>
</table>

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

From May 2017 to April 2018, Whipps Cross Hospital reported a vacancy rate of 22.7% for nursing staff in medical care, this was higher than the trust’s target of 6.3%.

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

The workforce matron played a key role in reducing long-term vacancies and improving daily fill rates. This had increased from 80% in January 2018 to 85% in August 2018 and the matron said the hospital was on track to achieve 94% by January 2019.

From May 2017 to April 2018, Whipps Cross Hospital reported a turnover rate of 13.6% for nursing staff in medical care, this met the trust’s target of 13%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)
From May 2017 to April 2018, Whipps Cross Hospital reported a sickness rate of 3.1% for nursing staff in medical care, this met the trust’s target of 3%.

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

From May 2017 to April 2018 Whipps Cross Hospital had a total of 31,398 nursing staff shifts. The trust provided a breakdown of bank and agency usage and unfilled shifts as shown below:

<table>
<thead>
<tr>
<th>Bank and agency</th>
<th>Number of shifts (% of total shifts)</th>
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</thead>
<tbody>
<tr>
<td>Bank</td>
<td>15,968 (50.9%)</td>
</tr>
<tr>
<td>Agency</td>
<td>6,634 (21.1%)</td>
</tr>
<tr>
<td>Not filled</td>
<td>1,465 (4.7%)</td>
</tr>
</tbody>
</table>

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

Ward managers used a traffic light system to identify staffing issues on each shift. A green shift meant 80% or more of planned shifts were filled and an amber shift meant 80% of required staff were on shift. A red shift meant the fill rate was less than 80% and there were deficiencies in the service as a result. The site team used this system during daily safety huddles and redeployed staff to areas of greatest risk.

Trust nurses spoke highly of agency and bank colleagues. They said use of agency nurses had decreased since July 2018 and were rarely used in most areas. Bank nurses were experienced staff familiar with the trust, policies and the environment.

The figures provided by the trust were for all medical services. We looked at the staffing levels for each ward we included in our inspection including vacancy rates. Acacia ward had a nurse sickness rate of 6.8% and a vacancy rate of 3.3%. Of the shift requests made for bank or agency staff, 98% had been filled.

Nurse staffing levels had improved with higher establishment levels and more reliable fill rates in most areas. For example, the establishment in AAU had increased from 12 nurses to 14 nurses since 2015 and from four healthcare assistants (HCAs) to six. This unit was fully staffed with no vacancies. The acute medicine leadership team had significantly improved nurse recruitment. This resulted in a change from a 50% vacancy rate in January 2018 to a waiting list for new staff to join in September 2018.

A senior nurse coordinator maintained oversight of the endoscopy unit Monday to Friday with a registered nurse and HCA on duty for each of the two clinical areas. In addition to the consultants and registrars in the endoscopy unit, three nurse endoscopists provided a range of treatment including upper gastrointestinal (GI) diagnostics and therapeutics and flexi sigmoidoscopies and colonoscopies. A specialist nurse for inflammatory bowel provided lower GI screening. At weekends the endoscopy service was led by a senior nurse coordinator and their team from an external organisation through a service level agreement.

Two senior nurses, two registered nurses and two HCAs operated the ambulatory care unit (ACU).

Nurse staffing levels on Elizabeth ward, a cardiology ward, were impacted by trust policy that required a qualified nurse to accompany each patient transferred to the trust’s specialist treatment centre. The nurse was required to wait with the patient and return with them. Senior nurses told us transfers took place approximately three times per week and delays with transport meant the
nurse was away from the ward for most of their shift. The ward had a planned daytime establishment of five nurses, which meant it was left short staffed at least three days per week.

Matrons provided the operations team with a daily report of where agency nurses were working. This enabled them to maintain oversight of skill mix and the ratio of trust nurses to agency nurses to ensure this was not disproportionate.

The head of therapies had encountered challenges in recruiting to senior occupational therapist posts and was developing leadership pathways for more junior staff to progress into senior roles. This would reduce senior-level vacancies and create opportunities for new junior therapists joining the hospital and reflected a restructure in the service since our last inspection.

The site team sometimes moved nurses between wards to cover unexpected short-staffing and ensure no single area had an excessive number of temporary staff working at the same time. Nurses told us this was often a positive experience as it offered them the opportunity to work in different medical wards and build more diverse skills. The workforce matron had visited another trust to learn from their programme of nurse redistribution and had identified a number of learning points for the hospital, such as identifying the most appropriate nurses to move on any given shift by assessing their clinical competencies. This was an innovative approach to responsive staffing and was in the process of development. The system ensured nurses would only be moved within their division to maintain safety standards. For example, this meant a medical nurse would not be moved to a surgical ward.

**Medical staffing**

Whipps Cross Hospital reported the following medical staffing numbers for medical care in March and April 2018. The staffing fill rate showed a slight increase from March to April 2018.

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<tbody>
<tr>
<td>Medical Care</td>
<td>95.9</td>
<td>138.7</td>
<td>69.1%</td>
<td>100.7</td>
<td>138.7</td>
<td>72.5%</td>
</tr>
</tbody>
</table>

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

From May 2017 to April 2018, Whipps Cross Hospital reported a vacancy rate of 33.1% for medical staff in medical care, this was higher than the trust’s target of 6.3%.

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

From May 2017 to April 2018, Whipps Cross Hospital reported a turnover rate of 17.1% for medical staff in medical care, this was higher than the trust’s target of 13%.

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

From May 2017 to April 2018, Whipps Cross Hospital reported a sickness rate of 0.4% for medical staff in medical care, this was lower than the trust’s target of 3%.
From May 2017 to April 2018, Whipps Cross Hospital had a total of 12,617 medical staff shifts. The trust provided a breakdown of locum and agency usage and unfilled shifts as shown below:

<table>
<thead>
<tr>
<th>Locum and agency</th>
<th>Number of shifts (% of total shifts)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Locum</td>
<td>8,615 (68.3%)</td>
</tr>
<tr>
<td>Agency</td>
<td>2,153 (17.1%)</td>
</tr>
<tr>
<td>Not filled</td>
<td>310 (2.5%)</td>
</tr>
</tbody>
</table>

In March 2018, the proportion of consultant staff and the proportion of junior (foundation year 1-2) staff reported to be working at the trust was lower than the England average.

Staffing skill mix for the 713 whole time equivalent staff working in medicine at Barts Health NHS Trust

<table>
<thead>
<tr>
<th>Staffing skill mix</th>
<th>This Trust</th>
<th>England average</th>
</tr>
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<tbody>
<tr>
<td>Consultant</td>
<td>41%</td>
<td>43%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>4%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>36%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>19%</td>
<td>22%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

Source: NHS Digital - Workforce Statistics - Medical (March 2018)

A doctor trained in the speciality of general internal medicine or acute internal medicine at level ST3 or above, or a registered healthcare professional with equivalent competences, was immediately available at all times.

Embedded systems were in place for consultant or medical review of patients being cared for as outliers, which meant they were accommodated on a ward not within the appropriate medical specialty. For example, most patients on Acacia ward were under the care of another medical specialty. From looking at six sets of patient records and speaking with the medical team we found patients received timely reviews and ward nurses said they found it easy to contact the doctor on duty for each specialty. A consultant and registrar led the outlier review service and four senior house officers (SHOs) each covered part of the outlier list and part of a named ward.
Medical staffing was planned at a divisional level. For example, the acute medical team covered the clinical decision unit, Forest Assessment Unit (FAU) and the AAU. A consultant and two senior house officers (SHOs) provided care on FAU. An SHO is a post-registration junior doctor.

Consultants in stroke, cardiology and gastroenterology services worked cross-site within the trust.

One medical consultant and one stroke consultant worked Monday to Friday from 9am to 5pm on Peace ward, the dedicated stroke unit. An SHO for stroke was on the ward from 9am to 5pm with an on-call system in place at other teams. For medical patients accommodated on the ward, care was provided by an SHO from 9am to 5pm and by the on-call registrar and foundation level 1 doctor who worked from 5pm to 9am.

The stroke consultant worked on a job share basis, part of which was covered by a locum consultant. Doctors told us any geriatric consultant would attend the ward to review patients but there was a feeling that the service had no robust clinical ownership. One registrar (SpR) was dedicated to the ward, and staff said when they were not available support was lacking. The stroke SHO post involved clinics and on-call duties and was provided by a job share by two long term locums. The ART provided cover at night and staff on the ward said patients often received lower priority than other acutely ill patients in the hospital. An SHO and a consultant based on ward B3 provided dedicated cover for medical outlier patients cared for on Peace ward, which meant patients always had dedicated medical cover.

There was a significant, long-term shortage of geriatricians and the hospital needed 16 WTE consultants to fully meet the demands on the service. The trust was temporarily addressing this through the use of locum consultants and increased working hours of specialist registrars.

Consultant-led ward rounds took place daily Monday to Friday and twice-daily in the AAU. At the weekend consultants reviewed the sickest patients and new admissions.

Two consultants, one of whom was a locum consultant, and six SHOs led care and treatment in the ACU. This unit relied frequently on locum doctors and an established escalation plan was in place to support them, involving the acute assessment unit coordinator and the clinical site manager. Locum doctors were typically long-term and had their own rota to reflect this.

Eight substantive acute medical consultants led care in the AAU and emergency department and led post take ward rounds Monday to Friday from 9am to 5pm. Post take ward rounds reviewed newly admitted acute patients such as those admitted overnight. Outside of these hours consultant cover was provided on a rotational on-call basis. A consultant ward round took place at 9am daily with support from a junior doctor followed by a comprehensive board round at 10am that included a wider team including nurses, therapists and social workers.

Daytime medical cover in urgent care was typically 13 junior doctors and four SpRs, two of whom were locums. Overnight one specialist registrar, four senior house officers and a foundation level doctor covered the AAU. An additional SpR provided on-call support to the medical wards.

Junior doctors who worked in AAU were required to carry out additional administrative and secretarial roles as the unit did not have receptionist support. This meant they spent time on non-clinical tasks that delayed their main responsibilities in patient care.

A consultant led care in the ACU Monday to Friday from 9am to 5pm, with a specialist registrar and up to three senior house officers provided care from 9am to 8pm. At weekends a specialist registrar led care from 9am to 6pm and was supported by four other doctors.

A consultant, four specialist registrars (SpRs) and two foundation year two (FY2) doctors led the respiratory service. The consultant led ward rounds twice weekly with additional reviews for new or
deteriorating patients. Staff on Faraday ward, a respiratory ward, said medical cover was insufficient for the acuity of patients and delays to discharge letters and to take-away (TTA) medicines often meant discharges were delayed.

Seven consultant cardiologists led treatment on cardiology wards on a weekly rotation system. The daytime established medical cover included two SpRs and two SHOs but at the time of our inspection one SpR post was vacant and one SHO was reallocated to duties elsewhere on a daily basis. Four FY1s provided additional support. There was limited cardiology medical cover overnight and at weekends. An SHO and two FY1s provided out of hours care and doctors told us they were also expected to support the on-call doctors on the wards, which reduced the attention they could provide to cardiology patients. Consultant cardiologists provided cover by phone from the trust’s other sites, which meant staff needed to transfer patients in the event of a cardiology deterioration. Although cardiologists were involved in the off-site on-call rota, they were not involved in the main on-call rota historically due to low acuity of patients and specialist cover at the trust’s other sites. The trust had a clear escalation procedure if a cardiology patient became unwell out of hours which staff understood well. During our unannounced weekend inspection of medical care services, we spoke with doctors about these arrangements. Whilst it did not reflect the most ideal level of medical cover they did not believe it impacted patient safety and said the escalation plans worked well.

Locum doctors were required to complete a local induction checklist, which included a briefing on referral and escalation procedures and expected standards of care. Senior clinicians maintained oversight of this through the trust corporate induction policy and clinical specialties established local induction requirements in addition.

A guardian of safer working monitored the safety of doctors’ working hours and reviewed exception reports, which junior doctors submitted when they had worked excessive or unsafe hours. Between November 2017 and January 2018 56 exception reports were submitted by junior doctors although 38% were submitted by a single doctor. The guardian reviewed each report and identified areas for improvement in support and flexibility and led work schedule reviews. The trust also appointed a dedicated champion for flexible working who carried out bi-annual surveys and ongoing engagement with junior doctors.

**Records**

The organisation was in different stages of implementing electronic patient records. For example, in the AAU staff used paper records for admission notes and prescription charts. Ward round data, discharge and outpatient letters were managed electronically. Endocrinology and older peoples services staff used paper records and cardiology and respiratory teams used electronic records.

Elizabeth ward was the first in the hospital to introduce a fully electronic patient records system as part of a staged roll-out to identify teething problems or unplanned issues.

Medical care services participated in a trust-wide audit of patient records as part of an information governance review in 2017. The audit included 168 records submitted from nine specialties, with 19% submitted from respiratory medicine, 16% from gastroenterology/hepatology and 14% from stroke. The audit included a mix of electronic and paper records and 63% of the audit was based on combined electronic and paper records. The audit included four broad categories for measuring standards of practice; patient information, clerking and preadmission, prescription chart and first entry/post clerking.

The clinical effectiveness unit project lead analysed the results and identified similar results to the previous year with no significant improvements and a need to improve the use of electronic
records. However, there were some areas of improvement. The audit had found an improvement on the documentation of safety alerts, from 68% to 86% although this was still below the trust’s standard of 100%. The audit found consistent standards of recording patient’s personal information, including 99% that included their NHS number, name, date of birth and gender. Staff had recorded patients’ GP details in 98% of cases and recording of next of kin dropped from 88% to 79%. The standard of entries was also good, with 99% of entries timed and dated, 100% contemporaneous with a patient identifier and 97% writing in plain English. This related to medical entries from the first doctor review after clerking; there was a need for improvement in these standards during the preadmission period, where only 68% of paper note additions included the patient name and 67% included the patient identifier. During both the preadmission and first entry stages clinicians did not consistently record their grade or designation, with completion at 74% and 79% respectively.

We looked at 19 patient records during our inspection and found doctors completed these in line with General Medical Council good practice standards. This included legible entries made by doctors or other health professionals who noted their name, grade or designation and the time and date of the entry.

**Medicines**

Medicines were stored securely and disposed of appropriately, except for controlled drugs (CD) storage. The CD cabinet on Acacia ward did not comply with The Misuse of Drugs (Safe Custody) Regulations (1973), as the cabinet was made out of wood and not metal. On Conifer ward CDs were over stocked. There were items which were not on the CD stock list as well as items that were for people who had been discharged from the ward. The CDs had not been returned to pharmacy to be destroyed.

Medicines and equipment for use in emergencies were readily accessible to staff and were checked regularly, and tamper evident seals were in use to ensure medicines were secure in accordance with guidance (UKRC). The trust had implemented a system that provided assurance that blood glucose testing kits were calibrated before use.

Staff on Acacia ward did not maintain records of the medicines nurses had dispensed to the ward, or to whom, as pre-labelled medicines to take away on discharge (TTAs). On Conifer ward, nurses recorded TTA medicines they dispensed on discharge in a recording book. They included who dispensed the medicine, who it was witnessed by, the date of dispensing, who it was dispensed to and drug name, strength and formulation. On both Acacia and Conifer wards there were no records of what named staff could dispense TTAs or records of competency assessments were completed. We checked a sample of 10 drug charts on Acacia and Conifer wards. Staff had fully completed them and there were no gaps or errors. Staff had recorded the allergy status of each patient in their electronic records and drug charts. Staff routinely recorded venous thromboembolism (VTE) risk assessment outcomes on the electronic records and drug charts. We saw that the pharmacy team carried out regular audits on the management of medicines and CDs to ensure improvements were being made where necessary. Staff took appropriate action to implement any learning outcomes from audits.

Arrangements were in place for patients to self-administer their own medicines. Patients own medicines were kept in trolleys as the bedside cabinets were not suitable to store medicines. people could ask nurses for the medicines as and when they needed them.
Staff could access medicines supplies and advice throughout the day and out of hours. Ward pharmacists conducted medicines reconciliation, discharge prescriptions and handled any medicines related concerns. Medicines reconciliation is the process of identifying an accurate list of a person's current medicines and comparing it with the current list in use. Nurses were authorised to dispense TTA medicines, which reduced the time people had to wait to be discharged. However, not all wards kept records of what medicines were being dispensed by the nurses on the wards and to who. Staff could not assure that all the medicines dispensed were accurate as there were no records.

Staff in each ward maintained a record of daily temperature checks, both for ambient medicine storage and refrigerated storage and took corrective action when temperatures exceeded the manufacturer’s guide limits. Where integrated digital fridge thermometers failed, staff reported this to the facilities team and used manual thermometers instead. Staff on each ward had an established stock rotation system and we found consistent safe storage, including locked cupboards and restricted access.

An audit lead found the standard of documentation relating to prescribing and medicines was variable in a 2017 audit. There was a prescription chart present in the notes in 94% of cases and of these 100% included the patient identifier, 99% included legible medication entries and 97% of medicine had been signed off as per trust standards. The key area for improvement related to the deletion of discontinued medicines, which was at 52% and represented a deterioration of standards from the previous result of 65%.

The pharmacy team carried out quarterly audits of medicines management and the management of CDs. In August 2018 compliance with trust policy on medicines management was 94%. This was an average and reflected a range from 71% on B3 ward to 100% achieved by Birch, Bracken, Nightingale and Faraday. The pharmacy team discussed areas for improvement with the ward manager and would ensure these areas were checked in the next audit. The most common area of non-compliance was the storage of expired medicines, which the audit identified was the responsibility of the pharmacy team to collect and destroy. The most recent CD audit related to quarter one of 2018/19 and demonstrated a significant improvement on previous audits, with 83% of wards rated good or outstanding. All wards were fully compliant with CD safety processes including the use of locked cupboards. The standard of documentation in the CD register was the most frequent area for improvement and the pharmacy team reminded staff trained to administer CDs not to cross out or later entries and to properly document the transfer of medicines.

An antimicrobial pharmacist led an antimicrobial stewardship programme based on the guidance of the UK Five Year Antimicrobial Resistance Strategy and assessed practice using four key performance indicators (KPIs). Results in 2018 showed no improvement overall from 2016, with a 1% reduction in compliance to 83% although compliance with documentation standards improved by 7%, to 96%. The results were similar to national averages and there were differences between specialties. For example, cardiology was the only specialty to score 100% for all KPIs in the 2018 audit. The pharmacist leading the audit identified a need for updated policies and the implementation of a consultant-led ‘champion’ role to improve practice amongst medical staff.

A named pharmacist and pharmacy technician were dedicated to each ward and supported staff with all aspects of medicines management. This team provided specific support to prepare to take-away medicines (TTAs) as part of advance discharge planning and reduce delays. We saw from multidisciplinary meetings the pharmacy team were proactive in acting on prescriber’s instructions and anticipating patient needs. An antimicrobial pharmacy specialist was assigned to Acacia ward and worked with the microbiology consultant to provide coordinated treatment to patients with an infectious disease.
A practice development nurse had worked with the AAU pharmacy team to develop a new drug chart. They considered the most common errors made by staff when completing the existing documentation and redesigned the format and drug calculation tests to address these issues.

New international nurses completed a structured medicine competency process to ensure they had the knowledge and skills to work safely with medicines management. The process included completion of competency training followed by five supervised drug rounds and five supervised TTA drug rounds before they were certified to practice alone. Following the successful completion of this process, nurses attended an intravenous drug study day.

**Incidents**

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

From August 2017 to July 2018, the trust reported one incident classified as never events for medical care at Whipps Cross Hospital: sub-optimal care of the deteriorating patient meeting serious incident (SI) criteria. A patient on AAU deteriorated, the ART team were asked to attend because the patient remained hypoxic on 15 litres of oxygen. On arrival to AAU they discovered that the patient was connected to air and not oxygen.

(Source: NHS Improvement - OBIEE NRLS STEIS)

In accordance with the Serious Incident Framework 2015, the trust reported 25 SIs in medical care which met the reporting criteria set by NHS England from August 2017 to July 2018.

The types of incident reported were:

- Sub-optimal care of the deteriorating patient meeting SI criteria: seven incidents
- Abuse/alleged abuse of adult patient by staff: five incidents
- Unauthorised absence meeting SI criteria: five incidents
- Medication incident meeting SI criteria: two incidents
- Surgical/invasive procedure incident meeting SI criteria: two incidents
- Adverse media coverage or public concern about the organisation or the wider NHS: one incident
- Confidential information leak/information governance breach meeting SI criteria: one incident
- HCAI/Infection control incident meeting SI criteria: one incident
- Slips/trips/falls meeting SI criteria: one incident

(Source: NHS Improvement - OBIEE NRLS STEIS)

We looked at the investigations and outcomes of the never event, four SIs and three additional root cause analyses that occurred between August 2017 and April 2018. In each case a multidisciplinary team of clinicians, patient safety staff and governance staff were involved in the investigation. In each case the investigation identified a series of events that contributed to the SI and a failure to follow trust procedure or protocol. For example, one SI related to a treatment delay that resulted in a patient not receiving pain relief despite suffering a fracture. The investigation found a specialist nurse failed to document reviews, staff did not correctly use a pain assessment
tool and did not prescribe as-needed (PRN) medicine. Key learning from this incident highlighted a need for better understanding of patient needs when they have reduced cognition. In each case the trust reported the SI and its outcome to the national reporting and learning service (NRLS) to facilitate shared learning. Outcomes were discussed between teams and across the trust’s sites to facilitate shared learning, including through case studies with band seven nurses and ward managers. Although an action plan was implemented for each of the outcomes, there was a lack of assurance these were followed through. For example, one SI related to the sub-optimal care of a deteriorating patient and found poor compliance with the NEWS policy and with the do not resuscitate (DNAR) policy. The action plan contained six points for completion by April 2018. However, in October 2018 four of the actions had not been signed off, including a review of the training needs of the staff involved in the SI.

There was evidence of learning from incidents regarding safeguarding procedures and understanding. This led to improved processes to assess mental capacity on Peace ward and improved safe discharge processes for patients living with dementia. The safeguarding lead carried out spot checks of staff practice to ensure they used accurate identification tools, such as positively identifying patients using wristbands. The safeguarding lead also attended team meetings to discuss outcomes and to identify training needs.

Most staff told us they felt the incident reporting culture was positive and resulted in improved practice and positive change. In each ward staff said they discussed feedback and learning outcomes from previous incidents in team meetings and handovers. They said these discussions included incidents relevant to them that had happened in other clinical areas. For example, staff on Faraday ward described the never event on another unit in which a patient had received piped air instead of piped oxygen. As part of the incident outcomes the ward decommissioned piped air valves so that the same issue could not happen again. However, some staff said repeated incident reports had not resulted in improved practice. For example, staff on Elizabeth ward had submitted incident reports when the unit had been left short-staffed. Staff said they had submitted suggestions to address the situation with incident reports but had received no feedback.

An incident had occurred when staff declared a major incident for a suspected fire and began to evacuate patients. The fire operational group carried out a risk analysis of the incident that included speaking with clinical staff involved in the evacuation. The results showed staff performed well and in line with their training and areas for improvement were faster communication from the trust command and smoother coordination at ward level.

Staff were encouraged to take ownership of improvement projects following incidents. For example, a senior nurse on Elizabeth ward had implemented a falls reduction programme following two incidents in which a patient had suffered a fracture and another serious bleeding. Since they introduced the programme in 2016, there had been three falls in total with no harm to patients.

One HCA on the AAU told us they did not know how to report an incident or why they would ever need to report one. This was an exception to our findings with other staff and we discussed it with the divisional team, who said they would address it immediately. HCAs across the trust had access to the incident-reporting system and training in its use.

The team on Peace ward had introduced new admission criteria for medical outliers following a series of incidents and complaints relating to patients with complex neurological conditions. The new criteria meant the ward would accept older peoples’ services medical outliers only, which reduced the incidents and complaints received. This was a planned approach to reducing risk and meant where patients were admitted to a ward as an outlier, this was to an appropriate area.
Safety thermometer

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

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

Data from the Patient Safety Thermometer showed that the trust reported 70 new hospital-acquired pressure ulcers (HAPUs), 37 falls with harm and 30 new urinary tract infections in patients with a catheter from June 2017 to June 2018 for medical services.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Barts Health NHS Trust**

1. **Total Pressure ulcers**
   - (70)

2. **Total Falls**
   - (37)

3. **Total CUTIs**
   - (30)

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

   (Source: NHS Digital - Safety Thermometer)

Each ward team displayed details of their safety performance, including the NHS Safety Thermometer, at the entrance. This included details of performance over time in staffing levels, falls, pressure ulcers and infections. Acacia ward displayed 491 days since the last avoidable hospital-acquired pressure ulcer and 483 days since the last unavoidable HAPU. This ward also
demonstrated a three-month period of 100% compliance with hand hygiene and five other safety scores, including with intravenous cannula insertion and completion of the VIP score. FAU reported 12 months without a HAPU, which was a significant track record as patients cared for on the unit were typically frail and there was a high turnover of patients.

Staff on Acacia ward had introduced a falls alarm system in response to a period of increased falls. This had resulted in a significant reduction in falls, with none reported in the seven days prior to our inspection. Ward teams had introduced visual prompts for patients to encourage them to call for help rather than risk a fall. Staff on Acacia ward said this was important as they found patients had previously fallen because they did not want to interrupt staff who appeared to be busy.

Staff from multidisciplinary teams contributed to a monthly harm free panel that reviewed incidents, NHS Safety Thermometer data and patient outcomes. This included reviews of root cause analyses led by the fundamentals of care team.

Ward teams discussed monthly safety monitoring results during team meetings as part of a standing agenda to track performance. Where performance fell short or was inconsistent, there was documented evidence of the action staff took to address this.

Is the service effective?

Evidence-based care and treatment

Care and treatment in all areas was based on trust and national best practice guidance and standards. All the staff we spoke with were aware of the professional and collegiate standards relating to their specialty. All services were active in audits and benchmarking against local and national standards. We looked at a sample of six audit processes, initial findings and resulting actions. In each case specialty teams and ward teams worked together to assess standards of patient care, acknowledge areas of good practice and implement action plans for improvement. As part of the strategy to benchmark care and treatment outcomes, the hospital participated in 13 national audits in 2017/18 and planned to contribute to 21 national audits.

The division used a monthly clinical effectiveness update to ensure new or updated guidance issued by the National Institute of Health and Care Excellence (NICE) was acted on in trust policies and practice. The updated identified the clinical area(s) affected by the guidance updates and when this would come into place. Governance staff used this data to identify levels of compliance with NICE guidance, including the completion of risk assessments for recent changes. In July 2018 overall compliance was 84%, which reflected a range from 50% in endocrinology to 100% in infection and immunology, rheumatology and stroke services.

The endoscopy team used a modified surgical safety checklist based on the World Health Organisation standard and in line with NHS Institute for Innovation and Improvement safety recommendations. The team carried out a monthly benchmark standard through an observation of 30 – 50 procedures per month measuring six standards: team brief, sign in, time out, sign out, documentation and de-brief. We looked at the audit results from September 2017 to August 2018 and found consistently high standards of practice. The team audited 574 procedures in this period, with 100% compliance in all six measures.

Clinical staff raised intranet access and usability as a key challenge in accessing policies. For example, doctors told us the user interface meant they could not search for documents or policies
by name, which meant the system was time-consuming to use. Doctors we spoke with were not aware of any trust provision to improve the intranet and were working on setting up their own access folders with policies specific to their practice in one place.

The endoscopy unit gained accreditation by the Joint Advisory Group (JAG) in May 2018, which indicated the service had been benchmarked against national standards. This reflected a significant improvement in standards since the group’s initial inspection of the service in May 2017 and found the team had addressed all areas in need of attention.

The end of life care (EoLC) team provided links to national and trust guidance on the intranet and worked with clinical staff to ensure they knew how to access them. This included guidelines for managing diabetes at the end of life, national prescribing guidance for syringe drivers and opiate conversion charts. The team was available on-site Monday to Friday and provided resources for staff in following the national five priorities for care of the dying adult and the NICE quality standard QS144 care of dying adults in the last days of life.

Practice development nurses (PDNs), as part of the nurse education team, held a key role in ensuring staff were aware of changes to national guidance or best practice standards. For example, the team had arranged training to introduce new confusion scoring criteria to staff that included practical sessions and group discussions.

As part of a programme of training to introduce the NEWS2 (national early warning scores) system, the education team introduced criteria for staff to help them assess in line with national standards and targets, such as for respiratory assessments and the escalation process for sepsis. The team had also introduced a new policy for the use of hi-flow oxygen therapy and initially piloted these with nurses on Faraday and Nightingale wards.

Allied health professionals (AHPs) maintained a specialty clinical audit programme on a rolling annual basis. The programme included a wide range of 57 national audits, local audits, activities to gather patient feedback and audits to benchmark care against NICE or British Thoracic Society (BTS) standards. Examples of work included a review of exercise classes led by physiotherapists and occupational therapists; a service evaluation led by dieticians and an evaluation of standard operating procedures for speech and language therapy (SaLT).

Therapies staff who provided weekend services use the international single generic assessment test to identify immediate physiotherapy needs and to issue equipment prescriptions. This enabled equipment needs to be identified early to facilitate faster discharge.

Clinical staff had introduced the falls rapid accelerator programme (FRAP) as a Royal College of Physicians (RCP) evidence-based benchmarking tool to audit patterns of falls on wards and reduce these. The hospital introduced FRAP in early 2017 and there was no data available for 2018 at the time of our inspection but initial data demonstrated a significant improvement in practice at ward level in 2017 compared with falls data in 2015.

**Nutrition and hydration**

Each ward had a nutrition and hydration board on display in the kitchen with detailed information for each patient. This included whether staff should support patients using the red tray scheme, which helped to identify individuals in need of extra help at mealtimes. Staff used the board to identify patients who needed energy-dense snacks or extra drinks. Wards displayed their track record of performance in audits of the malnutrition universal scoring tool (MUST). Acacia ward had a 94% compliance rate between June 2018 and August 2018, which reflected a steady improvement from 84% in June 2018 to 98% in July 2018 and 100% in August 2018.
Nurses completed a MUST risk assessment for each patient on admission. These were fully completed and up to date in all 19 records we looked at. A nurse or healthcare assistant (HCA) on each ward acted as a nutrition champion and ensured their colleagues adhered to hospital standards and facilitated access to individualised diet planning for patients. The team on Peace ward had completed a project from January 2018 to July 2018 to improve the use of MUST, which resulted from 51% compliance in January 2018 to three consecutive months of 100% compliance from July 2018.

The catering service on each ward was comprehensive and reflected a significant improvement from our previous inspection in 2016. This included 24-hour access to hot and cold snacks and meals to meet different nutritional requirements, continual access to fresh fruit, cutlery adapted for patients with sensory impairment or a loss of dexterity, a finger food menu, 16 cultural or religion-specific menus and menus printed in the five most common languages spoken locally after English.

All 23 of the patients we asked said their nutrition and hydration needs had been met. They felt staff provided a good range of meals and snacks and said they had never been left thirsty. One patient on Bracken ward said, “There’s a terrific choice of food. I’ve never had a bad meal and it really doesn’t taste like ‘hospital food’.” Patients on Cedar ward showed us the menu they had to choose from for lunch and dinner and said there was always a wide choice with several options they liked.

The SaLT team used signs at each bed space to identify specific dietary needs. Both SaLT and dieticians were available on demand to review patients and contribute to care planning.

A clinical lead dietician and a team of 11 dieticians of varying seniority bands provided the dietetics service. Dieticians provided dedicated cover for older people’s services, oncology and stroke and for patients in other services on demand.

The head of therapies, deputy head of therapy and professional lead for SaLT led a team of eight therapists, including SaLTs dedicated to acute stroke, acute medical inpatients and rehabilitation.

Scores for the quality of ward food in the annual patient-led assessment of the care environment (PLACE) had steadily improved in the previous four years, from 87% in 2014 to 95% in 2018. This was better than the national average of 90%.

**Pain relief**

A consultant led the pain management team with the palliative care team, who carried out daily reviews of each patient known to the service. The team had vacancies for two consultants and as a result were not able to meet patient demand. The team provided an acute and chronic review services Monday to Friday from 8am to 4pm.

The specialist pain team had carried out a one-day snap shot exercise of how patients experienced pain in the hospital. The team randomly selected 100 patients who were known to suffer from end of life, acute or chronic pain. The study focused on nursing documentation, including the completion of formal pain assessments, self-reporting, delivery of analgesia and patient satisfaction. Overall 78% of patients who had experienced pain in the previous 24 hours said they were satisfied or extremely satisfied with how staff had managed their pain. Of the remaining patients, 7% said they were dissatisfied. However, for patients with clinically significant pain (CSP), 66% said they were satisfied or extremely satisfied with pain management and 30% said they were dissatisfied.

Standards of documentation were good and 100% of patients had a formal pain assessment with appropriate frequency of review. Engagement with patients was variable and 67% of patients said...
staff had not asked them about pain in the previous 24 hours. However, 100% of patients who has asked staff for pain relief received this. The pain team concluded that staff underreported CSP and implemented a series of recommendations based on Royal College of Anaesthetists (2015) (RCoA) best practice in acute pain management. This included adherence to a 30-minute window for treating significant pain, increased educational opportunities for staff and a target of 95% completion of formal training. The exercise also highlighted that the trust did not mandate pain management training and there were gaps in access to RCoA guidance.

The end of life care (EoLC) team provided dedicated training sessions on the management of acute and chronic pain, including in the prescribing of opioids. Oncology senior house officers (SHOs) and haematology doctors provided key support for staff across the hospital in these areas of care.

The pain management team had increased annual study days to improve the knowledge and practice of ward-based staff but said this was still insufficient. To address the needs of patients the team was exploring opportunities to cross-train EoLC champions as pain champions, who would take responsibility for monitoring the quality of pain assessment.

The pain management team had introduced a number of service improvements that improved the quality of care and provided treatment options with fewer side effects than traditional treatments. The pain team planned to introduce the numerical rating scale for CSP management as part of the roll-out of NEWS2.

**Patient outcomes**

From March 2017 to February 2018, patients at Whipps Cross University Hospital had a higher than expected risk of readmission for elective admissions and a higher than expected risk of readmission for non-elective admissions when compared to the England average.

**Elective admissions**

- Patients in gastroenterology, cardiology and pain management had a higher than expected risk of readmission for elective admissions

**Non-elective admissions**

- Patients in general medicine, geriatric medicine and rheumatology had a higher than expected risk of readmission for non-elective admissions

**Elective Admissions - Whipps Cross University Hospital**

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.
The trust participated in the 2017 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 78.2%, which did not meet the audit aspirational standard of 90%. The 2016 figure was 72.3%.

In the 2017 audit, the proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 23.4%. This was good practice. The 2016 figure was significantly better than the national level.

In the 2017 audit, the proportion of fit patients with advanced (NSCLC) receiving Systemic Anti-Cancer Treatment was 81.3%. This was good practice. The 2016 figure was not significantly different than the national level.

In the 2017 audit, the proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 74.9%. This was within the expected range. The 2016 figure was not significantly different to the national level.

The one-year relative survival rate for the trust in 2017 was within expected range at 40%. The 2016 figure was not significantly different to the national level.

(Source: National Lung Cancer Audit)

The crude proportion of patients who had a vision assessment (if applicable) was 29%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 12%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 41%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients with mobility aid in reach (if applicable) was 71%. This did not meet the national aspirational standard of 100%.

(Source: Royal College of Physicians)

The hospital participated in the Sentinel Stroke National Audit Programme (SSNAP). From December 2017 to June 2018 the hospital maintained the maximum SSNAP level A, which reflected consistent performance that met or exceeded key indicators. Patient-centred key indicator results identified a need for improvements in care in the stroke unit and in multidisciplinary working as both areas achieved level C or below from April 2017 to June 2018.
The stroke management team had established an action plan to address these areas and there was evidence of continuous progress from June 2018 onwards, including the establishment of substantive relationships with trust psychiatrists and community GPs.

From September 2016 to February 2018, a diabetes project team led a re-audit of the National Diabetes Inpatient Audit. Assessing care against five key domains, the team found limited evidence of compliance in each, with a need for significant improvements to achieve at least 85% of care standards. The project team identified a series of recommendations and an action plan to improve standards although this noted on-going lack of staff resources would limit progress. Improvements included more robust education for junior doctors and nurses, more consistent involvement of patients in their care planning and routine patient foot examinations by doctors.

The hospital participated in the Royal College of Psychiatrists’ National Audit of Dementia Round 3 (NADR3) in 2017. The dementia and delirium team played a key role in this multidisciplinary audit, which resulted in 26 actions to improve care and treatment for patients. There was evidence of significant progress against the actions, including the reintroduction of finger food for patients and improved engagement from specialties in the monthly dementia strategy meeting.

Between May 2017 and March 2018, senior staff in OPS services led a re-audit of the National Audit of Inpatient Falls. The audit highlighted four actions for improvement, which the project team implemented. Actions included improved training for ward staff on falls prevention, more consistent rates of taking lying and standing blood pressure measurements and improvements in pharmacological intervention for the prevention of falls. The falls working group maintained oversight of the progress of action plans.

The 2017 medical care records audit indicated consistent practice. Of the 152 cases analysed, clinicians had documented the patient’s presenting problem, treatment objective and provisional diagnosis in 99% of cases.

Consultants led a review of each patient’s discharge plan once they had been in the hospital for seven days. This included reviewing the existing plan to identify opportunities to reduce delays and promote a safe, effective discharge. Clinical leads told us improved relationships with community services and governance systems meant delayed discharges were becoming less common.

We reviewed processes and spoke with staff on Sycamore ward, which was a surgical ward that regularly accepted medical patients as outliers. Patients were admitted to the ward with a consultant-specified management plan and the site manager maintained an up to date record of patients cared for as outliers. Consultants and junior doctors reviewed patients daily Monday to Friday and ward nurses contacted the on-call medical team for further review at weekends if needed. Specialist nurses, such as the acute response respiratory nurse, reviewed outlier patients on request. Although this system meant staff facilitated good patient outcomes for medical patients, Sycamore ward was designated for specialist orthopaedic trauma and staff told us the volume of medical patients interfered with care for surgical patients.

The EoLC team supported staff to coordinate rapid and complex discharges to help achieve patients’ preferred place of care. A rapid discharge policy was in place and the team had delivered training to junior doctors on leading discharges, which involved liaising with local community services provided by another NHS trust and the British Red Cross.

Staff on Peace ward said the current complement of two whole time equivalent (WTE) physiotherapists and one WTE occupational therapist was not enough to give sufficient therapy for the number of patients with complex needs, including those with physical disabilities. In addition, speech and language therapy cover was the equivalent of 0.5WTE and wards staff said this
needed to be doubled to meet demand. Nurses were trained to carry out physical exercise and swallowing assessments for patients at the weekend as there was no therapist cover available. However, the workload of nurses meant they were limited in capacity to carry this out in addition to their own duties. During our weekend unannounced inspection, we saw physiotherapists and occupational therapists provided cover in other medical areas and would provide urgent reviews or interventions on request on Peace ward.

Mary ward had recently reopened as a dedicated transition unit as part of the frailty pathway. Patients were initially cared for in Forest Assessment Unit (FAU) and then transferred to Mary ward. We looked at two care plans for patients on Mary ward. Both contained an activities of daily living section with information on nutrition and hydration, personal hygiene, elimination, pain and comfort, communication, spirituality and safe environment. However, both documents were blank and there was no evidence of the patients’ or their relatives’ involvement in care planning.

The nurse in charge said that as they were moving towards being paperless, the relevant information might be stored on the computer. However, they were not able to access the system that morning and they were unable to evidence any additional information that confirmed relatives’ involvement and or personalised information about patients.

The medical care PDN had worked with critical care outreach colleagues to develop new daily care records for nurses. The new records helped nurses to improve monitoring of patients who used hi-flow oxygen and the education team had secured training from the equipment manufacturer. Four admission avoidance nurses worked between FAU and the emergency department (ED). This team was trained in acute care and worked with medical colleagues to identify alternative opportunities for care in the community or at home. This team had established links with allied health professional therapists, community healthcare teams and social workers to prepare comprehensive care plans for patients and avoid an unnecessary inpatient hospital admission.

Clinical staff used the trust’s changing lives guidance to monitor and treat patients for delirium and ensure the best possible outcome. This included acting on changes in alertness and acute condition and specific pharmacological management.

The hospital participated in the national PJ Paralysis campaign, which aimed to improve patient outcomes by ensuring each individual developed a daily routine that involved getting out of bed, getting dressed and being more active. Staff understood the evidence underlying the campaign and used this to encourage patients to adopt a healthier daily routine, which contributed to better wellbeing and faster recovery. Staff from each ward presented the number of people out of bed and in daytime clothes during weekday safety huddles, which helped the senior team to maintain oversight of adherence to the scheme.

Clinical areas operated a ‘red to green’ tracking system to identify when staff had completed clinical checklists and patient care and treatment plans were up to date. The senior site team maintained oversight of this through daily safety huddles and redistributed staff resources to meet patient needs.

The Gillian Revell Therapy Unit provided a dedicated therapy rehabilitation service to inpatients being cared for on stroke pathways and those in older people’s services. The unit included a therapy gym and kitchen and a weekly programme of social rehabilitation activities that contributed to building patient’s independence and physical ability. Groups included exercise sessions, a music and movement group and a cognition activity group.

The tissue viability team was acting on audit results that demonstrated staff turned patients at risk of pressure sores regularly but this did not always result in effective relief of pressure areas.
reduce the risk and severity of pressure sores, the team was working one-to-one with nurses and HCAs on each ward to direct their practice. The team delivered training in more effective practice to 203 nurses and HCAs in 2017/18.

The discharge lounge team audited the amount of time patients spent with them before leaving the hospital. From April 2018 to September 2018, 1262 patients were cared for in the discharge lounge, of which 42% spent 30 minutes or less in the unit. Of the remaining group, 34% spent between 30 minutes and one hour in the unit, 6% between 61 minutes and 90 minutes, 13% between 91 minutes and two hours and 6% over two hours. The discharge lounge team demonstrated understanding of the need for well-coordinated and prompt discharge and worked with the transport service and colleagues across the hospital to facilitate this.

Consultants reviewed patients at least once every 24 hours when they were transferred from an acute area of the hospital to a general ward where this was clinically necessary.

Competent staff

Whipps Cross Hospital did not provide a core service breakdown for staff within medical care, therefore completion rates for appraisals were not available for this service.

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

Although the trust did not provide us with overall data on appraisal completion, we asked a sample of six ward managers for their local figures. In each case they demonstrated that all staff had undergone an appraisal within the previous 12 months or had one scheduled within a 12-month period.

We asked the trust to supply an anonymised sample of staff appraisals so that we could review their effectiveness and completeness against trust standards. However, the trust did not supply these. We asked staff in a cross-section of grades and roles about appraisals and supervision. In most cases we received positive feedback and staff felt they were well structured with clear support and goals for development. It was evident ward managers had close working relationships with their teams and it was part of the working culture for staff to support each other in workplace challenges and in identifying opportunities for progression. For example, the ward manager on Acacia ward encouraged their team to use appraisals to share ideas for service improvement or development. They then shared ideas with the whole ward team, who discussed the benefits and potential challenges. The ward manager was enthusiastic in implementing staff-led initiatives and required them to have the backing of the majority of their ward colleagues as part of a system to encourage team working and support.

The pain team had introduced the first trust-wide study day after an audit highlighted the need for more staff education and engagement. The first study day in May 2018 had been successful and as a result introduced an annual programme of four study days.

Ward managers and the nurse education team identified specialised training for teams where this would address risks specific to the ward or clinical specialty. For example, staff from older people’s service wards were due to attend pressure sore training delivered by a coroner to assist them with recognition of risk and documentation. Ward managers arranged weekly whole-team meetings to discuss pressure sores following past occurrences.

Where training was delivered electronically through self-study modules, specialist teams provided practical competency sessions to supplement these. For example, the safeguarding lead visited wards to carry out verbal competency tests with staff to check their knowledge and understanding of safeguarding processes and referral pathways.
A consultant lead in education improved teaching and learning opportunities for junior doctors, who had protected time to participate in projects, audits and research. A recent education project had been to explore lumbar puncture delays in cases of suspected meningitis with a review of policies and procedures to identify opportunities for learning.

Senior house officers who recently joined the trust told us the induction process and initial mandatory training programme had been comprehensive and useful. They had taken initial training in dementia care and a local, hospital-specific induction in addition to the overarching trust induction. New doctors had a clinical supervisor and an education supervisor and support from a registrar and consultant.

The EoLC team carried out education and training courses and events with staff across medical services to ensure they were competent in caring for patients when they transitioned to the end of life on inpatient wards. Recent opportunities included case study-based simulation training, a bereavement conference, training on resilience and self-care and sessions from a rolling programme on palliative care. The team produced a quarterly summary of the training delivered and the number of staff who attended. For example, the team delivered training specifically for HCAs in December 2017 and April 2018 and 25 staff attended each session. The team also delivered training for nurses on a preceptorship and joined tissue viability nurses to deliver multidisciplinary training, which was of significant benefit to ward-based medical staff. From April 2018 to August 2018 the team delivered training to 453 staff in the hospital, reflecting significant coverage of medical care staff. This included twelve staff nurses from medical wards who completed training on the use of syringe drivers, which improved the consistency of care of EoLC patients who remained on inpatient medical wards.

Fundamentals of care for older people were recognised trust-wide as a key education need and the EoLC team were leading on this by developing ward-based champions who developed skills in recognising frailty, understanding the application of the Mental Capacity Act (2005) (MCA) and dementia care. This was linked with the ‘getting it right every time’ palliative care training course.

The fire safety and operations team had introduced more advanced fire safety and evacuation training to take into account the impact of specific clinical conditions. For example, the new training included consideration of patients with limited mobility and those living with dementia. Staff also spent time exploring how their response to major incidents should be based on whether it was slow or fast-moving. The fire officer attended nurse huddles and offered guidance on each individual ward, including training in the practical use of equipment such as evacuation chairs and sheets. This was evident in most inpatient areas, with the exception of a partially-obstructed fire escape route on Cedar ward and confusion over the available fire exits on Peace ward. In both instances we discussed the issues with the ward manager or senior divisional staff who took action. They had developed a bespoke training programme for staff working in the ACU as this area presented unique challenges that would require a modified response in an emergency.

The team had developed training based on learning from fires and major incidents at hospitals in the UK and abroad, such as a neonatal fire in a US hospital and an oxygen explosion in a UK hospital. They also studied the outcomes of major incidents such as natural disasters and terrorist incidents and updated major incident training and plans to reflect the most recent understanding of such situations. Engagement with the local fire authority had resulted in them sending fire officers on two days to carry out practice drills with ward-based and site staff as part of the drive to enhance training and competencies.

Consultants had led a recent Grand Round and planned to carry out a further two rounds in 2018. Grand Rounds are a type of education methodology in which clinical cases are presented and
reviewed by doctors of varying grades and levels of experience. Junior and middle grade doctors we spoke with said the Grand Rounds had been valuable learning opportunities and reflected the hospital’s improved approach to training and development.

All HCAs had access to the national care certificate and were expected to complete this after completing their probationary period.

The deteriorating patient team worked collaboratively with the resuscitation team and nurse education team to implement the new national NEWS2 programme. This included new working arrangements and practical training for staff. The PDN for medicine was leading twice-weekly drop-in sessions for staff, which included clinical scenarios and practice using new observational charts. The education team had a target of 80% of staff to be fully trained in NEWS2 ready for the formal roll-out in October 2018. The team identified staff who needed more support and offered them additional sessions and set up mobile training sessions in wards to help staff access the sessions. The team had modified documentation relating to observation charts based on feedback that different clinical teams understood mnemonics differently.

The nurse education team included a PDN for medical care and a PDN for urgent and emergency care, which included the acute assessment unit and the ambulatory care unit.

The nurse education team recognised the value in providing training opportunities that were practical and interactive. For example, they developed a new drug chart that addressed previous issues of common errors and complete several charts with intentional mistakes as part of practical training. During intravenous drug study days, the PDN encouraged nurses to interact with patients to get feedback on how they felt about the nurses’ approach, manner and skills.

The medical care PDN engaged with international nurses to support them in preparation for their objective structured clinical examinations (OSCES). Through practical training sessions the PDN identified common themes in additional training needs, including for better compression techniques in basic life support. To address this, they worked with the resuscitation team to arrange simulations to support staff in delivering care bundles. They also sourced defibrillator pads that identified the correct pressure during chest compressions.

The PDN carried out regular spot checks on nursing staff to assess specific skills and standards and to provide ad-hoc support. Recent spot checks on wound management found staff were managing dressings well but had not consistently completed care assessment documentation.

Arrangements were in place to ensure agency, bank and locum staff had access to regular training and professional development. For example, a clinical lead ensured locum doctors undertook training on NEWS2 and PDNs facilitated agency and bank nurse attendance at weekly training sessions.

The nurse education team had established high-intensity training for new nurses, including practical skills-based training in catheterisation, naso-gastric tubes and non-invasive ventilation. This included a combination of simulated activities and scenario-based learning.

Although most staff said access to specialised and additional training was good, some teams identified areas they would like to see improvements in. For example, staff on Curie ward said they needed access to more advanced diabetes and endocrine training and more training on mental health to be able to fully meet patient needs. Patients with complex mental health needs were regularly cared for on the ward but staff said they did not have the skills to provide the care they needed. Staff on Cedar ward said there were limited opportunities for advanced gastroenterology training and the ward manager was working with the medical PDN to identify appropriate courses.
A dementia lead nurse provided support to staff and patients and was available on-call five days per week. Some wards had a dementia champion in post who worked with the trust lead to provide dedicated care and support ward-based colleagues. Most staff we spoke with knew who the dementia lead was, how to contact them and how to access dementia training. However, a senior staff nurse in the AAU said the trust did not provide dementia or learning disability training and they said this made providing care for some patients very challenging. Although they were aware of some dementia-friendly wards they were not aware of referral pathways and said the unit could not make any specific adaptations for patients.

The workforce matron was in the process of developing a dedicated enhanced care team to better meet the needs of patients who required one-to-one care. The matron had established a band six nurse coordinator and a team of band two enhanced care assistants who would have the opportunity to develop into associate nurse roles. The assistants recruited to date reflected a variety of professional backgrounds in care, including in mental health, learning disabilities and community care and would have the opportunity to progress to band three roles through competency assessments. The EoLC team were participating in the training and development programme to ensure enhanced care assistants had appropriate skills to support patients.

A customer service manager had joined the hospital team and provided training to staff in communication skills with patients and relatives. The training included specific support for staff in handling challenging situations at weekends.

Physiotherapists and assistant therapists completed enhanced competency training before they were able to work at weekends. This helped them work more autonomously and meant patients were seen by more experienced AHPs. Senior AHPs planned the skill mix of weekend teams and used role plays and scenario-based training to assess competence.

**Multidisciplinary working**

AHPs provided therapy services in two combined physiotherapy and occupational therapy (OT) teams; one for OPS and one for general and specialist medicine. In general and specialist medicine, a clinical lead for OT in complex conditions and a clinical lead for physiotherapy and OT led a team of 12 therapists dedicated to medical care patients. This included three rehabilitation support workers and an advanced rehabilitation support worker. In OPS, a clinical lead for physiotherapy and OT led a team of 23 therapists and rehabilitation support workers. Junior therapists were recruited to work across all five of the trust’s sites, which the senior team said helped improve recruitment as this was seen as an attractive option by new recruits.

Nurses generally demonstrated a working knowledge of multidisciplinary team (MDT) processes and input on patient care. There was room for improvement in some areas, such as in AAU where a nurse said they only ever dealt with other nurses and did not know who was in the MDT team for any given patient.

Staff used established MDT pathways to refer patients between specialties in the hospital and to refer to external specialist services. This included social care services and community-based services.

MDTs met weekly to review patients with complex needs, which they arranged based on the needs of each specialty. MDTs held board rounds to review patients on each ward daily, which were supplemented with ‘wrap-up’ meetings in the afternoon and weekly whole-team MDT review meetings. We attended board rounds on Syringa ward and Peace ward and MDT meetings on Peace ward and Curie ward. In both cases a wide range of professionals attended, including allied health professionals, social workers, community healthcare staff and in-reach teams. The teams
discussed each patient in depth and included their holistic and social needs when assessing them, in addition to their immediate clinical plan. Patient flow coordinators, therapists and the discharge team routinely attended board rounds and staff discussed the activities of daily living in depth for each patient, including elimination, skin integrity and mobility. MDT meetings in the FAU include social workers, staff from the British Red Cross and a rapid response team to prescribe intravenous antibiotics, take bloods and support ‘trial without catheter’ (TWOC) patients.

Nurses and HCA's adopted extended roles as champions in a range of specialisms, such as infection control, dementia and nutrition. The roles provided staff with the opportunity to meet with specialist teams, attend additional training and act as a point of contact on their usual ward for colleagues and patients. The pain team identified a need for pain champions to be introduced as a dedicated role and existing end of life care champions had agreed to undergo training for this. The EoLC team provided champions with extended training and development opportunities. They used a structured, competitive recruitment process for this role that required applicants to pass a knowledge test and commit to carrying out audits and research.

A specialist tissue viability nurse was available in the hospital five days per week. They worked closely with the safeguarding team and ward nurses to prevent hospital-acquired pressure ulcers and to treat and investigate community-acquired pressure ulcers.

Three clinical nurse specialist heart failure nurses provided support to patients and the cardiology team Monday to Friday, including through attendance at board rounds.

Therapy and pharmacy teams were organised by speciality to match medical teams. For example, the acute teams provided care in the clinical decisions unit, FAU and the AAU.

Nurses had access to weekly teaching sessions organised by the nurse education team and trainers from each specialty. For example, weekly teaching was provided for cardiology nurses and the ward managers endured they released at least two nurses for this.

The networked sexual health and HIV service provided care for ward-based patients such as rapid HIV testing and dedicated patient reviews from a consultant, specialist registrar and HIV pharmacist. The sexual health and HIV service was no longer based on site and the arrangements in place meant medical inpatients had access to testing, advice and treatment without a need to travel to the new centre. The infectious disease team maintained oversight of patients admitted to the hospital with HIV and liaised with the HIV specialist registrar based in the dedicated ward at another of the trust’s hospitals. The registrar could access the patient’s electronic records and arrange for a transfer to a specialist HIV inpatient bed if needed. This reflected an improvement in the HIV admission and treatment pathway following feedback from staff that the previous arrangements and options had been confusing.

A team of AHPs were dedicated to stroke rehabilitation on Peace ward and worked closely with the community stroke team, who joined hospital multidisciplinary meetings. The team ensured patients had access to a range of specialist care, including dietetics, SaLT, nutrition, occupational therapy and physiotherapy.

**Seven-day services**

Each clinical specialty had arrangements in place for seven day working and medical cover. Consultant cover was provided in all specialties on a seven-day basis with on-call arrangements in place for weekends in nine specialties. The trust had significantly improved seven-day cover since 2016, including additional consultant cover over four-day bank holiday weekends daily consultant ward rounds in the AAU Services in acute medicine had a service standard that all patients would
be reviewed by a consultant within 12 hours of admission and twice every 24 hours, which was
achieved with the established level of consultant cover.

Other seven-day services included a 24-hour gastrointestinal bleed rota including endoscopy,
physiotherapy and occupational therapy services and an MDT discharge team.

In April 2018, the trust audited seven-day cover using the NHS Improvement standard that all
patients receive a consultant review within 14 hours of admission. The audit found 82% compliance in the hospital, which included surgery and emergency medicine. In the sample five patients in older people’s services, one patient in respiratory medicine and one patient in an unknown speciality did not receive a consultant review within 14 hours. The medical director had established medical workforce priorities to ensure improvements in consultant cover continued and key vacancies were recruited to.

The ambulatory care unit provided a triage, rapid assessment and treatment and admission avoidance service seven days a week from 9am to 6pm.

A cardiology specialist registrar carried out weekend ward rounds on Saturday and Sunday and a consultant provided on-call cover from another hospital in the trust. We reviewed this arrangement during our unannounced weekend inspection and found doctors on site provided patient reviews when needed although told us it meant patients would need to be transferred to another hospital if they needed more specialist care.

The EoLC team had secured social funding that would enable them to provide services through a seven-day community partnership. This would significantly increase options for patients to be treated outside of the hospital at weekends.

The discharge lounge was open from 8.30am to 5.30pm Monday to Friday, which would extend to 6.30pm following a planned relocation. The service had trialled a seven-day service but this had not proven to be feasible.

Social workers were available on site from 7am to 6pm seven days per week. The hospital was based between three local authorities, not each of which provided a seven-day service.

The discharge team provided a seven-day service, including on bank holidays. During our unannounced weekend inspection, the discharge team demonstrated the effectiveness of their service, including liaison with out of hours community services and a clear focus on safe and timely discharge planning.

AHPs provided a seven-day service. At the weekend a team of three physiotherapists and two assistant therapists provided care to patients in general medicine, the AAU, cardiology and respiratory between 8am and 6pm. An occupational therapist was based in the emergency department at weekends and provided support to patients in medical wards in urgent situations. The team ensured all patients admitted overnight to the FAU or AAU received a therapy review to identify immediate needs. The heads of therapies said weekend cover was highly targeted and aimed at providing continuous care to patients with the greatest chance of benefiting for ongoing therapy. However, there was not a seven-day rehabilitation service for patients in the stroke service. The heads of therapies had reviewed this and identified a need for 24-hour, seven-day rehabilitation cover. They did not have a timeline from the trust on when this could be achieved.

The pharmacy team provided a seven-day service to all areas. This included an on-call pharmacist from 5pm to 8pm weekdays and an emergency medicine room via the site manager from 8pm to 9am. At weekends pharmacy staff were on site from 10am to 2pm with an on-call system from 2pm to 4pm. Between 4pm and 10am site managers had access to the emergency medicine room.
Health promotion

There was a demonstrable drive across the hospital to embed health promotion materials in clinical and public spaces. Support groups were also advertised for people living with specific conditions, such as a diabetic patient support forum and facilitated drop-in support sessions for patients diagnosed with type 1 diabetes. The team on each ward maintained a selection of printed health promotion material relevant to patients. For example, Peace ward included a range of material from a specialist stroke organisation that helped patients with recovery topics such as diet, vision, sexual activity and reducing future risks. Information was provided specific to lifestyle and ethnicity and include signposting to online stroke support communities.

Staff in the FAU had recently organised a tea party for national older people’s day. This provided patients with activities and social activities and acted as a celebratory event. Staff in this unit facilitated a range of health promotion activities as part of care on the frailty pathway, including physiotherapy-led exercise classes.

The EoLC team were proactive in engaging staff across medical services in training and events to promote the wellbeing of patients at the end of life. This included participating in Dying Matters Week in 2018 in which they promoted the service and the resources available to staff in the hospital. The team also supported staff to attend a conference on individual patient experiences of death. A key goal was to stop staff from automatically transferring each patient to a hospice when they began an EoLC pathway, which the team said had been successfully achieved.

During our inspection the sepsis team led an event for World Sepsis Day. This involved the lead sepsis nurse, the matron, a senior infection control practitioner and an antimicrobial pharmacist to promote understanding of sepsis. The team engaged with staff from multiple services and departments and provided health promotion guidance and resources for use in clinical areas, such as sepsis boxes. Posters on sepsis awareness were displayed around the hospital, including in clinical and public areas, which highlighted the ‘red flags’ that should prompt a sepsis risk assessment.

A Macmillan Information and Support Centre was based in the hospital and available Monday to Friday. A team of volunteers operated the centre and provided a wide range of health promotion information to patients, relatives and visitors affected by cancer. Nine cancer support groups were available that covered a range of topics such as managing fatigue, healthy eating and body image. Although the centre was based in the main hospital building, wayfinding maps and navigation aids for hospital departments did not include it.

Nutrition champion nurses and HCAs and the catering contractor team led events in the hospital for Nutrition and Hydration Week 2018. This was a health promotion event that aimed to raise awareness amongst patients, visitors and staff about the importance of good hydration and a varied, well-balanced diet.

Printed material was readily available in medical wards and public areas of the hospital that signposted patients and visitors to services that helped with smoking cessation, alcohol and drug use reduction and obesity.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

All 17 patients we asked said staff always asked for their consent before carrying out an examination or a procedure. Relatives also said they felt consent processes were consistent.

Mandatory safeguarding training included the MCA, the Deprivation of Liberty Safeguards (DoLS), consent, best interest assessments and referral pathways. We spoke with 23 ward staff about this training and these areas of knowledge and found generally good standards of knowledge. Where
wards routinely cared for older people or those with complex social needs, staff demonstrated more detailed knowledge. In all cases staff knew who to contact for help and where to locate policy and practice information online.

Each patient had a nurse assessment bundle that included proformas for a DoLS assessment and a best interest assessment. We reviewed 10 DoLS authorisations and associated safeguarding and best interest documentation in three different wards. In each case staff had completed documentation fully and evidenced appropriate risk assessments and best interests discussions. We found effective risk assessments for patients when staff applied for an urgent DoLS authorisation. For example, where a patient was admitted with rapidly increasing confusion and staff were aware of significant family pressures, they initiated a behaviour tracking chart, risk assessment and enhanced 1:1 nursing support.

We reviewed the completion of 32 do not resuscitate (DNAR) authorisations, all of which were fully and correctly completed with appropriate sign-off and documented reasons for their implementation. The team on Peace ward had implemented improved DNAR tracking after a resuscitation audit identified a need to improve recording so that staff could identify immediately which patients had a DNAR in place.

Staff from each department discussed the number of patients with an active DoLS authorisation as well as those with a DNAR authorisation on their ward during the daily site safety huddle. This enabled the site team to maintain oversight of patients in the hospital with restrictions on movement or care.

Systems were in place to ensure learning and a review of practice following incidents relating to mental capacity. For example, following an incident involving a patient who absconded, staff on Peace ward reviewed their training and standards of practice for assessing mental capacity.

Ward managers monitored the completion of dementia assessments through monthly well-run ward audits. Each audit included a random sample of patients and the manager checked whether staff had completed dementia assessments in line with trust policy. In July 2018 and August 2018 completion rates were 100% in all inpatient wards.

The EoLC team had worked with ward-based colleagues in medical specialties to improve consent processes for patients. This meant each patient had a named nurse who was required to be involved in discussions of consent with the patient and/or with their relatives about care towards the end of life.

Is the service caring?

Compassionate care

The Friends and Family Test (FFT) response rate for medicine at Whipps Cross University Hospital was 17% which was worse than the England average of 25% from July 2017 to June 2018.
Although the FFT response rate was below the national average, it was significantly better than other sites in the trust. Each ward team displayed their most recent results, including response rate and recommendation rate, prominently on their ward or clinical area. There was a clear drive in the hospital to promote the FFT and some teams displayed information on how it resulted in improved care on their wards. Where response rates were typically poor for a particular specialty, teams identified new engagement methods.

Ward managers measured ward performance and standards of care in a monthly caring audit as part of the well-run ward audit. This included a review of the care provided to a sample of patients assessed against trust standards and using feedback from patients in response to questions such as whether they felt staff treated them positively and with compassion. This provided each ward with an overall performance percentage that indicated areas of good practice and areas for improvement. Wards achieved consistently high-performance ratings for caring, with an overall average of 97% and a range from 90% to 100%.

The EoLC team had previously used a text message system to engage relatives with the FFT but this resulted in low levels of responses. The team had changed to a paper-based system that enabled more involvement from ward-based teams and the bereavement service, which resulted in the service receiving four times as many responses per month.

We observed caring, positive and meaningful conversations across medical care services. Staff were patient and sensitive and did their best to meet requests. There was a lot of eye to eye contact between staff and patients when having conversations; staff touched patients gently to provide reassurance and patiently repeated questions when patients were not able to understand them. Our observations of positive communication and personable rapport included all staff who came into contact with patients, including housekeepers, catering staff and doctors. For example, we observed a catering staff member encourage a patient to choose their lunch mains and dessert. A health care assistant (HCA) asked the patient whether they wanted cold or warm milk with their cereals. They had to ask this several times before the patient understood the question and made a choice. The staff member did not lose their patience and remained calm throughout.
the conversation, gently rephrasing the question. On Birch ward we saw a staff member requesting the patient not to rush and take their time in finishing their breakfast. They said, “No need to rush, take your time, I’m not in a hurry!”

All 23 patients we spoke with were positive and complimentary about their interactions with staff. One patient on ward B3 said, “I don’t want to be in hospital but at least it’s a nice one with lovely staff. They are so patient and caring it almost makes me feel sad to want to go home.” A patient on the acute assessment unit (AAU1) said, “The whole [team] is lovely. The cleaner has chats with me and it’s nice to have some company. It’s good to know they take their job so seriously, they polish the floor so well there’s sparks coming off their heels!” A patient on Victory ward said, “I’ve always been treated with dignity and respect in this very busy ward with some very ill people. I appreciated them always remembering me even when some people were so sick.”

We observed caring, compassionate and kind interactions between staff and patients with complex needs who were being cared for on an enhanced care pathway. For example, during a meal service on Peace ward an enhanced care HCA sat patiently with a patient, explained what the food was and gently encouraged them to eat it. The HCA spoke with the patient cheerfully and talked to them about current affairs and what was happening on the ward when they became restless. The HCA documented their interactions with the patient and spoke with ward nurses when they noted a change in the patient’s condition.

The team on each ward or clinical area we visited displayed messages and cards of thanks they had received from patients and their relatives. A relative had written to staff on the Forest Assessment Unit (FAU) and noted their family member had been, “…cared for excellently in every respect and was treated with great kindness and respect.”

The ward manager on FAU had arranged a birthday cake and candles for a patient celebrating a birthday who had no family to join them. This reflected the team’s social, inclusive approach to the care of older people. Staff on Birch ward had assisted a patient to plait their hair and on Peace ward staff encouraged patients to use the tranquillity garden with their relatives. A matron gave earplugs to a patient who woke up in the night confused that nurse call bells on their ward were doorbells and became disorientated and distressed. The team on Acacia ward had organised a welcome party for a patient who they knew was anxious about being transferred from another part of the hospital. These were examples of the kind and compassionate care we saw across the hospital.

We spoke with a volunteer dedicated to Birch ward who supported patients with companionship, recreation and personal support. For example, they found patients were often afraid of going for blood tests. In such cases they held the patient’s hand and accompanied them to provide reassurance.

We observed numerous examples of staff interacting with patients with complex or additional needs during our inspection. In each case we saw staff were patient, friendly and kind. For example, on Curie ward we observed the matron assist a patient with learning difficulties to make themselves a hot drink. The matron was reassuring and took their time and the patient was demonstrably happy with the interaction.

The hospital had a variable track record in the annual patient-led assessment of the care environment (PLACE) in the measure for privacy, dignity and wellbeing. In 2018 the hospital
achieved 77%, which was a 6% improvement on the score for 2017 but 7% lower than the national average.

**Emotional support**

Patients and relatives said staff routinely offered them counselling or chaplaincy support when needed. They also said most staff were good at recognising when they were feeling low or needed some emotional support or companionship. One patient on Birch ward said, “I get quite emotional thinking about my condition and sometimes I get weepy just talking to staff. They are so patient and lovely though, it never puts them off talking to me!”

The endoscopy service team planned the unit and discussions with patients to ensure they could meet patient’s emotional needs appropriately. For example, the unit had private space for clinical staff to discuss diagnoses with patients and where information was likely to be upsetting, clinical nurse specialists delivered this.

The hospital provided a range of counselling services and psychological support for patients and their relatives. This included a bereavement counselling service, young person’s counselling and play therapy for children. The Woodland Centre was based on site and provided dedicated space for therapy, counselling and bereavement support.

The trust provided an annual bereavement service in St Pauls cathedral, which was open to staff, relatives and patients.

During our inspection we observed numerous examples of staff providing emotional support, both subtly during routine conversations and more directly when patients were in distress. For example, on Bracken ward we observed the ward manager spend time with a patient who said they were fed up of being in hospital. The member of staff demonstrated excellent, compassionate listening skills and provided emotional support to the extent the patient became less anxious and was laughing and smiling by the end of the conversation.

Staff proactively referred patients to a British Red Cross befriending service. This helped patients at risk of social isolation or loneliness to connect with community social groups, which promoted improved emotional and psychological health.

Nursing staff proactively reviewed patients’ medical and social history when they presented with low mood and used this information to tailor individual care to help them feel better.

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

The trust audited how clinicians documented the involvement of patients and their relatives in medical records. In the 2017 records audit, there was evidence of involvement in 59% of cases and this was identified as a key area for improvement. Our review of care plans on Mary ward confirmed this and staff were unable to confirm if the medical team had discussed their plans with patients or their relatives. However, all 23 of the patients we spoke with said doctors had involved them in discussions about their care. One patient in AAU1 said, “I’ve had a full explanation of what’s wrong with me and [everyone] takes the time to discuss what happens next.”

Patients said they felt able to ask questions and doctors took the time to explain things clearly. One patient on ward B3 said, “Staff have been excellent. I think you can sometimes feel intimidated by doctors when they speak to you in medical terms but that hasn’t happened here; they seem to check how much you can understand and then speak to you like that.” Seventeen patients said they appreciated being given options and being able to challenge decisions. One patient said, “The doctor doesn’t just come in to say, “This is what we’re doing”, she tells me what she thinks should happen but gives me choices and the chance to say I don’t like an idea.”
Relatives said they were pleased with how staff navigated communication challenges to make sure patients were as involved as possible. For example, the relative of one patient who had limited mental capacity and could not communicate verbally said they felt very involved in care. They said, “[Patient] can’t talk but the doctors never exclude them from discussions and they look for eye movements and body language and other sounds and they work with me to make the best decisions. It’s a good sign of respect but shows they really care.”

We spoke with a patient and their relative, both of whom had specific needs relating to culture and religion. They said staff had, “Gone out of their way”, to accommodate them and they felt very reassured that staff had treated them as individuals. They said this included the provision of food that met their religious needs.

During our observations of enhanced care and discussions with staff delivering this, it was evident staff knew patients well. For example, we spoke with an HCA who helped a patient to eat during a meal service. They knew the patient could not speak to them but had developed a communication strategy with them and used this to identify two key foods the patient liked to eat. The HCA arranged for this to be supplied as it was not routinely available outside of the breakfast service. They also provided personal care and knew the patient sometimes did not want this. As they could not provide verbal consent, the HCA interpreted their eye movements and body language to ensure the patient was happy to be helped with personal hygiene.

The end of life care team was working to address frustrations reported by relatives on delays to discharge following lengthy inpatient stays. This included supporting ward-based staff to prepare compassionate care plans and work with relatives to ensure patients were discharged to a safe, appropriate location at the end of life.

During ward rounds we observed the consultant and doctors involved patients and their relatives where requested and necessary to discuss their health and next steps. For example, on Birch ward a patient had their relative with them during ward rounds to translate information and enable them to make decisions. The consultant and doctor was patient with the process and asked the patient if they would like them to book an ambulance service.

At our last inspection in 2016 we observed patients’ dignity was sometimes compromised as inpatients wore hospital gowns that exposed them and staff did not always intervene when this happened. At this inspection we saw staff were much more aware of patient’s personal presentation and dignity. They encouraged patients to bring in nightclothes for a planned admission and liaised with relatives and community organisations when they were admitted in an emergency to obtain clothes for them. Where this was not possible, staff ensured patients wore two gowns so that they were not inappropriately exposed when moving around the wards. For example, on Birch ward we saw staff discreetly provide a second gown for a patient who had not noticed they were partially exposed.

Staff demonstrated attention to detail in maintaining patient's privacy and dignity in the ward environment. For example, we saw staff ask patients for permission to enter their bed space when privacy curtains were drawn. We asked patients and their relatives about their experiences of privacy and dignity. All 29 people we asked said they felt staff had a good understanding of this. One patient on Bracken ward said, “Staff always ask before doing anything and they respect my space. I feel looked after and like I’m important.” We spoke with two relatives on Cedar ward who spoke candidly about their experiences with staff. They said every member of the team, regardless of their role, had made them feel welcome and never like an imposition. They appreciated being able to attend outside of scheduled visiting hours with permission and to have private time with their family member whenever they wanted.
We observed meal services in Peace ward and on Mary ward we carried out a structured observation of the interactions between staff and seven patients over a 30-minute period. Staff were attentive, person centred and caring towards people’s needs. Patients’ privacy and dignity was maintained whilst meeting their personal care and medical needs. The matron turned the radio on and patients were seen enjoying listening to classical music. We observed a staff member support a patient walk up and down the ward with appropriate assistance and the patient was demonstrably happy with this. Patients were seen enjoying breakfast at their preferred pace and staff were seen bringing fresh cups of hot drinks when requested.

Although wards did not have privacy and dignity champions, staff we spoke with demonstrated detailed understanding of maintaining these areas during their usual duties. For example, a member of staff on Birch ward said, “It is my job to ensure patients’ privacy and dignity is maintained, whilst talking to patients ensure confidentiality is maintained. Treat patients as individuals. Do not rush patients, support them at their pace. For example, sometimes patients do not want a wash in the morning, I respect their wishes.”

The team on Birch ward had provided a radio for patients following feedback they needed more stimulation. This was used regularly and we saw patients enjoying taking part in singalongs with staff.

Ward managers were aware of the first impressions patients and relatives sometimes had based on the environment, which sometimes caused anxiety. To address this, they ensured patients had time to visit the wards in advance of planned transfers or elective admissions. For example, the ward manager on Peace ward showed a patient and their relative around the ward communal areas, recreation room, gym and landscaped garden to help them see the work that had been completed to make the ward a welcoming environment.

**Is the service responsive?**

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

**Elective Average Length of Stay - Whipps Cross University Hospital**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>This site</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>4.3</td>
<td>6.0</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>2.9</td>
<td>4.3</td>
</tr>
<tr>
<td>Cardiology</td>
<td>4.5</td>
<td>2.6</td>
</tr>
<tr>
<td>Pain management</td>
<td>2.4</td>
<td>3.9</td>
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*Note: Top three specialties for specific site based on count of activity.*

Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in general medicine is lower than the England average.
- Average length of stay for non-elective patients in geriatric medicine and rheumatology is higher than the England average.
The hospital monitored the average length of stay for medical patients cared for as outliers on surgical wards. Between March 2017 and March 2018, the average length of stay was 6.95 days, reflecting a range from 4.89 days on Poplar ward to 10.24 days on Sycamore ward.

The hospital used a ‘golden discharge’ system, which denoted a successful discharge prior to 10am. This was beneficial for patients with a package of care as it meant they had time to meet their community care team after they left the hospital. This also meant ward staff could better prepare for new patient admissions.

Four nurses and a service development professional led a dedicated admission avoidance service based in the Forest assessment unit (FAU). This team worked with colleagues in the emergency department (ED) and acute assessment units (AAUs) to coordinate care for patients that would not necessitate a hospital admission. The ward manager had led a pilot scheme to increase the scope of the FAU and develop a medical frailty pathway. The success of the pilot scheme resulted in an increase from seven beds to 10 beds and two chair spaces.

The average length of stay in the AAU was two days for patients who were discharged home or admitted to a specialist service, which was within the trust target of operating the unit as an acute short-stay unit. The cardiology service provided a treatment pathway in the AAU for patients who needed to be admitted when the cardiology ward was full. This meant patients remained in the AAU and were cared for by the cardiology team. The average length of stay for these patients was four days, which extended to seven to eight days if they were waiting for an angiography at the trust’s specialist facility.

We spoke with staff in Rowan ward and Sycamore ward, which were surgical wards regularly used to provide care for medical patients as outliers. In Sycamore ward staff said the length of stay for medical patients varied from three days to 14 days with an average of five days. Staff in Roman ward said the length of stay for medical patients was typically longer, with an average of 10 days and a maximum of four weeks.

A care of the elderly consultant provided dedicated review for patients cared as outliers on Peace ward, which was primarily a stroke ward. A senior house officer from the older people’s services (OPS) team provided additional support.

Four relatives we spoke with expressed frustration with the discharge process and planning of continuing care in the community. One relative said, “We’ve been here for weeks but we’re going round in circles.” However, this was not reflected in conversations with patients. Patients we spoke with on Birch, Syringa and B3 wards said staff always involved them in discussions about going home and they felt this was a priority for staff once they were medically fit.
The scheduling team and endoscopy secretaries worked together to make patient lists reliable and the scheduling team send out bowel preparation packs. A slot was left on each list for emergency endoscopies from the wards. However, that was not enough to cover emergency referrals and on one day of our inspection the service received 17 referrals. Staff therefore saw emergency cases in gaps when listed patients did not turn up. This meant staff saw each emergency case in 24-48 hours of referral. A bowel cancer screening service was managed as a separate department with its own staff and lists.

A private healthcare company provided the endoscopy service on a weekend and provided six lists per day on Saturday and Sunday. This organisation staffed the clinic with their own registered nurses, scoping staff, healthcare assistants (HCAs) and consultants, who used the hospital’s equipment. This meant the service could continue to address patient demand and the need for emergency appointments seven days a week. Hospital nurses often worked bank shifts in the clinic on a weekend, which ensured there were staff on site experienced with local procedures. The senior divisional team maintained oversight of the training and clinical competencies of external staff through service level agreements.

The cardiac catheter lab at the hospital had closed and patients were transferred to another hospital in the trust for interventions. Although waiting times for some interventions had decreased, such as from four weeks to one week for a coronary artery bypass graft, other services resulted in some disruption for patients. For example, patients who needed electrophysiology and pacemakers typically waited up to five days to go to the other hospital as a day case and returned to the hospital the same day. Staff told us they often returned as late as 12am, which caused considerable inconvenience. However, the waiting time for angiography was typically less than two days. Senior staff were not aware of any plans to address this.

As part of the development of the specialist frailty pathway and service, the trust planned to designate the hospital as a specialist centre for fractured neck of femur. This meant patients presenting with this condition at other hospitals in the trust would be stabilised, made comfortable and then transferred to Whipps Cross Hospital for specialist care and rehabilitation. This was a decision based on staff understanding of the local population and the increasing demands on the service for older people’s care. Clinical leads and directors said they had the freedom to make decisions based on trends in the local population, of which this was an example.

OPS staff were developing a specialist frailty pathway as part of their vision of an integrated elderly care system between the hospital and local authority services. They had joined a frailty network and participated in regional workshops as part of the development.

Hyper acute stroke treatments were delivered by other hospitals in the trust and the stroke unit at the hospital provided ‘step down’ care, which meant patients were medically stable and not at heightened risk of acute deterioration. Peace ward, which was the designated stroke ward, was not ringfenced for stroke patients and frequently provided care for general medicine patients. However, this meant general medicine patients were transferred to another ward if a stroke patient needed a bed.

Ward clerks organised transport for transfers and discharges and liaised with relatives and community providers to coordinate these. Ward clerks we spoke with said they received support from ward managers but when agency nurses were scheduled to work it added significant additional pressure to their role. The trust provided its own transport service, which meant ward clerks and ward managers had more direct influence on arrangements.

Each ward had a designated patient ambassador who acted as a link between department heads for catering, domestic work and security and non-clinical service supervisors. This role ensured
supplementary services worked well for patients and released clinical staff to provide care and treatment.

Divisional and senior teams recognised patients could be better cared for by reconfiguring some wards and services to more closely match the needs of the local population. For example, Victory ward had 19 rehabilitation beds but demand for this service was lower and Peace ward did not routinely use all of its beds for stroke patients. To address this issue, the hospital planned to establish 12 protected stroke beds and merge the teams from Peace and Victory wards. Practice development nurses (PDNs) worked with both teams to integrate their skills through additional learning sessions.

The end of life care (EoLC) team had grown following a successful business case to ensure they could better meet the needs of the local population. This included the addition of two acute clinical nurse specialists and a dedicated consultant’s secretary. The hospital team had developed more extensive working opportunities with the community palliative team, which enabled them to provide more responsive care.

The Margaret Centre was a dedicated EoLC centre on site and provided direct referral and transfer services to medical patients. The discharge team and EoLC team had daily contact with the consultant in the Margaret Centre and prioritised patients in medical wards who had the greatest need for an urgent discharge to the centre. During our unannounced weekend inspection, we observed the process work effectively and in the best interests of the patients. For example, the medical discharge team worked with the consultant in the specialist centre and prioritised a patient for discharge before 7.30pm and one for discharge after this time.

Staff on each ward used a local homeless person’s referral pathway to ensure patients had early access to specialist support in the community. The discharge team and admission avoidance team liaised with homelessness services to coordinate support that would reduce the risk of readmission to hospital.

Elizabeth ward, a cardiology service, provided telemetry for up to 10 patients. Telemetry enables clinical staff to monitor a patient remotely, meaning they can leave the ward and still be safely cared for.

The trust organised medical care in line with the Academy of Royal Colleges Guidance for Taking Responsibility: Accountable Clinicians and Informed Patients principle that care was delivered by a named consultant and transfers of care were minimised. Each ward and clinical area had well-defined working practices to adhere to the guidance and medical outliers were cared for by a named responsible consultant.

The urology and ED teams had worked collaboratively to establish a new pathway for urology stones. This meant patients seen in the ED were discharged with pain relief and an appointment to attend the urology stones clinic. This avoided the need for an unnecessary admission to the AAU and meant patients received specialist care more quickly.

Meeting people’s individual needs

A dedicated learning disability team worked across the trust’s hospitals and provided patients, their relatives and carers and staff with support. The team provided patients with a learning disability passport if they were not admitted with one and worked with ward teams to implement adjustments to care to help people living with conditions such as autism.

During all our observations of care and reviews of treatment plans, we saw staff considered patients’ needs in detail and with a holistic perspective. For example, in one multidisciplinary (MDT) meeting staff demonstrated a detailed understanding of the family and relationship
dynamics of each patient, including the barriers that would challenge a good recovery at home. Staff considered issues such as a patient’s reluctance to bathe and a patient’s need for smoking cessation support. In both cases the MDT team collaborated to source the most appropriate support and solution for each patient.

In units with waiting areas, such as the ambulatory care unit, self-service fresh drinking water, a hot drink vending machine and an accessible toilet were provided. Staff provided these to visitors in request in inpatient wards.

Staff used the national standard ‘forget me not’ care plan for patients living with dementia and we saw good examples of effective use. On B3 ward staff showed us how they used this information to build a relationship with patients by getting to understand their family and social history.

Staff used patient feedback to develop their service and better meet individual needs. For example, staff on the Forest Assessment Unit (FAU) provided an activity box to provide stimulation for patients living with a sensory condition or mental health need.

The ward manager on FAU had engaged with an external non-profit organisation to supply individual blankets for patients. Patients on this unit were often frail and it was challenging to heat the unit, therefore the blankets provided additional warmth and added a homely feel to the patient’s stay. For infection control purposes the blankets could only be used by one patient, which meant each patient took their blanket home with them.

Ward staff and flow coordinators adhered to NHS national guidance on mixed-sex accommodation, which meant inpatients were accommodated in same-sex areas. To facilitate this the hospital had configured clinical areas to provide care segregated by gender. For example, the endoscopy unit had recovery areas allocated separately for men and women, the FAU had separated bed bays and the respiratory service offered care in wards wholly for men or women.

The endoscopy recovery area included provision for hot drinks and light snacks and staff ensured patients had something to eat and drink before they left. There were relevant and clearly-written aftercare leaflets on gastroscopy, colonoscopy and bronchoscopy.

Qualified, certified staff provided complementary therapy from the Woodland Centre, which was open to all patients and relatives. This included sleep therapy sessions for relatives who found sleep difficult due to worry or stress about a family member’s health or for those experiencing insomnia because of their own condition. We joined a sleep therapy session and spoke with the facilitator. They ran the sessions over an eight to 10-week period with 40 sessions offered across the trust. Patients accessed this therapy by referral from staff in the oncology service and sessions were funded by Macmillan, local non-profit organisations and patient legacies. The therapy team were developing mindfulness sessions for teenagers to help them self-manage their condition. A therapist provided aromatherapy to patients being cared for on a palliative pathway, which could take place at their bedside in an inpatient ward.

Following a refurbishment and reconfiguration, the division had reopened Mary ward as a dedicated unit for female patients who would stay in the hospital between two and five days. This was an extension of the service provided by FAU as part of the development of a new frailty pathway.

Syringa, Birch and Peace wards had undergone refurbishment to provide a dementia friendly environment. Each ward had day rooms that patients and their relatives could use for recreation, socialising or relaxing away from the clinical area. The environments had been adapted to make them more accessible and navigable for patients living with dementia. For example, each bay in Syringa ward had been painted in a different colour to help patients remember where their bed
was and pictorial signs had been installed to help patients navigate. The flooring had been replaced with a wooden, non-slip material to help prevent falls. Improvements to the environment were reflected in the hospital’s track record on dementia and disability scores in the patient-led assessment of the care environment (PLACE) system, both of which had improved by 11% in the previous 12 months.

Staff adapted their approach to care and communication based on individual needs, including those with complex conditions. For example, one patient cared for on Birch ward reverted to their first language when dementia progressed. Staff worked with their family and arranged translators where necessary to ensure they understood their changing needs. On Curie ward a patient used an online translation application to help them communicate with staff. Although both approaches meant patients could communicate more easily, patients and relatives said they had not been offered the use of a formal translation service and staff said they rarely used the trust’s telephone translation provider. In another instance on Curie ward we saw four family members were translating for a patient to staff. Although staff did not believe the patient was at risk of safeguarding issues there was not a system in place to ensure safeguarding risks were mitigated using a translation service. On the AAU we found staff were more responsive in securing translation services and had done so within two hours of identifying the need for two patients.

Staff on Birch ward demonstrated proactivity in providing individualised care to patients with complex needs, including dementia and learning difficulties. For example, the team had contacted a patient’s residential home and asked them to complete a hospital passport document to help support a successful discharge.

Staff completed mandatory equality and diversity training and could demonstrate how they practiced this during their duties. For example, staff facilitated access to foods of importance to some religions and cultures such as kosher food. Staff ensured patients had access to preferences of female or male staff for areas such as personal care and provided care without discrimination to personal characteristics such as sexual identity, race, gender or religion. A member of staff on B3 ward said, “When we admit patients from the Caribbean, or Jewish and Asian patients, we ask them about their culture in relation to their dietary needs so that we meet preferences of meat and vegetables are met. Some patients do prayers around their bed and we give them their privacy. We had a patient who would go to the chapel every morning and a priest comes every Sunday to offer communion and pray for patients.”

A dementia and delirium team worked across all medical areas and provided planned reviews of patients, on-demand assistance and attended multidisciplinary meetings. This team supported staff in the use of the hospital passport scheme for patients living with dementia or a learning disability and ensured patients had individualised care plans in place.

Staff on B3 and Bracken ward had introduced an out of hours menu following feedback from patients.

As part of a wider strategy to engage patients living with dementia, learning difficulties or conditions that presented the risk of social isolation; social workers, champion nurses and volunteers worked collaboratively with ward-based staff to provide enhanced social care.

The team on some wards had prepared printed information and welcome booklets for patients and their visitors. For example, the Forest Assessment Unit (FAU) team had prepared a detailed leaflet that used clear English and straightforward explanations about the care and treatment patients could expect. The leaflet included the names and job roles of staff in the unit as well as practical information such as visiting times, meal times and the structure of discharge planning. In some
wards, such as Acacia ward, staff provided printed information in languages that reflected those most commonly spoken by patients as well as in large print.

The trust advocacy service ensured patients had access to information in a format to meet their needs, including in British Sign Language and Braille. All staff wore new name badges that were high-contrast and easier to read for patients with reduced visual acuity. The trust had launched a new website that could be translated into over 100 languages instantly and adjusted for patients with visual impairments. These improvements were implemented as part of a wider programme to improve information in line with the NHS Accessible Information Standard.

The FAU team arranged music days for patients and hand massage therapy, which the EoLC team had implemented across multiple staff teams. HCAs took a lead role in hand massage therapy and complementary therapy was also provided.

All nurses and HCAs on Curie ward had been trained in dementia care and care for patients living with a learning disability. The ward had persistent nursing vacancies, which meant there was no dementia or learning disability champion. However, the ward team ensured patients had access to additional support, including through liaison with the dementia and delirium team and use of resource such as an activity box with items for stimulation.

A landscaped sensory and tranquillity garden was attached to Peace ward. A retired HCA maintained this space, which patients used regularly for fresh air, relaxation and meetings with staff. The garden was wheelchair-accessible and included covered space.

All 23 of the patients we spoke with said staff responded quickly to call bells and relatives commented that staff were quick to respond as well.

The workforce matron was leading a project to increase the number of staff employed to deliver enhanced care to patients. This was one-to-one care provided to patients with complex needs or who were vulnerable and needed more attentive support. For example, staff were trained to provide stimulation to patients during the day so they did not become restless and anxious during the night. The team provided holistic care to patients, including personal care, and ensured their individual privacy and dignity needs were met.

Ward managers implemented a cohorting system when patients presented with similar risks or needs and could be better cared for if they were in the same area. For example, during our weekend unannounced inspection staff in the daily safety huddle identified a need to cohort patients on B3 ward as staff had identified a number of individuals with similar falls risks. This reflected good practice and meant ward staff could provide more focused care in a smaller space to reduce risk.

Liaison nurses and community staff were available on demand for staff, including at weekends, when they needed support for patients experiencing alcohol or drug dependency or homelessness.

The hospital had a variable performance track record in the annual patient-led assessment of the care environment (PLACE) in relation to scores for dementia and disability. In both scores in 2018 the hospital performed significantly worse than the national average, with a 64% result for dementia compared with a national average of 79% and a disability score of 71% compared with the national average of 84%. However, both scores reflected a significant improvement from scores in 2017.
Access and flow

Curie ward:
From April 2017 to March 2018, 61% of individuals did not move wards during their admission, and 39% moved once or more.

Elizabeth ward:
From April 2017 to March 2018, 68% of individuals did not move wards during their admission, and 32% moved once or more.

Both wards demonstrated slight increases in ward moves from the previous year April 2016 to March 2017.

(Source: RPIR Universal – ward moves tab)

From April 2017 to March 2018, there were 2,814 patients moving wards at night across 18 wards within medicine. During the reporting period August 2017, January 2018 and March 2018 showed the highest number of ward moves at night. (January: 306, March: 295, August: 278)

The top three wards with the highest moves at night were:

- Curie ward: 454 moves at night
- Conifer ward: 308 moves at night
- Cedar ward: 298 moves at night

(Source: RPIR Universal – moves at night tab)

Dedicated flow coordinators worked in the hospital seven days a week and worked with the admissions avoidance team, discharge team, site managers and ward managers to facilitate timely admissions, transfers and discharges from each medical area.

The ambulatory care unit (ACU) provided care and treatment aimed at avoiding unnecessary admissions. The service included three doctor examination rooms and an ultrasound service led by sonographers. The unit saw approximately 60 patients per day seven days a week and 8% of attendances resulted in an admission. Patients accessed this through a direct referral from their GP or following triage in the emergency department.

The acute assessment units AAUs accepted patients triaged from the emergency department and approximately 30% were streamed to the ACU. A dedicated nurse attended the ED periodically to proactively identify patients who could be admitted to the ACU. This reduced pressure on the ED team and meant staff saw patients more quickly. ED specialist registrars supported this process to ensure patients were suitable to be moved.

Although the trust had improved and expanded the emergency care system, clinical staff described significant challenges in managing the flow of patients through the AAU. For example, to relieve the pressure on the emergency department the senior team routinely admitted patients to the AAU for a short period of time, often a few hours. Staff noted this was a time-consuming process to arrange the nursing, portering, domestic and junior medical cover needed to facilitate a short-term admission, which also duplicated medical records and reduced overall efficiency.
Acacia ward and the discharge lounge had additional bed spaces that were used for escalation during periods of exceptional demand. For example, the discharge lounge had been converted from an inpatient ward and the structure remained the same. This meant during the 2017/18 winter pressures period the trust opened the ward to inpatients, which accommodated up to 14 patients per night. Acacia ward had a four-bedded bay that was often used to provide inpatient care for medical outliers who would otherwise experience significant delays in admission. This reduced delays for patients admitted through the emergency department.

Four inpatient wards were regularly used to accommodate medical outlier patients from other specialties and arrangements were in place for medical management.

As part of the work to establish dedicated frailty pathways, the divisional team had engaged with NHS Improvement and a performance consultancy group and established dedicated clinical meetings for long-stay patients. The team used these processes to better understand flow and improve outcomes such as length of stay, successful discharge and preventing readmission.

A consultant, an SHO and a foundation level 1 (FY1) doctor led a dedicated discharge team seven days a week, including bank holidays. During the winter pressures period, a physiotherapist joined medical colleagues. This team carried out ward rounds in the medical services and identified patients awaiting discharge home or transfer to another service. The pharmacy team prepared to take away medicine (TTAs) prior to the weekend in anticipation of planned discharges and the team checked and dispensed these to avoid discharge delays and ensured patients were medically fit for discharge. The pharmacy team audited the time taken to prescribe TTAs. There was a significant improvement in standards between December 2017 and August 2018. During this period 95% of urgent TTAs were dispensed within one hour, which was better than the 85% trust standard. In this period 94% of non-urgent TTAs were dispensed within three hours. The SHO in the discharge team was able to issue FP10 prescriptions, which reduced delays awaiting the consultant if the service was very busy.

Lack of capacity in the mental health team and social services teams contributed to delayed discharges. However, we saw from attending daily safety operational meetings that senior staff liaised with these services and coordinated care for patients with the greatest priority for discharge.

The band seven nursing team were trialling a new weekend role for a nurse to lead escorted discharges. This helped to provide additional capacity to the discharge team and provided patients with complex social packages of care with facilitated access to community services. The service had operated on Saturdays from 7.30am to 3.30pm during the trial period and staff were preparing a business case to extend funding past January 2019.

The senior nurse leading the discharge lounge coordinated transport with ward managers and the trust’s ambulance service. This meant if a transfer from a ward to the discharge lounge would be disruptive to a patient, the team could arrange direct transport home from the ward. The team also coordinated discharges and transport with other local NHS trusts using established agreements.

A respiratory consultant and junior doctor reviewed all patients on a Friday and identified those suitable for discharge. Nurse coordinators then assessed patients for social or community needs to ensure a discharge would be appropriate.

The medicine and OPS division prepared a winter contingency and escalation plan to open Chestnut ward in January 2018 to increase inpatient capacity. This included a formal staffing structure with plans for consultant review and processes for admission, transfer and discharge that ensured patients were safe and supported flow through the hospital during a period of exceptional demand.
Learning from complaints and concerns

From April 2017 to March 2018, there were 60 complaints about medical services at Whipps Cross Hospital. The trust took an average of 53 days to investigate and close complaints, this was in line with their complaints policy, which states complaints should be completed between 10-60 days.

The top three wards with the most complaints were:

- Peace ward: seven complaints
- Cedar ward: seven complaints
- Cardiac clinic: five complaints

The highest category of complaints related to diagnosis/treatment, the general themes from these complaints involved poor care provided to patients and poor communication from staff.

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

From April 2017 to March 2018, there were 39 compliments given to Barts Health NHS Trust. No site or core service breakdown is available.

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

We reviewed five anonymised complaints received by the hospital between June 2018 and August 2018. In each case the medical director had provided a clear summary of the investigation along with their findings and the impact or changes on policies and practice. Senior staff invited complainants to meet with them to discuss their concerns in person when appropriate and always explained what the outcome meant in plain terms. Where complaints were about other healthcare providers, the investigator ensured they were involved in the outcome where appropriate.

All 23 of the patients and four relatives we asked said they knew how to make a complaint if they needed to. Information on how to make a complaint and how to contact the patient advice and liaison service (PALS) was clearly posted on each ward and in public areas of the hospital.

Ward managers maintained oversight of complaints relating to their ward and discussed these with the whole team during monthly meetings.

Senior ward, divisional and trust staff worked together to investigate and resolve complaints using thorough processes. For example, the associate director of nursing for emergency care and the director of clinical governance worked with the team on Peace ward to investigate a complaint about staff practice. They involved appropriate colleagues, such as the safeguarding lead, and worked with the ward team to understand what caused the issues raised. Learning was identified from all complaints, such as a need for more consistent incident reporting by staff and attention to detail in professional development in this case.

The hospital tracked compliments received as part of monthly quality, performance and governance monitoring. The ACU was leading the hospital for the most number of patient compliments received and staff had displayed a large number of thank you cards they had received. In them patients commented on the kindness of staff and also on their ability to identify other pathways for treatment that avoided a hospital inpatient stay.
The end of life care (EoLC) team had identified two wards with a track record of complaints relating to the service. The EoLC facilitator met with the ward teams and identified areas for development relating to attitudes and behaviours and how patients and relatives perceive these. The team developed training for these wards and incorporated it with fundamentals of care training planning for staff who cared for older people. A customer service manager delivered this training to assist staff apply MDT concepts. The session was delivered interactively and included topics such as end of life communication, empathy, misunderstanding, listening, adverse body language, and creating a welcoming atmosphere. Trainers incorporated the trust’s core values to help staff apply their learning in the context of the sessions and used specific case examples. Nurses said this session was particularly useful as they did not routinely undertake training on breaking bad news and so lacked the communication skills to deliver it.

The senior leadership team for general medicine said their complaint themes had changed from the attitude of staff in 2015/16 to minor communication issues in 2017/18, which they were addressing through improved communication training.

PALS operated Monday to Friday from 9.30am to 4.30pm and patients could make contact by phone, e-mail or by visiting the office. Where patients were being cared for on a ward, PALS staff offered to visit them to talk through their concerns. The PALS service was supplementary to serious complaints investigated by divisional staff. Two PALS officers were readily available to meet or speak with patients, relatives and visitors and had managed 4248 concerns or complaints between August 2017 and August 2018, of which 293 were formal compliments. Of the areas of concern, access to care, communication, advice and information and medical care were the most common themes. There were inconsistencies in use of the recording and tracking system. For example, PALS staff said that premature discharge was a common theme of concerns and complaints but this category was used on only 14 occasions in the above data. This was because complaints could only be assigned a single category and problems with discharge were often categorised as a communication issue.

Is the service well-led?

Leadership

Leadership triumvirates led medical divisions, which were divided into acute medicine, specialist medicine and general medicine. Each triumvirate consisted of a clinical lead, a matron and a general manager. A senior nurse for medicine worked across each division.

A clinical director was responsible for older people’s services (OPS), end of life care (EoLC), acute medicine and stroke. A service manager was supported by three service delivery managers.

An associate general manager for older people’s services and EoLC, a matron for the medicine division and lead EoLC nurse and an EoLC facilitator led EoLC services.

Practice development nurses (PDNs) said improved approaches to leadership meant the education team was more integrated with colleagues in different clinical areas and ward managers and divisional leads were positive about the development opportunities available for their teams.

The nurse education team worked with senior nurses to develop their leadership and management skills and competencies. This included practical activities such as redeploying senior nurses from their usual place of work to gain experience in other environments on a secondment. This had recently taken place with nurses on B3 ward and Victory ward and participants provided positive feedback about the opportunities this had provided.
A discharge lounge manager was responsible for the application of the standard operating procedure for the service, including liaison with ward teams and reporting of patient outcomes to the lead clinical site manager. This ensured staff across medical wards had support in ensuring patients experienced a smooth transfer through the discharge process and that patients were cared for in the unit in line with the inclusion criteria.

Site managers provided clinical and operational support to medical services and across the hospital and provided senior oversight and leadership at weekends. The team had three whole time equivalent vacancies and had recruited to one post. Once fully recruited the team would provide a 24-hour, seven-day service.

Two individuals worked on a job share basis to provide a head of therapies post. They led allied health professionals across the hospital with responsibility for teams providing care to medical inpatients.

**Vision and strategy**

The trust had an overarching vision and strategy based on improving the quality and safety of services and improving staff cohesion. All staff we spoke with recognised this vision and it was prominently advertised around the hospital. Divisional and specialist teams had developed their own local and service visions. For example, the leadership triumvirate responsible for OPS had developed a service vision based on pain-free care for older people and on joining the nursing and medical teams in a single vision for geriatrics. This reflected the trust’s transformation priorities for 2018/20, which included integrated care systems.

A fourth procedure room was planned for the endoscopy unit and the ambulatory care unit (ACU) was in the process of submitting a business case for expansion after the average number of patients seen per day doubled from 30 to over 60.

A redevelopment team acted as advocates for the hospital and lobbied stakeholders for the resources they needed to progress development plans and upgrades to the site. This was a key part of achieving the hospital’s strategy and staff told us they were excited about the changes and looking forward to developing their new wards and clinics.

Senior teams acknowledged the significant progress made in recruitment and had established a further strategy to address long-term gaps, such as for geriatricians. This included new approaches to head-hunting, scoping the introduction of nurse consultants and increasing the number of physician associates. Local leadership teams were working with their counterparts in other trust hospitals to identify opportunities for cross-site working that would reduce the impact of gaps in staffing.

The significant new opportunities for development offered to staff reflected the trust’s plans for future sustainability and growth. Staff told us the development of the nurse associate role and the implementation of the advanced care certificate made them feel valued and wanted by the trust and they said it helped them to plan a positive professional future.

The trust had a clinical service strategy that aimed to develop specialties within trust-wide networks. The strategy was based around five key themes including meeting the needs of the growing local population, prioritising prevention and standardising the quality of care.

Senior trust teams were engaged with NHS Improvement to develop a hospital redevelopment programme that would ensure growth and sustainability were maintained at the centre of the trust’s work.
The therapies service had a five-year strategy that supported the overall trust strategy while promoting development in the specialist services. The heads of the service met with senior therapists annually to plan the year ahead and identify key benchmarks in progress against the strategy. Individual teams reviewed their progress in monthly meetings and reported to the heads of therapies. Key priorities for 2018/19 were to standardise pathways and care planning across the trust, increase productivity through new ways of working and the redesign of discharge processes. Planned improvements in productivity included the introduction of new training to help therapists increase their capacity.

**Culture**

At our last inspection the hospital was in the process of significant change at provider level. Staff did not feel fully integrated with or respected within this process and there was a presiding culture of uncertainty, dissatisfaction and bullying. At this inspection we found the culture had improved as staff in all roles, departments and levels of responsibilities were positive, motivated and passionate about their work. Senior staff said their teams had developed their own identity, which in turn enabled them to take ownership of service developments and improvements.

We found teams and individuals across the hospital had facilitated a significant improvement in the working culture. Staff representing a wide range of roles, functions and responsibilities spoke positively of the hospital as a place to work. Two occupational therapists said there was an improved willingness amongst staff to get involved with service improvement and they said senior teams welcomed this. A physiotherapist said, “Morale has come on leaps and bounds. It’s a great place to work now, much better than two years ago.” Nurses on Cedar ward said there had been a shift in the atmosphere in the hospital and one nurse said, “It feels like a community now. There’s lots of us been here for a long time and we’re pleased our loyalty and hard work now means something.”

We spoke with the senior leadership team (triumvirate) for acute, general and specialist medicine, which included the senior nurse for medical care, about morale. They said a new culture of engagement had been introduced and sustained and staff generally felt more empowered to challenge poor practice, contribute to new thinking about care and treatment and work with the quality improvement team.

The improved working culture included significant focus on safeguarding and staff told us a drive to promote understanding and knowledge was of significant benefit in helping them deliver care, particularly for vulnerable patients.

We spoke with a consultant in acute medicine who was the education lead for junior doctors. They described a significant improvement in job satisfaction amongst junior doctors in the previous three years. This followed a period of successful recruitment and was reflected in improved results in the General Medical Council survey.

Doctors in emergency care, including locum doctors, told us the emergency care team and system had become more integrated following the introduction of team meetings that included doctors at each grade and service managers.

The hospital had introduced a dedicated ‘improving working lives’ department that provided staff with an on-demand health and wellbeing service. This contributed to improved team cohesion and working conditions and had created an online marketplace community for staff. Staff who travelled long distances to work in the hospital said this was of particular use to them.

Four relatives we spoke with commented that they had overheard ward staff talking to each other in public areas about low morale and dissatisfaction with pay and working hours.
All staff we spoke with took pride in their work and their own achievements, as well as those completed as part of their team.

Allied health professionals told us the hospital had a greatly improved working environment and culture since our last inspection. This was also reflected in positive feedback from the 2018 staff survey and closer working relationships with the senior team. Staff had identified a lack of opportunities for development and excessive cross-site working as key concerns, both of which had been addressed. Although this reflected a trajectory of improvement, senior staff said it was still a challenge to be recognised as an important service in the trust and that they were often excluded from business cases and development opportunities at service level.

A number of staff cited more consistent team meetings as a notable aspect of the improvements made in the hospital. We looked at a sample of team meeting minutes from Acacia ward, Birch ward and the FAU in August 2018. Each meeting had been well attended and there were detailed notes of ward performance including incidents, complaints and NHS Safety Thermometer results. Each team had also discussed issues specific to their ward and medical specialty and had the opportunity to discuss ideas, concerns and feedback.

**Governance**

The trust had significantly improved governance structures and processes since our last inspection in 2016. This included a series of monthly governance, safety and committee meetings and individual ward meetings held at least monthly. A divisional quality, safety and governance meeting took place monthly that included details of all inpatient wards as well as acute medicine. This meeting reviewed new incidents and the progress of previous investigations as well as complaints, clinical effectiveness updates and other measures of performance in the division.

A quality and patient safety committee met monthly and included representatives from clinical governance, quality improvement, clinical engineering, nursing, patient panels and health and safety teams. We reviewed the minutes of meetings held from March 2018 to August 2018. During this period attendees maintained a consistent review of factors affecting patients and the delivery of care, including infection control, operational matters and staff training. Where performance fell short or the committee identified governance concerns, they documented the action taken to work towards a resolution.

Ward managers used a monthly well-run auditing tool as a key element of the local governance monitoring process. This included sampling patient records and testing the knowledge of random staff on duty on topics including the duty of candour, risk management, incident reporting and patient acuity. This enabled ward managers to maintain oversight of ward performance over time and to track areas for improvement and areas of consistently good practice. The trust had a target of 90% overall compliance with standards in each audit. Between July 2018 and August 2018 inpatient wards consistently met or exceeded the minimum standard and achieved 96% overall compliance. This reflected a range from 84% to 100%, including four wards that achieved 99% or above.

We reviewed a sample of 15 medical specialty governance meetings that took place from April 2018 to August 2018. There was evidence of consistent, effective governance processes in each. This included reviews of incidents and complaints and discussions of case reviews of complex care.

Clinical specialties, including diabetes, respiratory and older peoples’ medicine, were networked services across the trust and held network governance meetings on a cross-site basis. A medicines board maintained governance oversight of all networks and ensured they worked as far
as possible on cross-site working that benefited patients. Each clinical network had a director who worked with nursing and operational leads to develop areas of good practice and innovation and to ensure cross-site governance was effective. We looked at the minutes of 12 meetings that took place between January 2018 and July 2018 and found they were well attended by appropriate network staff with clearly defined terms of reference and outcomes.

Senior operations staff described a shift change in learning from incidents, complaints and risks. This included enhanced IT security and improving accountability and timeliness in governance processes. Senior teams had increased engagement with ward teams to facilitate the development and upgrade of the site and they said directorate teams had been enthusiastically involved in planning, which helped to reduce the impact of the disruption.

Each speciality structured their own governance processes. For example, a cardiology governance meeting took place every two weeks and was attended by the lead cardiology consultant, ward staff, representatives from the heart failure team, the physiologist, administrator, and the service manager.

Divisional teams had well-structured and defined governance and operational systems. A transformation board for integrated care was leading developments and progress with an NHS community trust to improve services and discharge processes. Operational teams reported to quality and safety network boards, which maintained oversight of services across the trust. Monthly operational meetings and a series of quality and safety meetings at divisional and board levels contributed to the trust’s overall governance, quality and safety structure.

OPS services were part of an established network, moderated by a chairperson and with a clear pathway to the executive board, which the leadership team said helped to progress the development of the frailty service.

Consultants led monthly morbidity and mortality meetings (M&M) by specialty and service and learning was shared through governance processes. We reviewed a sample of three M&M action logs completed between July 2018 and September 2018 in older peoples’ services and found teams led detailed discussions and case reviews that demonstrably led to improved practice and standards. For example, one mortality review led to specialised training being delivered for junior doctors in navigating challenging discussions with large family groups when relatives had disagreements amongst them about care. Another discussion led to more clearly defined referral pathways to the respiratory service and one discussion led to an improved system of tracking patients with a do not resuscitate (DNAR) authorisation in place at ward level.

There were multiple projects ongoing with community trusts and providers, including to strengthen existing relationships and establish new pathways. In most cases this provided staff with positive opportunities to expand capacity and working. However, it also presented challenges to governance processes as it meant senior teams had to work with multiple clinical commissioning groups, each with their own processes and structures.

Governance systems were in place for the weekend endoscopy service provided by an external organisation. This included an established standard operating procedure, escalation plans for patients who deteriorated and minimum staffing requirements. The team used existing hospital policies when they needed to refer patients to specialist services, such as when they found evidence of cancer. The service provider held Joint Advisory Group (JAG) accreditation, which meant standards of care were the same as endoscopy services provided weekdays by the hospital team.
Management of risk, issues and performance

At our last inspection in July 2016, site and operational teams had introduced a daily safety huddle to review the status of each clinical area. At this inspection we saw this process was fully embedded and a key element in the daily performance and risk management of the site. We attended two meetings, including one during our weekend unannounced inspection. At each meeting ward managers and service leads demonstrated a detailed understanding of the key challenges in their areas of responsibility as well as the immediate risks and what they needed from the senior team for support. A member of the team from each service, including contracted services, contributed to the meeting. This meant the domestic, transport, portering, cleaning, catering and security teams maintained an up to date awareness of the demands on the service and could work more closely with clinical colleagues to coordinate the service.

Divisional teams used risk registers to monitor and track risks in their services, which reflected our findings. We saw senior staff used this system effectively to improve safety standards as part of the governance and risk management system. For example, the environment on Acacia ward had been listed on the risk register for an extended period due to the infection control challenges presented by the age and configuration of the building. The ward was due to be relocated within 12 months of our inspection and in the interim the contracted soft facilities provider had taken steps to prevent the risk increasing. Staff on Cedar ward had submitted a request to enter a side room on the risk register. The room could accommodate one patient but was very cramped and during a previous cardiac arrest staff had found it difficult to access the patient with all of the equipment needed. The matron and ward manager had escalated this to the divisional governance team six weeks earlier but this had still not been added to the risk register.

The therapies team maintained a risk register of their service, which included one risk relevant to medical inpatients. This involved a lack of occupational therapy staff that resulted in delayed discharges. The risk had been in place since 2016 and related to three vacant band seven posts and two band six posts filled by junior staff. The therapies leads had implemented a number of mitigating strategies, including staff retention focus groups, the development of a new occupational therapy education programme and an international recruitment drive.

The trust operated a well-run ward quality and performance system. This reviewed the performance of each ward monthly using criteria from the safe domain and the caring domain of the CQC inspection framework. This system enabled ward managers to track results to identify new issues, resolved issues and repeat issues. We looked at safe and caring ward results for each inpatient medical ward for July 2018 and August 2018 and found consistently good results and trajectories of improvement.

The fire safety and operations team had engaged with an external consultant group to carry out a complete and intrusive safety review of the whole site prior to a period of major development work. This had led to immediate risk reduction strategies, such as the installation of a system to link the fire alarm system with lifts to prevent people using them in a fire. The team would repeat this at each stage of development to ensure risks were continually managed. This team was proactive in learning from other incidents at trusts across the country and attended briefings where other fire safety teams discussed incidents and what they changed as a result. The team had found some discrepancies in knowledge between clinical staff, the estates team and the fire safety team. To address this the fire safety team introduced more collaborative, multidisciplinary training and planning and worked with each ward manager to develop a risk management plan for their area. This had not yet been fully embedded as demonstrated by the issues we have highlighted in Faraday, Cedar and Peace wards.
Senior operational staff attended risk management meetings and weekly resilience meetings and the fire operational group maintained oversight of risks on the estate and in individual clinical areas. The group tracked fire alarm activations and monitored these for trends such as the location and time of alarm activations. They used this information to address issues such as security of the site and wards.

Senior divisional staff had improved performance and reduced complaints and discontent amongst staff by empowering teams and individuals to be more proactive in resolving problems and challenges. For example, ward managers were coached to address a problem as soon as it became apparent and to establish relationships with their teams that enabled them to proactively resolve their own challenges.

The AAUs did not have visitor reception desks in use and throughout our inspection entrance doors were unlocked and unmonitored. During our weekend unannounced inspection, we observed a concerned relative approach the doctor’s desk to ask for help. Three doctors were present and after six minutes of not being acknowledged, the visitor left the area to ask someone else for help. This was reflective of ward staffing, which did not include a receptionist or ward clerk. However, our observation highlighted gaps in security and in the awareness of some staff to the environment.

Site meetings took place three times daily with a structured leadership system in place and a demonstrable focus on operational performance and patient safety. We attended a site meeting as part of our inspection. Staff from all services and specialities attended the meeting to present admissions, transfers, discharges and risks. Staff used this meeting to ensure patients cared for as outliers were reviewed by the medical team. The flow team reviewed patients waiting for a package of care prior to repatriation and the meeting structure and attendees demonstrated an integrated, effective system.

The workforce matron worked with the fundamentals of care nurse lead to monitor quality and safety performance in relation to staffing. For example, they monitored if there were changes in the instances of pressure ulcers and falls as staffing levels changed and used this information to plan risk reduction work.

The serious incidents risk management assurance panel (SIRMAP) met weekly to review serious incident investigations. A range of staff from different specialties and services attended SIRMAP meetings, including clinical governance coordinators and senior governance staff. Matrons, senior nurses and associate directors of nursing also regularly attended. We looked at a sample of 12 meeting minutes from SIRMAPs that took place from May 2018 to September 2018. Staff involved with specific incidents attended meetings where this would contribute to the investigation or was important to implement learning and changes to practice. The panel documented where incidents were reportable to external bodies and maintained a continuous track record of how they met duty of candour responsibilities.

Ward managers monitored compliance with the duty of candour through a quality and safety dashboard. Between April 2018 and August 2018 inpatient wards performed consistently well, with 100% compliance with trust policy in instances in which the duty of candour applied.

The Forest Assessment Unit (FAU) ward manager met with a frailty consultant every three months to review the quality and performance of the developing frailty pathway. This team had led a pilot of the new service and the quality and governance arrangements meant they could respond to areas of reduced performance and tailor the service to patient need.

The clinical support services division held the risk register for therapies services and heads of therapies presented these to the quality and safety board on a quarterly basis. Key risks were a
lack of computers in wards and no plinths in the therapies gyms. Heads of therapies had raised a previous significant risk of a lack of equipment on inpatient wards. The trust had carried out an audit to corroborate the evidence and supplied new equipment for moving and handling as a result.

**Information management**

The discharge lounge team used a digital system to indicate to the flow and operations teams when a bed was available following a successful discharge. This system also alerted porters, the catering team and housekeeping team to tasks when a patient moved, which saved time compared with the previous system of discussing each task by phone.

Where staff did not work cross-site with colleagues in other trust hospitals, they were proactive in identifying ways to meaningfully share information that would benefit patients and develop practice. For example, the PDN for medical care liaised with colleagues through a forum to discuss opportunities for cross-site learning. They used this to strategise delivery of training to staff in units in which it was difficult to release staff for training, such as the AAU and FAU.

Clinical staff in some services told us case continuity with other hospitals in the trust needed to be improved, where a lot of their patients came from. Staff felt the handover process was awkward. For example, most of their notes were electronic that were subsequently printed to be sent and were often incomplete or omitted important treatments, such as anticonvulsants. Written drug charts were retained and sent as a photocopy, which then had to be quickly rewritten.

Improvements in the trust IT system meant clinicians could access electronic records remotely although this varied widely between specialties. However, staff cited IT as an on-going concern and said there were not enough serviceable computers in most clinical areas. For example, staff in the AAU said they often had to queue to use a computer, which wasted time they could spend with patients. They said this issue was long-standing despite escalation to senior staff. In other areas, such as Acacia ward, there was restricted space for mobile computer terminals. This meant doctors had to use them in narrow corridors, which partially blocked emergency escape routes and presented an additional risk that visitors would see confidential information.

The hospital had introduced enhanced security in the IT system following a malicious cyberattack in 2017. This protected patient and staff data from unauthorised access and ensured staff had local access to records in the event of a server failure.

A substantial programme of work was underway to adapt services to meet the NHS Accessible Information Standard. Clinical and IT staff had worked together to ensure patients’ needs relating to accessible information could be flagged on the electronic records system and to provide staff with access to detailed guidance on the intranet. This included the implementation of a staff resource to support them in delivering care to patients living with learning disabilities and those who communicated using Makaton. Staff involved in this project had also produced training material for staff to help them understand the communication needs of patients living with autism. The trust was working with a specialist information accessibility organisation to create an online guide for patients and visitors living with disabilities. This would help people to plan ahead their route once inside the hospital and identify how best to navigate the hospital buildings, such as step-free routes.

**Engagement**

Staff survey results in 2018 indicated a response rate increase of 18%, to 38% of eligible staff, since 2015 and highlighted key areas of improvement and areas to be addressed. The hospital performed better than the trust in the difference staff thought they made to patient experience,
their reporting of unsafe practice, training opportunities and acting on feedback from patients. However, only 62% of staff said they felt valued by their manager, 40% said their managers could not be counted on to help and only 50% said they felt supported by their line manager. The survey also highlighted a need for significant improvement in staff health and wellbeing, including relating to peer pressure to work when unwell. Senior divisional teams established action plans to address the results, which resulted in improvements such as opportunities for structured contact with colleagues through team meetings and more opportunities for professional development.

Medical divisions had introduced a suggestion box following staff survey results in 2017 as a strategy to enable anonymous feedback and suggestions.

Leadership triumvirates had action plans to improve staff well-being through more consistent, substantive engagement. For example, during a recent heat wave staff worked under very challenging conditions. To help support them managers ensured they had a continuous stock of cold bottled water and installed temporary air conditioning units around the hospital.

Senior teams promoted new opportunities for multidisciplinary working, including as part of individual professional development. For example, the operations team encouraged patient ambassadors and security staff to spend a shift shadowing a colleague in a different role, such as a pharmacy technician. The trust provided such opportunities on a quarterly basis as part of engagement events. This helped to build relationships between staff in different roles, which facilitated understanding of the challenges they faced.

Ward managers were developing standard operating procedures (SOPs) for their new departments as part of the hospital site redevelopment plans. We spoke with ward managers on Acacia ward and the discharge lounge about this and saw they had contributed to the plans and were working with their respective teams to ensure the transition was smooth.

There was evidence of staff engagement and active feedback from most levels of activity. For example, trainers asked staff to complete evaluation forms after specialist or ad-hoc study days. We looked at six examples of feedback after an EoLC study day, all of which were positive and provided constructive feedback on what worked well and what they would find more useful.

Staff engaged with each other through secure hospital social media accounts. A ward manager showed us how this worked in practice, including sharing of special projects and of successes. For example, the FAU team used social media to promote a new community partnership that had resulted in colourful blankets being provided for patients.

The hospital chaplaincy provided discussion sessions with staff on the impact of death as a support and engagement strategy. Staff said this was particularly useful if they experienced deaths unexpectedly or a death when these were not common in their clinical area. For example, staff on Acacia ward described four patient deaths in a 48-hour period, which had an impact on the team. Discussion sessions with the chaplaincy, EoLC team and senior nurses helped them to maintain their own wellbeing after this period. The EoLC team provided staff with self-care skills during study days as a supplement to the in-hospital support provided.

The EoLC team had identified 40 actions following results of the staff survey relevant to medical care services. For example, medical care staff reported uncertainty or a lack of confidence in providing EoLC and identified areas in which they would like more training. This was part of a broader service-wide engagement event in which the trust invited staff to attend discussions of the survey results.

Each ward had a schedule of meetings based on staff role or for the whole team. Staff told us attendance from staff outside of working hours tended to be very good as ward managers
provided incentives to attend. This meant ward teams were typically well informed with positive working relationships.

The nurse education team had identified alternative methods of staff engagement to support learning and development outside of the usual training structure. For example, the team had introduced a sepsis board game that engaged staff to test their knowledge and develop new understanding use methods that helped them spend time off the ward and in an environment without distraction.

Senior teams readily engaged with staff when reconfigurations would affect them. For example, the associate director of nursing and the medical care PDN met with staff on Victory and Peace wards in advance of a planned integration. They used this to outline their plans and get feedback and suggestions from staff.

The EoLC team were planning their first in-hospital conference, which would facilitate audit and research presentations from staff from across medical care and other services. This was part of the team’s efforts to embed EoLC more consistently in the daily work of medical care staff who often provided care at the end of life on wards. The conference would address care specifics such as how nurses could support patients in the final hours of life and care after death processes and symptom control and opioid prescribing for junior doctors.

Staff on some wards, such as Acacia ward, had prepared hand washing and hygiene posters for patients and their visitors. This helped to prevent infections on the ward and engaged patients in creating a safer environment.

The trust had launched a new patient information policy that included a process of review by the patient information review group and the patient readership panel. This ensured new information was accessible to patients and reflected best practice set by the NHS Accessible Information Standards and the Plain English Campaign.

The dementia and delirium team were closely involved in the patient engagement strategy to help develop a more accessible, inclusive environment and more individualised care planning. This team used the strategy to ensure staff adhered to the carer’s policy in adapting the service and access provisions to each person’s circumstances.

Each ward displayed ‘you said, we did’ information to demonstrate how the team had acted on patient feedback. For example, following feedback about standards of communication, the ward managers on Nightingale and Faraday wards introduced customer service training for all staff. Patients on Mary ward said they sometimes felt bored during the day and staff developed a relaxation area with books, games and music. Each ward introduced a ‘meet the ward manager’ time every day in response to feedback patients and visitors did not know who the ward manager was.

The equality and diversity team (EDT) was proactive and engaged with staff across medical care services and senior divisional staff encouraged their teams to attend events and training of importance or interest to them. The EDT led a trust-wide inclusion training for equality, diversity and human right and disability programme and worked with ward staff from black and minority ethnic (BAME) backgrounds to engage with the National Leadership Academy Stepping Up programme and the Windrush Leadership Development Programme. The team worked with ward managers to ensure they could support staff interested in the workforce race equality standard experts programme to attend. The trust had a staff diversity network, which the EDT supported and the team were working to promote inclusion ambassador roles to promote peer support.
Subgroups of the staff diversity network included a BAME group and a lesbian, gay, bisexual and transgender (LGBT) group. Subgroups met monthly and made the minutes of their meetings and their project work readily available for colleagues.

**Learning, continuous improvement and innovation**

The trust had an ambitious plan for redevelopment and upgrade of the site, many areas of which presented significant challenge due to the age of the existing buildings and the need to continue providing safe care to patients. We saw examples of well-coordinated planning between governance, operational, clinical and patient-focused teams to ensure plans to improve services maintained momentum. At the beginning of our inspection the lead nurse for the discharge lounge showed us plans for the relocation of the unit, which would provide patients with a more pleasant environment with level access to transport. Later in the inspection the hospital opened the new discharge lounge on time and on budget, which reflected the commitment and dedication of all those involved.

The trust had recognised a number of wards and individuals for exceptional standards of work and innovative contributions. For example, a member of the administration and reception team in endoscopy for their work in developing the cohesiveness of the team. The Syringa ward team had received three awards, including a Barts Health Heroes award, a Health and Care Top 70 Stars of 2018 award and a patient-led care award for consistently achieving recommendation feedback above 90%. The team on Cedar ward had won an award for their work in safety processes and had received a Barts Health Heroes nomination for engagement.

A volunteer on Birch ward had been based there for seven years and visited regularly, including every Christmas Day to provide patients with companionship. The trust had recognised them with an award for their service.

The ward manager on the FAU worked with a consultant and matron to prepare a business case for funding that would establish a post for a senior nurse to lead a discharge coordination role. The manager had also successfully secured charitable funding for a new bladder scanner and the unit had achieved recognition from the tissue viability team for achieving 365 days without a pressure ulcer. The manager had also been recognised in the Barts Hero Award programme for three consecutive years from 2015 to 2017.

As part of the development of a new frailty pathway and inpatient ward, the senior leadership team were developing plans for an integrated elderly system with a local authority.

A matron had moved from older people’s services and stroke into a workforce development role as part of a staff development and future sustainability strategy. They led a weekly drop-in service for ward managers and a ‘career clinic’ for all staff to help provide dependable support. The matron worked closely with staff across medical care to support them and help improve their job satisfaction. For example, they had visited another trust that had introduced a new system for nurses who were transferred to another ward during their shift to backfill gaps due to sickness. This trust had established a system that staff used to identify where they were most confident in working outside of their usual area and the workforce matron was establishing a similar system at Whipps Cross Hospital.

There was evidence of work across the hospital to ensure staffing was sustainable through development and promotion. For example, the ward manager on Acacia ward was developing the band five nurse team by providing shift leadership opportunities alongside training and supervision to support this. Healthcare assistants (HCAS) on this ward were working towards advanced care
certificates and the ward manager had recommended a band two HCA for enrolment on the associate nurse programme.

A multidisciplinary team had carried out substantial work developing a frailty pathway. This was a significant, evidence-based project that included a review of Office of National Statistics data on the local population and a review of the presentation of frail patients in the hospital. The team had established a vision for frail older patients and identified strategies to improve holistic outcomes for patients, including a better quality of life and reduced risks of readmission. The pathway was designed to be dynamic and change along with the population and included capacity to monitor outcomes and impact.

Staff in some teams and specialties were research-active and developed projects as a strategy for continuous care improvement. For example, the complementary therapies service had carried out a project to identify how therapy could help symptom management in patients hospitalised with an advanced cancer diagnosis. The gastroenterology and dermatology teams were involved in 23 distinct research projects aimed at furthering knowledge and understanding of specific conditions and the palliative care team worked with medical care colleagues to identify opportunities to improve inpatient care.

Ward managers demonstrated a detailed understanding of the future challenges of continuity in their ward and made adjustments accordingly. For example, one ward manager identified the potential retirement of a significant number of nurses in the near future as a risk to the service. To encourage staff to remain in post they offered flexible working, modified rotas, part time working, occupational health support and extra training.

There was a drive to significant increase the number of senior nurses who could prescribe in the AAU and in the EoLC care, both of which would enable faster service to patients and less reliance on doctors out of hours.

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**Surgery**

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**Facts and data about this service**

Whipps Cross hospital is part of Barts Health NHS Trust which is currently in special measures. Whipps Cross University Hospital provides a range of elective (planned) and emergency surgical services to people living in the London Borough of Waltham Forest. The service includes a range of specialties - orthopaedics, general surgery, vascular surgery, colorectal surgery, urology, upper gastro-intestinal trauma, ear, nose and throat (ENT) and ophthalmic surgery.

The operating theatres are located in three separate areas within the hospital. There are 12 operating theatres in total. Two theatres are dedicated to ophthalmology. Four theatres are used to carry out day-case procedures and two were designated emergency theatres that were available for operations 24 hours a day, seven days a week. The ophthalmic unit was a separate standalone unit, including outpatients and theatres.

The hospital provides 24 hour emergency care on the Whipps Cross site and through links to other hospitals within the trust. The hospital has a wide range of outpatient clinics to support surgical
services. There is a pre-operative assessment unit where patients due to have a general anaesthetic will have their fitness for surgery assessed. Patients undergoing day surgery attend a day-case unit which has 28 beds. There are 86 acute surgical inpatient beds, 27 trauma orthopaedic beds with 12 elective orthopaedic beds.

All services are supported by a multi-disciplinary team with some specific services linked to other specialist hubs. There is a close relationship with the oncology and radiotherapy units to provide cancer patients with integrated treatment pathways. Anaesthetic services are also part of the surgery division providing anaesthetic cover for surgical specialties and a specialist pain management service.

The trust had 54,372 surgical admissions from April 2017 to March 2018. Emergency admissions accounted for 15,410 (28.3%), 29,246 (53.7%) were day case, and the remaining 9,716 (17.8%) were elective. Between April 2018 and August 2018 a total of 7,089 surgical procedures had been carried out.

(Source: Hospital Episode Statistics)

When we previously inspected this service in April 2018 Poplar and Sage wards were used as ‘surge’ beds. The beds were re-designated to accept patients from a range of specialties, admitted as emergencies over the busy winter period. The trust informed us this was a temporary measure and the wards would return to their original functions once winter pressures had subsided. Sage ward usually functioned as an elective orthopaedic ward. Elective orthopaedic surgery was suspended over the winter months. At this inspection, we found Sage ward had returned to providing elective orthopaedics in May 2018 and Poplar ward was caring for short stay surgical patients. The 14 additional beds opened on Poplar ward over the winter had been kept open.

Is the service safe?

Mandatory training

The trust set a target of 85% for completion of mandatory training. A breakdown of compliance for mandatory courses as of the 4 June 2018 for nursing staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/ No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality and Diversity</td>
<td>209</td>
<td>210</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Working at Bart’s Health</td>
<td>208</td>
<td>210</td>
<td>99%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness</td>
<td>207</td>
<td>210</td>
<td>99%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fraud Awareness</td>
<td>206</td>
<td>210</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling - Patient Handling Practical</td>
<td>205</td>
<td>210</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>205</td>
<td>210</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety</td>
<td>205</td>
<td>210</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Security</td>
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<td>210</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Privacy and Dignity</td>
<td>204</td>
<td>210</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Name of course</td>
<td>Number of staff trained (YTD)</td>
<td>Number of eligible staff (YTD)</td>
<td>Completion rate</td>
<td>Trust Target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>----------------------------------------------------</td>
<td>-----------------------------</td>
<td>-------------------------------</td>
<td>------------------</td>
<td>--------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>142</td>
<td>150</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>140</td>
<td>150</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling - Patient Handling Low Risk</td>
<td>139</td>
<td>150</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Consent</td>
<td>139</td>
<td>150</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness</td>
<td>137</td>
<td>150</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Nursing and midwifery staff exceeded the 85% completion target for 26 out of 27 mandatory training modules. Risk assessment for managers failed to meet the trust target with 81%.

A breakdown of compliance for mandatory courses as of the 4 June 2018 for medical staff in surgery is shown below:
Medical staff exceeded the 85% completion target for 20 out of 25 mandatory training modules. The lowest scoring module was medical gas safety with 74%.

The surgical division was making a concerted effort to ensure staff completed their mandatory training and rates had improved since our last inspection. The division of surgery’s leadership team monitored compliance rates monthly and managers reminded staff collectively and individually about the need to complete the training.

We did not see specific training provided in sepsis identification and treatment. However, staff told us they covered sepsis awareness in their early warning training. During our previous inspection in April 2018, the hospital was running an awareness raising campaign about sepsis. We saw displays on wards and on the corridors reminding staff about the importance of early identification and treatment. All ward staff exceeded the target for training on the early warning system used by staff to identify deteriorating patients.
(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Safeguarding

The trust set a target of 85% for completion of safeguarding training. A breakdown of compliance for safeguarding courses as of the 4 June 2018 for nursing staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Level 1</td>
<td>209</td>
<td>210</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>205</td>
<td>210</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>199</td>
<td>205</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>201</td>
<td>210</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Nursing and midwifery staff met or exceeded the 85% completion target for all four safeguarding modules.

Staff we spoke with were aware of when and how safeguarding referrals should be made. 100% of nursing staff had completed level 1 safeguarding training and 96% had completed level 2. Most staff had completed the necessary safeguarding training. We were aware of one incident during our inspection which potentially raised a safeguarding concern. This had occurred a few days before our inspection began. When we asked the ward manager about this they showed us the incident form which had been submitted and we saw the matter had been passed on to the safeguarding team who were investigating. We also saw several incident reports where staff had identified safeguarding concerns based on information patients had disclosed or because staff had noticed bruises or other signs of harm which were not fully explained. Incident reports had been submitted and the safeguarding team had investigated and referred the matter to the local authority safeguarding service. Staff we spoke with were aware of the risks of female genital mutilation (FGM).

A breakdown of compliance for safeguarding courses as of the 4 June 2018 for medical staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Level 3</td>
<td>7</td>
<td>7</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
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<tr>
<td>Safeguarding Children Level 1</td>
<td>146</td>
<td>150</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>145</td>
<td>150</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>132</td>
<td>143</td>
<td>92%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>133</td>
<td>150</td>
<td>89%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Medical and dental staff exceeded the 85% completion target for all five safeguarding modules.  
(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

**Cleanliness, infection control and hygiene**

The environment in theatres and on the wards was visibly clean. Cleaning schedules described the tasks cleaning staff on the wards were required to undertake but there were no records of checks carried out to confirm they had been fully completed.

Improvements had been made to the process for decontaminating reusable medical devices which met national standards. At our previous inspection staff had described problems with the service. There were problems with surgical instrument packs which were not correctly packed and items of missing equipment. However, at this inspection we found the service had successfully resolved the problem.

We saw the cleaning schedules in theatres which showed all the necessary tasks for the week prior to our inspection had been completed. Daily cleaning checklists were visible, pinned to the wall.

Hand washbasins and hand sanitising gel were provided at the entrance to all wards and theatres. Hand gel dispensers were also located throughout the wards on corridors and at the entrance to bays. There were posters throughout the wards encouraging staff and visitors to use the gels. We observed nursing, medical and other staff following hand hygiene procedures, washing their hands before and after patient contact. Staff wore appropriate personal protective equipment (PPE), including gloves and aprons and we saw this equipment was available throughout the wards.

Waste bags in theatre were marked with information including date, theatre, and case number in line with association for perioperative practice (AfPP) recommendations for safe practice.

Equipment in theatres and on the wards had ‘I am clean’ stickers with the date they had been cleaned. We also saw staff in theatres decontimated equipment correctly.

We observed that computer keyboards were in use in theatres. This is not best practice as they can present an infection control risk. We raised this with the theatre matron who told us they would arrange to have these replaced.

At our previous inspection, we found that patients from other surgical and medical specialties were cared for on an elective orthopaedic ward. The British Orthopaedic Association (BOA) guide to good practice (2006) recommended that elective orthopaedic patients should only be nursed in dedicated elective orthopaedic wards to minimise the risk of cross-infection. At this inspection we found the ward had returned to only providing care for elective orthopaedic patients.

Patients were screened for meticillin-resistant staphylococcus aureus (MRSA) either as part of the preadmission process or received a blood test when they arrived on the ward.

The trust provided us with information about the number of reported cases of MRSA and other acquired infections for the five months between April 2018 and August 2018. This showed there had been no cases of MRSA. However, the incident information which had also been supplied to us by the trust referred to four incidents where there had been issues associated with providing appropriate care to patients with MRSA. On the 13.04.2018 a patient was transferred to a surgical ward requiring isolation because they were MRSA positive. Another patient was transferred from a surgical to an orthopaedic ward and screened shortly after admission to the orthopaedic ward as part of the admission process on 14.05.2018. A positive result was received three days later when the patient was transferred to a side room. The other patients in the bay were informed and they were re-screened. A patient with MRSA was allocated to an orthopaedic ward because of a
shortage of beds on 27.05.2018. On 06.06.2018 a laser was transferred between two theatres. The investigation into the incident found that, “although one of the patients in theatre 12 was MRSA positive the machine was not used on this patient and standard cleaning of equipment was felt to be sufficient and although not ideal this caused minimal delays between lists”.

Within the reporting period, there were no cases of E coli and one case of Clostridium Difficile. There were two methicillin-sensitive staphylococcus aureus (MSSA) cases, which were investigated. The likely sources were identified and discussed with the trust’s microbiology team.

At our last two inspections, we found that surgical site infections (SSIs) were not being effectively monitored or reviewed. An SSI is a type of healthcare-associated infection in which a wound infection occurs after an invasive (surgical) procedure. There had been no cases submitted for the period January – March 2018 because planned hip and knee replacements were suspended due to winter pressures. Since March 2018 the trust had submitted data monthly.

The audit results for May – June 2018 were not available at the time of our inspection. They were expected later in 2018.

The trust had previously provided us with information for the period March 2017-December 2017. This related to 180 hip and knee patients who were contacted after discharge. Those figures showed there were four cases of post-operative infection identified between March and December 2017. Surgical site infection rates were collected through post discharge questionnaires reviewed 30 days following surgery, a review in the outpatient department and finally followed up after a year. Any cases identified were reviewed by a multi-disciplinary group of clinicians.

The trust provided us with the results of hand hygiene audits undertaken between April 2018 and August 2018. These showed variation between wards and between months for example the results for Plane Tree ward ranged from 91% to 100%, between 73% and 100% on Poplar ward, between 95% and 100% on Primrose ward, 78% and 94% on Rowan ward, 98% to 100% on Sage ward and 95% to 98% on Sycamore ward. Audits in theatre showed 100% compliance apart from August when it was 98%.

We observed staff followed the trust’s hand hygiene policy and staff in contact with patients were bare below the elbow.

The trust provided us with records of deep cleaning and regular periodic cleaning in theatres which showed theatres 9-12 were deep cleaned in April 2018 and theatres 3-4 were deep cleaned in July 2018, whilst theatres 5-8 had a regular clean in June 2018. This was in line with the minimum NHS standard, but not with best practice recommendations as the per association for perioperative practice (AfPP) which states theatre deep cleaning should take place every six months.

**Environment and equipment**

On our previous inspection, staff were concerned about the need to replace the anaesthetic machines in theatres. This affected several sites across the trust and the timescales for replacing these was not clear. At this inspection we found that the service had been trialling new machines and the funding had been authorised to replace all 15 machines. However, there was also a concern about six operating tables which could no longer be maintained. The service’s leadership team told us they were fully aware of the need to replace these by February 2019 and were looking at ways of doing this.

The division of surgery risk register also highlighted the problems staff encountered daily with the anaesthetic machines frequently failing their initial test in the morning, resulting in delays to the operating lists starting on time.
Theatre staff told us that there were problems with repairing or replacing larger items of broken equipment. Managers told us the trust had provided significant funds for major equipment replacement. However, we found 25 out of a total of 47 items on the surgical division’s risk register related to items of theatre equipment which were obsolete or at the end of their life. The number of equipment risks logged had reduced slightly since our last inspection. Staff on Plane Tree ward told us they experienced difficulty obtaining replacement equipment if an item was broken. They told us that a piece of equipment used in urology for testing urine had been condemned and they were trying to obtain a replacement. During the factual accuracy process, the trust provided us with the 2018-2019 medical equipment replacement log which showed information was collected on items of equipment which required replacement. Although the log showed the business case status for the 2046 items of equipment recorded, it did not provide details for when the equipment would be replaced or if the necessary funding had been allocated. During this inspection staff told us there were still issues accessing equipment or getting broken equipment repaired.

Four theatres (theatres 5-8) had been refurbished since our previous inspection. This was part of a programme for improving the environment throughout the main theatre areas. During our previous inspection we found chipped paint work and cracks in walls and ceilings. These had all been rectified at this inspection. However, the surgical division’s risk register showed theatres three and four were in need of refurbishment and the emergency and paediatric theatres were not compliant with Department of Health standards. The leadership team told us these theatres would be refurbished as part of a rolling programme of environmental improvements over the next 12-18 months.

We observed the fabric covering some stools used in theatre were split, exposing the inner foam which could pose an infection control risk.

At our previous inspection, the service had experienced problems with instrument packs. Items of equipment were often missing. A new arrangement was in place with a company who cleaned and packed the equipment needed for each procedure. The service had taken steps to improve the situation and at this inspection we found the problem had largely been resolved. The surgical division’s risk register, which was updated for this item in August 2018, was still indicating there were occasional problems. The risk had initially been assessed as 12 out of 20 and had not been downgraded despite the action taken to mitigate the risk.

We also found, at our previous inspection, that staff had difficulty accessing equipment on the wards. Staff raised this issue with us again at this inspection. They told us they had difficulty obtaining patient monitoring equipment and infusion pumps. We asked the trust about this, who told us, the age of the pumps and the rotation through the equipment library for repairs sometimes led to shortages. The trust were planning to purchase additional pumps.

We reviewed the anaesthetic log books and found the appropriate checks were carried out each day in accordance with the Association of Anaesthetists guidelines. We checked the resuscitation trolleys in theatres and found these included all the correct equipment. Records showed they were checked daily by staff and they were sealed to ensure they were tamper proof. We also checked the ‘difficult airway’ trolley and found it contained appropriate equipment, which was also checked daily. There were clear policies in place for the use of lasers and x-ray equipment, which staff understood and followed. Other equipment in theatres had undergone electrical safety checks, which were up to date.

At our previous inspection, we found equipment used by staff carrying out procedures on patients with tracheostomies stored in an area which was adjacent to a patient bay. The equipment was
not secured. We also found ENT equipment in an unlocked room. At this inspection we found the areas had been cleared and the room locked.

At our previous inspection, we found the current chronic pain treatment room was not suitable for treating patients. Staff told us the table was on an equipment replacement list. The room was also small with limited space for staff to scrub up. We advised the trust that the room did not meet current health building standards (HBN 26). At this inspection we found a new table had been purchased however, the service had not been relocated to more suitable accommodation.

Managers had developed a plan for re-locating the service and told us this would be carried out after the theatre refurbishment programme. In the meantime, as many procedures as possible were being carried out in main theatres when there was capacity.

Several patients we spoke with commented on the noise levels on the ward during the day and at night. They said some patients had dementia and were calling out but staff were not always able to attend to them, others were keeping people awake by being on mobile phones late into the evening.

Assessing and responding to patient risk

In theatres, staff met each morning at 8am to discuss the surgery planned for that day and to anticipate any risks or issues which might affect the day’s work in theatres. We observed theatre staff discuss the patients due for surgery, any changes to the order in which operations would take place and ensuring the appropriate equipment was available. The order of one list of patients was changed which did not conform to AFPP recommendations because of the risk of confusing patients and procedures. Theatre staff contacted ward staff to confirm the change and the list was altered by hand. We did not see a new printed list reflecting the changes.

Staff completed appropriate checks before, during, and after surgery. They used the five-step approach to safer surgery based on the World Health Organisation (WHO) surgical safety checklist. The service had also developed a number of local surgical safety checklists. Local checklists had been developed for tracheostomy, pleural drainage, intubation and insertion of central venous catheter (CVC).

Use of the surgical safety checklist was audited monthly using an observational tool by the theatre matron or practice development nurse. A minimum of five cases per month were observed to ensure compliance with all five stages of the safer surgery process. Audit results showed 100% compliance with all stages of the checklist across all theatres between April 2018 and August 2018.

We observed staff in theatres follow best practice guidelines for the swab count and recording what happened during the procedure.

The checklist approach was used to reduce errors and adverse events, improve teamwork and effective communication. We observed these checks being carried out. These involved all the staff present in theatre. Patient details were checked, equipment requirements discussed and any special needs highlighted. During the process we observed anaesthetists carry out a full check of the patient’s consent, check if they had any allergies and that they had fasted for the correct period of time. The pre-operative checklists were completed in full. All elements of the “Sign In” section of the checklist was verbalised so that all staff could hear the checking process was being completed.

There were two surgical pre-assessment units; one for day case patients who would be receiving a general anaesthetic, the other for all surgical in-patients. Nursing staff collected information about patients’ medical history. Patients who represented a risk were assessed by anaesthetic
staff who reviewed the patient’s medical records and the information gathered by nursing staff. The details of clinical risks were highlighted so that theatre staff were aware prior to surgery and could make an adjustment as necessary. As part of the surgical pre-assessment process an anesthetist reviewed patients with a high risk of cardiac problems.

Medical staff we spoke with expressed concerns about the absence of a surgical assessment unit (SAU). There was a clinical decision unit but this was led by medical staff from the emergency department rather than surgical staff. Acute surgical patients were transferred to one of four acute surgical wards depending on the beds available. We asked if there was a process for identifying the most acutely ill patients to enable surgical staff to prioritise which patients they should see first. The surgical site leadership team told us medical staff were experienced in prioritising which patients they needed to see first but this was not formalised. They told us there had been no incidents reported about patients who had been harmed or were at risk of being harmed because of delays in assessing their care. At our previous inspection the leadership team told us the creation of a surgical assessment unit was a high priority. The leadership team acknowledged that it had not been possible to identify the correct location for a surgical assessment unit but this remained a high priority within their service improvement plan. This meant there was a risk of a delay in medical staff reviewing the most acutely ill patients.

During the factual accuracy process, the trust told us they recognised that there was a risk of delay in medical staff reviewing the most acutely ill surgical patients. The trust mitigated this risk by having a consultant-led dedicated team to review, assess and provide management plans for emergency patients. The surgical service also had a system in place for escalating patient delays where a patient in the Emergency Department could be assessed by a surgical doctor. Pathways were in place for patients with an urgent surgical condition for example an abscess or appendix problem. The surgical team had also set up “hot” clinics for all surgical specialties which meant surgical patients could be seen quickly in a clinic. The majority of surgical emergency patients were admitted to surgical wards, where surgical doctors were located. Surgical patients were admitted to the acute assessment unit (AAU), if they could not be admitted to a ward, where they are reviewed by the surgical team. During this inspection, although staff we spoke with acknowledged the triage arrangements, staff told us they felt the risk remained.

When we raised this with the trust they told us they had completed an option appraisal on the best approach to establishing a SAU. Several different sites within the hospital were considered and through clinical engagement and risk assessment, the hospital management board decided not to pursue the options because it introduced more risks. The hospital was undergoing a capacity and demand planning process which was likely to result in changes to the wards and at the end of the process a suitable area might be found.

The trust told us that in the meantime arrangements were in place to triage and manage surgical patients. These included a full 24/7 general surgery, orthopaedic and surgical specialties on call service. A surgeon of the week in place in orthopaedics and general surgery. Emergency patients were seen by teams in the emergency department, clinical decision unit and admissions assessment unit. There were full handover meetings at 8am and 5pm and consultant led ward rounds in all specialties with patients seen daily. A process was in place for escalation if there were any clinical concerns. All patients were seen by a consultant within 14 hours of admission and any clinical concerns would be seen immediately and receive immediate intervention. All emergency patients were seen daily by a consultant or senior registrar on a post take ward round. The service had also implemented a service improvement project aimed at improving patient flow (PERFORM). The trust told us these measures all reduced the risks associated with the absence of a surgical assessment unit.
We saw incident reports about ward staff having difficulty obtaining medical assistance for patients during the night. For example, one patient needed IV fluids, anti-sickness and pain relief. Ward staff reported that they called the on call surgical senior house officer (SHO) on 4 different occasions from 2300-0700. The doctor was busy in accident and emergency (A&E), arriving on the ward at 7.20 in the morning despite reporting the patient as being unwell.

At previous inspections, we found some patients were cared for overnight in the theatre recovery area if there was no bed available on a ward. When we last inspected in April 2018 staff told us this practice had reduced and only occurred on the rarest of occasions. At this inspection staff told us the practice had stopped all together. Although information provided by the trust showed there had been three reports of overnight stays in recovery in April 2018 (1) and May 2018 (2), there had been no further instances between June 2018 and August 2018.

We found risk assessments had been completed for venous thromboembolism (VTE), nutrition and pressure ulcers.

Nursing staff used a recognised tool for assessing the risk of patients developing pressure ulcers (SKINN) bundles to monitor the risk of pressure ulcers. The condition of patient’s skin was assessed on admission, with any concerns discussed at the daily ward meeting. As a result of the risk assessment staff might order a pressure relieving mattress, identify the need for re-positioning the patient every two hours and use appropriate barrier creams. Staff told us they completed an incident form if they identified any pressure damage. The tissue viability nurse would visit and check the grade of a reported pressure ulcer and provide a more detailed care plan. The tissue viability nurse reviewed patients every three days or if the pressure ulcer deteriorated in which case staff would also submit a further incident report. Practice development nurses told us they were concerned about the number of pressure ulcers on the wards and said they were reviewing practice to ensure the trust’s policies were being followed correctly.

Staff told us they assessed the risk of patients falling and we saw care plans where assessments had been carried out. In some cases, patients had one to one staffing if they were at a high risk of falls. Practice development nurses were working with ward staff to reduce the number of falls which was high. As a result staff had requested alarms which would alert them to at risk patients in armchairs standing up. Staff said they had learned about these being used in other areas of the hospital and requested them as they thought they would provide further assurance.

Ward staff told us the trust had recently had a “Big push” on identifying patients at risk of developing sepsis. They told us staff had received training on symptom recognition and they were able to access medicines quickly from a sepsis trolley. We observed posters in clinical areas with information about the signs of sepsis.

The service also wanted to increase the number of patients who received nutritional assessments, as ward managers were concerned about identifying patients who were most at risk of malnutrition. Efforts had concentrated on Rowan ward with positive results. Between April 2018 and August 2018, the proportion of patients screened had increased from 24% to 99%. Assessments on Sage ward had also improved from 86% to 93% and from 74% to 76% on Poplar ward. However, rates had fallen from 77% to 49% on Sycamore ward and from 75% to 41% on Primrose ward.

The service used the national early warning scoring system (NEWS) for identifying deteriorating patients. Ward staff told us nurse practitioners were available 24 hours a day to assess and treat deteriorating patients. Staff said the critical care outreach team responded quickly if they contacted them about a patient and there was also 24-hour consultant cover. Records showed NEWS scores were being used and recorded.
in theatres. We checked six records and saw scores were recorded accurately in accordance with the trust’s policy. The service was shortly introducing NEWS 2 which was a more up to date and detailed scoring system.

**Nurse staffing**

Whipps Cross Hospital reported the following nurse staffing numbers for surgery in March and April 2018. The trust’s fill rate was below 90% in March and April 2018.

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</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>225.1</td>
<td>286.3</td>
<td>78.6%</td>
<td>226.1</td>
<td>280.3</td>
<td>80.7%</td>
</tr>
</tbody>
</table>

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

We attended a theatre staffing meeting and found staffing levels for the day were reviewed in accordance with the AFPP safe staffing guidance.

From May 2017 to April 2018 Whipps Cross Hospital reported a vacancy rate of 19.3% for nursing staff in surgery, this was higher than the trust’s target of 6.3%.

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

At our previous inspection, we saw the surgical division’s risk register identified nurse staffing levels as a risk describing how patients might come to harm if nursing care was not provided at the required level. The risk register also noted that staff satisfaction, access to training, team meetings and overall daily stress levels could be affected as a result of gaps in staffing rotas, unfilled shifts or temporary staffing. The risk rating at the time of our inspection was 12 out of 20 and we saw that at this inspection the rating had not changed. When we spoke to the leadership team about nurse staffing they told us there were 38 vacant posts for registered nurses but 33 posts were now filled. New staff were due to take up posts in September and October 2018. There were 14 healthcare support worker vacancies, three of which were filled.

There were 13 whole time equivalent vacancies in theatres. All the posts had been recruited to or were out to advert. The vacancies were covered by bank and agency staff. There were four nursing vacancies in the ophthalmology theatres. The service had recruited replacement staff but they had not yet taken up post. The vacancies were covered by bank and agency staff.

At our previous inspection, staff told us there were a large number of vacancies which were being covered by temporary bank and agency staff. They told us the high use of temporary staff added pressure to the work required on a busy ward. Agency staff had a minimal induction to the ward. A practice development nurse told us they were developing an induction programme for temporary staff.

Managers told us they had held a recruitment drive to recruit newly qualified nurses and nurses from overseas. At this inspection, the trust provided us with information about the results of the recruitment process. Although nurse staffing levels had improved since our last inspection, further improvements were required to meet the trust target of 6.3%. During this inspection, the vacancy
rate on Primrose Ward was 11% compared with 34% previously, 18% on Sycamore compared with 26% previously, 16% on Rowan 16% compared with 36% previously.

The trust had recently announced the creation of 26 new posts on Poplar ward. The number of beds on Poplar ward had increased from 15 to 28 over the winter period and the surgical division had decided to keep the additional beds open. At our last inspection, temporary staff were used to cover the increased number of beds. Consequently, the ward had 21 vacancies with 11 staff in the recruitment pipeline, many of whom were expected to be in post in September 2018.

The matron for surgery told us staffing levels were reviewed several times a day and discussed at the site safety meeting which took place each morning. Managers would redeploy staff if a ward had less staff than required. We saw that hospital-wide bed management meetings were being used to identify and address gaps in staffing. Staff were moved to provide cover on wards which were short staffed.

The matron told us they tried to ensure there were two trained nurses on each ward as far as possible. Each ward had a supernumerary ward manager, or a junior ward manager to cover this role. However, ward managers told us they spent a large proportion of their time working clinically, which meant they sometimes spent as little as one day a week on management and staff supervision.

An electronic staffing acuity tool had been implemented which calculated the staffing levels required based on patients’ dependency levels. The system used a red, amber, green (RAG) score for highlighting where staffing levels were safe or unsafe. Managers had recently started to use the system for moving staff between wards or for requesting additional bank and agency staff.

From May 2017 to April 2018, Whipps Cross Hospital reported a turnover rate of 15.6% for nursing staff in surgery, this was higher than the trust’s target of 13%.

Managers told us they were creating rotational posts designed to broaden staffs’ experience and provide more career development, as a means of retaining nurses.

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

From May 2017 to April 2018 Whipps Cross Hospital reported a sickness rate of 4.6% for nursing and midwifery staff in surgery, this was higher than the trust’s target of 3%.

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

From May 2017 to April 2018, the Whipps Cross Hospital had a total of 18,756 nursing staff shifts. A breakdown of bank and agency usage and unfilled shifts is shown below:

<table>
<thead>
<tr>
<th>Bank and agency</th>
<th>Number of shifts (% of total shifts)</th>
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<tbody>
<tr>
<td>Bank</td>
<td>8,353 (44.5%)</td>
</tr>
<tr>
<td>Agency</td>
<td>3,624 (19.3%)</td>
</tr>
<tr>
<td>Not filled</td>
<td>852 (4.5%)</td>
</tr>
</tbody>
</table>

The number of shifts filled by bank and agency staff was 91% in April 2018, 94% in May 2018, 96% in June 2018, 93% in Jul 2018, 93% in August 2018. Fill rates in theatres were 98%, 93%, 95%, 97% and 92% for the same months.

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

**Medical staffing**

Whipps Cross Hospital reported the following medical staffing numbers for surgery in March
The trusts fill rate was above 90% in March and in April 2018.

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</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>186.9</td>
<td>208.7</td>
<td>89.5%</td>
<td>183.3</td>
<td>209.4</td>
<td>87.5%</td>
</tr>
</tbody>
</table>

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

From May 2017 to April 2018, Whipps Cross Hospital reported a vacancy rate of 14.9% for medical and dental staff in surgery, this was higher than the trust’s target of 6.3%.
(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

From May 2017 to April 2018, Whipps Cross Hospital reported a turnover rate of 5.7% for medical and dental staff in surgery, this was lower than the trust’s target of 13%.
(Source: Routine Provider Information Request (RPIR) P18 Turnover)

From May 2017 to April 2018, Whipps Cross Hospital reported a sickness rate of 0.8% for medical and dental staff in surgery, this was lower than the trust’s target of 3%.
(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Consultants provided on site medical cover Monday to Friday, five days a week. On call and out of hours surgical cover was provided by a consultant of the week model in general surgery and trauma and orthopaedics. Elective commitments were cancelled during on call period to ensure consultants had the capacity to deal with emergencies. Out of hours cover on site was provided for all surgical specialities by junior medical staff from general surgery.

Other surgical specialities (ENT, ophthalmology, urology) provided a 24/7 consultant rota supported by a middle-grade doctor.

Acute and emergency surgical patients were reviewed by a consultant within 14 hours of admission. Rotas and working patterns did not permit consultants to review patients within the 12 hour standard. Consultants or other senior medical staff were available to review patients whose early warning score (NEWS) showed deterioration. A critical care outreach team was available for patients requiring emergency medical intervention out of hours.

Consultant led ward rounds of all emergency admissions and acute patients took place seven days a week.

Within trauma and orthopaedics there was a daily consultant led trauma and emergency meeting and ward round. There was on site consultant presence from 8am to 5pm daily including weekends supported by a registrar and SHO.

The ENT, urology and ophthalmology services were provided by consultants available on site daily supported by non-resident middle grade staff and a specialist registrar or trust grade doctor.

All three specialties provided daily review of all emergency and acute patients.

There were daily consultant led ward round of all emergency admissions and acute patients including week-ends.
At night, surgical and anaesthetic cover was provided by a consultant anaesthetist between 8pm to 6am. An ITU consultant provided on site cover seven days a week from 8am until 8pm, Monday to Friday and 8.30am until 2pm at weekends. There was also a resident ITU registrar available 24/7.

From May 2017 to April 2018, the Whipps Cross Hospital had a total of 5,797 medical staff shifts. A breakdown of locum and agency usage and unfilled shifts is shown below:

<table>
<thead>
<tr>
<th>Locum and agency</th>
<th>Number of shifts (% of total shifts)</th>
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<tbody>
<tr>
<td>Locum</td>
<td>2,056 (35.5%)</td>
</tr>
<tr>
<td>Agency</td>
<td>860 (14.8%)</td>
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<tr>
<td>Not filled</td>
<td>47 (0.8%)</td>
</tr>
</tbody>
</table>

This means that half of all shifts were provided by locum or agency staff. 
(Source: Routine Provider Information Request (RPIR) P21 Medical Locum)

From March 2018 to March 2018, the proportion of consultant staff and junior (foundation year -2) reported to be working at the trust were lower than the England average.

**Staffing skill mix for the whole time equivalent staff working at Bart’s Health NHS Trust**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
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<tbody>
<tr>
<td>Consultant</td>
<td>42%</td>
<td>49%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>5%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>47%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>7%</td>
<td>11%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

**Records**

The service was using both electronic and paper-based medical records. The trust had introduced a new electronic clinical information system and told us they were moving away from paper records to electronic records. Since our last inspection new portable electronic records consoles had been put into operation. These allowed staff to view and update patients’ electronic records by the bedside.
We reviewed eight sets of paper based nursing records which were all fully completed. We also reviewed five sets of medical notes in theatres and found these had all been comprehensively completed. These contained national early warning scores (NEWS) for identifying patients whose condition deteriorated. The records also contained risk assessments for example venous thrombo embolism (VTE) assessments.

Nursing records included information about nutritional needs, mouth assessment, a moving and handling assessment, falls risk, a bedrails decision tool to help determine if these were needed. An assessment of the patient’s independence was included along with fluid balance charts and a hydration (Waterlow) assessment.

Agency staff told us they were unable to access patients’ electronic records and had to ask admin staff to access a patient’s records if they wished to check their care plan.

We found unsecured medical records at previous inspections. At this inspection, records were all stored in lockable trolleys although not all the trolleys were locked. Staff we spoke with were all aware of the importance of keeping patient identifiable information secure and there were notices up on the wards reminding staff of the need to keep patient information secure.

An audit of theatre records was carried out in each theatre monthly reviewing data on the theatre information system or written health care records. There was no equivalent review of patients’ other clinical records.

Incident report information supplied by the trust showed there were a large number of incidents relating to incorrect or incomplete information about patients attending for eye surgery. The incidents included incorrect patient identification information, incorrect recording of whether sedation or general anaesthetic was planned and incorrect information about the implant the patient required.

**Medicines**

Following our last inspection in April 2018, we issued the trust with a warning notice for medicines management as we found access to medicines was not appropriately restricted on the surgical wards and the trust’s medicines management policy was not being followed in relation to medicines storage and expired medicines. On this inspection, we found the trust had addressed many of the concerns we highlighted. For example, we found improvements in the access to medicines in all the surgical areas we visited. The locks on the doors to the room where medicines were kept had all been replaced. Medicines trolleys were locked when not in use. Medicines were stored securely and disposed of appropriately. Medicines were stored in line with trust policy and when room or fridge temperatures went out of range, staff took remedial action.

On our last inspection, we found medicines related incidents were not always reported. On this inspection, we found the reporting of medicine related incidents had improved. Ward managers were reminding staff about the importance of reporting incidents and all the staff we spoke with were aware of recent medicines incidents. These were discussed at handover and at the weekly ward meetings.

Although we found staff adherence to the trust’s medicines management policies had improved, we did find exceptions were policies were not followed. For example we found one ward, where the air conditioning unit had been set to 27 degrees on the day of inspection. The maximum temperature recorded for the room had exceeded the recommended temperature set by the trust for 10 days. Staff had not taken any action and had not followed the trust’s policy. Medicines in trolleys were not always in their original packaging and some were mixed with other brands of medicines.
Medicines and equipment for use in emergencies were readily accessible to staff and were checked regularly. Tamper evident seals were in use to ensure medicines were secure in accordance with national guidance.

Antibiotics were reviewed periodically in line with trust’s antibiotic stewardship policy. Patients prescribed antibiotics were reviewed once the patient had started taking the medicines. Medical staff reviewed patients’ response to the antibiotics, carrying out observations at set time. We saw evidence that doctors were reviewing patients at trust set intervals to ensure the antibiotic was effective or changed.

Prepacks were stored in a locked cupboard within medicines room on all the wards. Pre-packs are medicines in their original packs, supplied by the pharmacy with labels which nurses completed by inserting the patient’s name and the date they were dispensed before they were given to the patient on discharge. Nurses dispensed prepacks or pre-labelled medicines to speed up the discharge process. However, there was no record of what was dispensed, by whom, or who checked the medicines before they were dispensed. This meant there was no audit trail which allowed pharmacy to track their stock levels and identify any errors. A record of the medicines dispensed was included on the patients discharge letters which went to the patient’s GP and a copy was scanned into the patients’ electronic notes. This meant however, pharmacy were not able to review what was being dispensed without accessing individual patients’ records. This did not comply with the trust’s policy on issuing pre packs of medicines. Pharmacy said they did not have oversight of this.

One patient told us they had been given several medicines to take home including one controlled medicine. Controlled drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse. They told us they were unsure about how they should take them and had been given no information on which medicine to take when.

Arrangements were in place to ensure there were adequate supplies of emergency medicines and equipment especially out of hours via an emergency medicine cupboard and on-call pharmacist. There was an emergency medicines cupboard at the hospital. Other medicines which were not available from the emergency cupboard could be requested from Royal London Hospital for delivery. However, staff we spoke to said they did not feel the pharmacy operated a 24-hour service as they did not have support from a pharmacist out of hours. We saw two recent medicine incidents which were avoidable. Staff had not followed trust policy and had not called the emergency line for pharmacist support. One incident resulted in a missed dose and another resulted in the destruction of medicines.

Audits were carried out on medicines safety by the pharmacy team across all surgical wards every two weeks. Reports were provided for the ward managers who discussed the findings with their staff at the safety briefing at every hand over. We saw examples of the reports and the issues raised which included for example a liquid medicine which did not have the date opened recorded. We observed staff discuss the issues and take the necessary action to address them.

The lead pharmacist told us reporting medicine related incidents had improved. Ward managers believed this was due to reminding staff of the importance of reporting all medicines incidents. All the staff we spoke with were aware of recent medicine incidents.

Ward staff could use a quality and safety trigger application on smart phones for carrying out audits. Staff were encouraged to complete audits of different wards and not their own wards. For example, we saw the results of an audit on locked medical cabinets which showed these were all secure. The results of the audit reports were discussed at safety briefings.
The ward pharmacists conducted medicines reconciliation, organised discharge prescriptions and handled any medicines related concerns. (Medicines reconciliation is the process of identifying an accurate list of a person’s current medicines and comparing it with the current list in use.) A new ‘top up service’ had been introduced by the pharmacy team and the top up team staff were based on one of the surgical wards. The team topped up the stock medicines for each ward once or twice a week. Ward staff could order additional items when needed.

We checked a sample of patients’ drug charts and saw that they were completed fully with no missing administrations.

Patients’ allergy status and Venous thromboembolism (VTE) risk assessment outcomes were routinely recorded on the electronic records and drug charts. Orange stickers were used to alert staff to patients with has allergies however, these were not consistently used.

We saw the pharmacy team carried out regular audits on the management of medicines and Controlled Drugs (CDs) to ensure improvements were being made where necessary. The quarterly CD audit for April to June 2018 showed that three of the surgical wards had been rated outstanding for their management of CDs. All the other surgical wards were rated as good. Additional medicines safety audits were carried out routinely by the pharmacy team and findings were reported to the senior staff on the ward. We saw these were discussed at handover to all staff and staff implemented any actions.

On one ward external medicines and liquid medicines were stored together. The ward manager was aware this did not comply with the trust’s medicine’s policy. The medicines in trolleys were not always in their original packaging and we found four different medicines which were not in any packaging.

During our inspection we observed a nurse sign a drug chart to confirm an intra venous drug had been administered. The nurse was in fact preparing the medicine prior to administration. We observed the same practice on our previous inspection in April 2018, on the same ward.

We also observed total parental nutrition (TPN) being checked by two nurses in the clinical room. Neither staff checked the TPN chart to confirm what was prescribed by the dietitian.

Controlled drugs were checked twice a day in theatres. We checked the CD register and saw this was signed by two members of staff with a very small number of corrections and no omissions.

We saw two incident reports which described how on two occasions outpatient prescription pads went missing on the ophthalmology unit and despite a search and staff interviews, were not found.

We saw a plan for improving medicines management in 2018. The plan included medicines management pharmacy technician training, staff recruitment from May 2018 to July 2018 to support the implementation of the ward top-up service throughout surgery, the development of ward-based dispensing, including allocating space for drug storage and to increase ward stock. The role of ward based teams was also to be reviewed and a medicines safety thermometer introduced to monitor key performance indicators. Additionally, a business case was to be developed for a dispensary robot to automate the dispensing process.

**Incidents**

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

From August 2017 to July 2018, the trust reported one incident classified as a never event for surgery at Whipps Cross Hospital. This was a surgical/invasive procedure incident meeting the
criteria for a never event. The patient underwent cataract surgery to their right eye. In preparation for the left eye surgery, a nurse checked to ensure that the lens was available, and noted that the lens intended for the left eye had been inserted into the right eye.

(Source: NHS Improvement - STEIS)

In accordance with the Serious Incident Framework 2015, the trust reported 11 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from August 2017 to August 2018.

The types of incident reported were:

- Treatment delay meeting SI criteria: three incidents
- Surgical/invasive procedure incident meeting SI criteria: two incidents
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results): two incidents
- Abuse/alleged abuse of adult patient by staff: one incident
- Apparent/actual/suspected self-inflicted harm meeting SI criteria: one incident
- Environmental incident meeting SI criteria: one incident
- Pressure ulcer meeting SI criteria: one incident

(Source: NHS Improvement - STEIS)

The service reported incidents using the trust’s electronic incident reporting system. Minutes of ward quality and safety meetings showed incidents were discussed and reviewed and the learning disseminated following investigations. All the staff we spoke with were familiar with the process for reporting incidents. They told us their ward managers reminded them about the importance of reporting all incidents so that they could be investigated and the appropriate actions could be put in place to reduce the risk of similar incidents occurring in future.

Information provided by the trust showed there were a total of 827 incidents reported in the five months between April 2018 and August 2018.

Of these, the largest number of incidents related to pressure ulcers (63), medication errors or omissions (38) records or communication (62), problems with equipment (44) and patient falls (43). Problems with staffing and the acuity of patients were reported as incidents on 6 occasions.

We saw that morbidity and mortality reviews were held for urology, general surgery, ENT, trauma and orthopaedics. Some of the meetings were held for half a day where audit results were presented as well as reviewing the cases of patients who required further intervention. The care of patients who died was discussed to identify what lessons could be learned. Whilst most of the meetings were well attended, we saw references to the difficulties of reviewing cases when the clinicians involved were not in attendance.

Safety thermometer

The safety thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.
Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 31 new pressure ulcers, 14 falls with harm and eight new catheter urinary tract infections from June 2017 to June 2018 for surgery.

### Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at Bart’s Health NHS Trust

1. **Total Pressure ulcers**
   - (31)

2. **Total Falls**
   - (14)

3. **Total CUTIs**
   - (8)

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

(Source: NHS Digital)

The minutes of ward quality and safety meetings showed ward managers reviewed safety thermometer information and discussed performance on key issues with ward staff. Practice development nurses were also reviewing clinical practice and providing training on issues where there were concerns for example pressure ulcers.

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**Is the service effective?**

### Evidence-based care and treatment

The service participated in a range of national audits. These included the national hip fracture audit, bowel cancer, vascular, oesophago-gastric cancer and emergency laparotomy.

Clinical guidelines and protocols were developed and reviewed in line with the National Institute for Health and Care Excellence (NICE), the Royal Colleges and other relevant public bodies. Policies and protocols were available for staff to access on the hospital intranet. Staff we spoke with told us that the intranet was accessible and easy to use. There was a clinical excellence lead
in post who was responsible for ensuring hospital protocols continued to be in line with relevant
guidance. NICE guidance was managed through the hospital’s internal clinical effectiveness
directory. New guidance was emailed to relevant clinical effectiveness leads, specialty leads and
other stakeholders for whom the new guidance was relevant. The directory automatically notified
clinical effectiveness leads when guidance was up for review. Compliance with guidance was
regularly monitored and reviewed.

We saw that guidelines and policies had future review dates set; they were reviewed by the
department’s quality and safety board.

Staff we spoke with told us that policies and protocols were easily accessible and that the trust
intranet worked well.

The department was not compliant with NICE guidance TA460 for treating non-infectious uveitis in
adults as they did not use both recommended drugs. The department audited and risk assessed
their performance in this area to mitigate any adverse effect on patient treatment.

We observed the care provided to patients by medical staff and found clinical practice was
provided which met Royal College of Surgeons guidelines.

The hospital used the national early warning score (NEWS) to identify deteriorating patients. This
was monitored in line with National Institute for Health and Care Excellence (NICE) guidance
CG50 ‘Acutely ill-patients in Hospital.’

The service had introduced ‘enhanced recovery’, a service improvement designed to help patients
recover more quickly following surgery. This was based on an evidence based guidance
introduced by the Royal College of Surgeons. However, the full potential to improve patient care
and length of stay was not being fully utilised as enhanced recovery was not embedded
throughout all the surgical specialties at the time of our inspection. The trust told us they had re-
established enhanced recovery in colorectal surgery three months prior to our inspection which
meant it was not fully embedded during our inspection. During the factual accuracy process, the
trust provided us with further information which showed enhanced recovery was fully embedded in
orthopaedics.

The service had an audit programme for 2018-2019 which included 236 audits. These included
audits of compliance with NICE guidance.

We saw the results of three snap shot audits in theatres which checked anaesthetic machine log
books were completed, drug expiry dates, anaesthetic and recovery drugs fridges. Monthly spot
checks were also carried out in theatres. The audits included hand hygiene, urinary catheter
insertion, insertion of peripheral lines, WHO checklist and medicines.

**Nutrition and hydration**

All the patients we spoke with told us they received enough to eat and drink. They told us they
thought the meals were fine. Ward staff assessed patient’s nutritional and hydration needs and
obtained specialist advice from a dietitian when required. Patients daily food and fluid intake was
recorded daily. Ward staff also identified patients’ cultural or religious needs. There were different
types of menus available, for instance halal and vegetarian meals and gluten free options. Staff
recorded patients’ nutritional requirements on a board on each ward where staff could check at a
glance if the patient required softened foods, was diabetic or had any religious requirements.

Ward staff told us they could request food 24 hours a day and they could make toast for patients in
the kitchen.
One patient told us their experience of staff support with their dietary needs had varied. They had told staff they required a halal diet and staff on one ward had ensured they receive appropriate meals whilst staff on another ward had been disinterested and told them halal meals were not always available.

Staff were trained in nutritional care as part of the trust’s mandatory training programme. 96% of staff on the wards had completed this training module.

On our last inspection we found the trust target of 95% for completion of MUST (malnutrition universal screening tool) was not consistently being met. During this inspection, we found that ward managers were focusing on improving screening.

A monthly audit was carried out of completion of the Malnutrition Universal Screening Tool (MUST) on each surgical ward. The average results in the six months prior to inspection varied from 67% to 85%. Ward managers told us they had been concentrating on improving the number of patients receiving an assessment and that the rates had improved significantly. Efforts had concentrated on Rowan ward with positive results. Between April 2018 and August 2018, the proportion of patients screened had increased from 24% to 99%. Assessments on Sage ward had also improved from 86% to 93% and from 74% to 76% on Poplar ward. However, rates had fallen from 77% to 49% on Sycamore ward and from 75% to 41% on Primrose ward.

There were posters advertising the importance of staying hydrated. We saw that hydration assessments and fluid charts in patient notes were correctly filled out.

One patient was instructed to arrive at Plane Tree Centre at 7am. They were informed that they would not have their procedure until 3pm but could have water until 11am. The patient had not eaten since 8pm the previous evening. The patient’s procedure was carried out after 4pm that day which meant they had not eaten for 20 hours. Another patient waited eight hours for surgery and did not understand why they were required to attend at 7am if their procedure was not scheduled to take place until the afternoon.

**Pain relief**

Comfort rounds on the wards included management of patient’s pain. Most patients we spoke with told us that their pain was managed well and they were able to obtain analgesics. However, one patient felt they waited too long for nursing staff to provide pain relief.

Ward staff told us they could refer patients to the consultant led multi-disciplinary pain team for assessment and treatment. Staff told us the team were responsive and came to see patients quickly. The pain service operated five days a week between nine and four pm. Nurse specialists CNSs were available during the day and on call to provide pain management support. There were nominated pain champions responsible for gathering and disseminating pain audits and liaising with the pain team.

The service used the Abbey pain scale, a nationally recognised tool for measuring pain, to assess the level of pain and the effectiveness of pain relief. This required patients to score their pain from zero to three, with zero meaning no pain and three severe pain. The tool allowed staff to monitor patients pain and request changes to medicines or refer to the pain service for specialist advice.

A snapshot pain management audit had been taken in June 2018 of 100 patients reporting moderate to severe pain. The audit looked at nursing documentation, pain intensity, timely delivery of analgesics and patient satisfaction. The audit showed that 78% of patients reported being satisfied or extremely satisfied with their pain management with 7% dissatisfied.

**Patient outcomes**
From March 2017 to February 2018, all patients at Whipps Cross University Hospital had a higher expected risk of readmission for elective admissions when compared to the England average.

- Urology and ophthalmology patients at Whipps Cross University Hospital had a higher expected risk of readmission for elective admissions when compared to the England average. When we asked managers about this they were unsure of the reasons for this.
- General surgery patients at Whipps Cross University Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.

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

All patients at Whipps Cross University Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.

- General surgery and ear, nose and throat (ENT) patients at Whipps Cross University Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.
- Trauma and orthopaedics patients at Whipps Cross University Hospital had a higher expected risk of readmission for non-elective admissions when compared to the England average.

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

(Source: Hospital Episode Statistics)

In the 2017, National Hip Fracture Audit, the risk-adjusted 30-day mortality rate was 5.8% which was within the expected range. The 2016 figure was 7.3%. The national average was 6.7%.

The proportion of patients having surgery on the day of or day after admission was 67.6% which failed to meet the national standard of 85%. The position had deteriorated from the 2016 postion when 79% of patients received surgery within a maximum of two days. The service was also
unable to give patients a new fracture clinic appointment within the recommended 72-hour time frame following hip fracture surgery.

The service’s inability to provide a fracture clinic appointment was recorded in the service’s risk register but the difficulty providing surgery within national recommended guidelines was. However, the service acknowledged these both represented potential clinical risks for patients.

The perioperative medical assessment rate was 94.2%, which failed to meet the national standard of 100%. This was in the middle 50% of trusts. The 2016 figure was 96.8%.

The most recent data for April to August showed that 98.2% of patients received a perioperative medical assessment. This was better than the national average of 88.7%.

The proportion of patients not developing pressure ulcers was 96.6%, which failed to meet the national standard of 100%. This was in the middle 50% of trusts. The 2016 figure was 91.5%.

The length of stay was 22.1 days, which falls within the middle 50% of trusts. The 2016 figure was 23.6 days.

(Source: National Hip Fracture Database 2017)

In the 2017 Bowel Cancer Audit, 76.3% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was worse than the national aggregate. The 2016 figure was 85.5%. The service had made a small improvement through the implementation of the enhanced recovery programme.

The risk-adjusted 90-day post-operative mortality rate was 0% which was within the expected range. The 2016 figure was 3.7%.

The risk-adjusted 2-year post-operative mortality rate was 22.2% which was within the expected range. The 2016 figure was 19%.

The risk-adjusted 30-day unplanned readmission rate was 14.4% which was within expected range. There was no 2016 figure.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 44.8% which was within the expected range. The 2016 figure was 45.4%.

(Source: National Bowel Cancer Audit)

In the 2017 National Vascular Registry (NVR) audit, the trust achieved a risk-adjusted post-operative in-hospital mortality rate of 2.7% for Abdominal Aortic Aneurysms. The 2016 figure was 2.2%.

Within Carotid Endarterectomy, the median time from symptom to surgery was 9 days, better than the audit aspirational standard of 14 days.

The 30-day risk-adjusted mortality and stroke rate was 4.2%, this was within the expected range.

(Source: National Vascular Registry)

In the 2017 National Oesophago-Gastric Cancer Audit, the age and sex adjusted proportion of patients diagnosed after an emergency admission was 24.4%. Patients diagnosed after an emergency admission are significantly less likely to be managed with curative intent. The audit recommends that overall rates over 15% could warrant investigation. The 2016 figure was 25%.

(Source: National Oesophago-Gastric Cancer Audit)
The National Emergency Laparotomy audit awards three ratings for each indicator. Green ratings indicate performance of over 80%, amber ratings indicate performance between 50% and 80% and red ratings indicate performance under 50%.

In the 2016 National Emergency Laparotomy Audit, Whipps Cross Hospital achieved a green rating for the crude proportion of cases with pre-operative documentation of risk of death. This was based on 12 cases.

Whipps Cross Hospital achieved a green rating for the crude proportion of cases with access to theatres within clinically appropriate periods. This was based on 10 cases.

Whipps Cross Hospital achieved an amber rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on 6 cases.

Whipps Cross Hospital achieved a green rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on two cases.

The risk-adjusted 30-day mortality for Whipps Cross Hospital was within the expected range based on 92 cases.

(Source: National Emergency Laparotomy Audit)

Theatre staff told us they participated in an audit event every month. The event lasted half a day. Feedback from incidents and service improvements were discussed. Staff told us they had been working on improving communication and team working amongst theatre staff and between theatres and the wards.

Staff on the Plane Tree day case unit completed monthly perioperative audits which included reviewing consent, surgical safety, hand hygiene and completion of the surgical checklists. The results of these audits were discussed at monthly audit days.

The trust told us they had implemented a new pathway for surgical site infection (SSI) from April 2017. All SSIs in hip and knee surgery were recorded and reviewed. Patients included in the surveillance were followed up from the time of surgery as inpatients, to readmission or any other return visit to the hospital for example outpatient clinic. Staff were identified to find patients who returned to hospital after surgery for treatment because of infection. The service was planning to send a post discharge surveillance questionnaire to all patients for more complete data on SSIs that may occur post-discharge.

Compliance with the world health organisation’s surgical safety checklist was audited monthly in theatres. A sample observational audit was undertaken.

There were a total of 63 unplanned returns to surgery between April 2018 and August 2018. The specialties with the highest numbers of unplanned returns to surgery were general surgery and trauma and orthopaedics with 15 and 11 respectively. The number had increased in comparison to the period April 2017 to March 2018 when there were 49 unplanned returns to theatre.

We saw that departmental action plans were in place in response to patient outcome audits. The action plans included recommendations with details on the appropriate member(s) of staff to complete the actions and a review date.

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin hernias
- Varicose veins
- Hip replacements
• Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.

In 2016/17 performance on groin hernias was better than the England average.

For varicose veins, performance was better than the England average.

For hip replacements, performance was better than the England average.

For knee replacements was better than the England average. (Source: NHS Digital)

Competent staff

From April 2017 to March 2018, 99 members of medical and dental staff were eligible to receive an appraisal, they achieved 92% completion rate against a trust target of 90% (91 members of staff received an appraisal).

Whipps Cross Hospital has not provided a breakdown of staff working in the surgical division for non-medical staff therefore we are unable to provide any completion rates. (Source: Routine Provider Information Request (RPIR) P43 Appraisals)

The surgical division’s risk register highlighted that neither registered nursing staff or healthcare assistants had received the training necessary to comply with the General Dental Council standards when assisting with oral maxillary facial surgery. The risk register indicated that the service had removed the nurses from surgery and were in the process of reviewing the training requirements.

A surgical rotation programme was being set up for band 5 nurses. This was aimed at developing specialist knowledge in surgery. The programme would include 18 study days and the service would provide the necessary cover to enable nursing staff to be released to attend.

Two practice development nurses (PDNs) were now in post reviewing clinical practice and training needs. They also supported staff with re-training and competency assessment for example following a medicines error. The practice development nurses had been in post since December 2017, initially focussing on improving mandatory and statutory training rates. These were compliant with the trust target at the time of inspection and the PDNs were focussing subsequently
on further training such as cannulation and reducing pressure ulcers. The PDNs we spoke with appeared motivated and enthusiastic about improving nurse education and training.

We heard mixed reports from nurses we spoke with about the opportunities for development and progression in the trust. Some nurses we spoke with felt that they had been at their current banding too long and the trust did not support them to progress. We spoke to trainee doctors who felt well supported by their seniors.

At our previous inspection staff in theatres told us they felt there were few opportunities for development. At this inspection they told us nothing had changed. When we spoke with the leadership team about this, they said they recognised they had a dedicated highly effective team of staff and they were aware of the need to support staff with development.

Nurses we spoke with were positive about the quality of their appraisals and the coaching and mentoring available from seniors, though there was some confusion around the role of the PDNs. We heard from the PDNs that they felt there was some work to do to raise their profile in the department and help staff understand their role.

**Multidisciplinary working**

Daily board rounds took place on each ward every day. A nurse who knew the patient presented information about plans for discharge or the most recent clinical decisions. The meeting was attended by medical and therapy staff, pharmacists and clerical staff who identified what needed to be done to facilitate the patient’s discharge. Ward staff told us these meetings had improved communication between staff groups and helped co-ordinate patient care.

‘Board rounds’ were carried out daily and involved a multidisciplinary team assessing every patient on the ward for pain management, nutrition and hydration and length of stay.

Nursing staff told us there were link nurses for continence, diabetes, tracheostomy care, tissue viability, stoma care, pain and sepsis they could call on for to provide specialist care for patients. They also provided information, advice and training for nursing staff.

There was a daily multidisciplinary bed meeting with input from clinical, therapies and bed managers. Representatives from all wards shared information regarding risks and interruptions to services and facilities.

We heard from staff we spoke with that different staff groups worked well together. We observed good multidisciplinary practice on wards with doctors and therapy staff collaborating to discharge patients home. We observed cohesive team practice in the theatres and there was multidisciplinary input to completion of the WHO checklist.

Members of the occupational therapy and physiotherapy team attended the surgical ward board rounds on a daily basis to input and collect referrals. Following the board round the therapists prioritised patients for assessment and intervention. Ward staff referred patients to the speech and language therapy service and dietitians if they had concerns about patients with difficulty swallowing. Dietitians assessed patients who required total parental nutrition if they unable to eat normally.

**Seven-day services**

There was 24-hour consultant cover seven days a week in surgical specialties including ENT, ophthalmic and urology. This was provided by middle grade doctors. There was out of hours consultant cover in general surgery, trauma and orthopaedics provided on a consultant of the week model. All emergency and acute patients were reviewed daily.
There was pharmacy cover for all surgical wards Monday to Friday between 9 am and 5pm. The on-call pharmacist was available between 5pm and 8pm. Outside these times staff had access to pharmacy advice via an emergency line. During the weekend the inpatient pharmacy was open between 10am to 2pm and staff had access to the on-call pharmacist between 2pm and 4pm. After 4pm staff would call the emergency line on the switchboard.

A physiotherapy service was provided Monday to Friday from 8am to 6pm. There was a weekend service for prioritised patients from 8am to 6pm Saturday and Sunday to allow patients to be discharged at week-ends. There was emergency physiotherapy on-call cover outside of these hours. Occupational Therapy provided a standard core service from Monday to Friday from 8am - 6pm with some weekend cover. Speech and Language Therapists (SLT) and Dietetics worked Monday to Friday 8am - 6pm.

Radiology services (CT, X-ray, ultrasound and MRI) operated Monday to Friday 9am to 5.30pm. The service was provided 24/7 for inpatients. MRI for inpatients was available from Monday to Friday 8am to 8pm. Speech and language therapy provision (SALT) was provided an 8.30am – 5pm service Monday to Friday. Speech and language therapists contributed to ward rounds where there were patients who had a tracheostomy.

The dietetic service provided an 8.30am to 5pm service Monday to Friday.

**Health promotion**

Pre-assessment staff referred patients to smoking cessation clinics prior to surgery. The service provided patients with information leaflets about their condition and the steps they could take to prepare for surgery.

There were posters throughout the hospital providing a range of health promotion information for patients including around smoking cessation and preventing falls.

There was information available on the trust’s website about staying healthy during Ramadan and advice on when to seek medical attention. The website featured patient information leaflets and videos on physiotherapy at home and managing a range of conditions such as diabetes, fractures and cataracts.

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

At the last inspection we found that patient consent was taken on the day of procedure as standard across the department, this continued to be the case. Managers we spoke with told us that they were aware this was not ideal and that they hoped to introduce consenting earlier in the patient flow and were awaiting proposals to introduce this from the surgical board. However, the procedure including the risks and alternatives were usually discussed with patients as part of their out-patient consultation prior to surgery. We saw examples of information leaflets provided for patients prior to surgery. The information was based on guidance from the Royal College of Surgeons and the Preoperative Association. The leaflet described the condition the patient was experiencing, the benefits of surgery and any alternatives to surgery, what might happen if the patient did not have surgery were also explained. There was a description of what would happen during the operation, advice on medicines. Possible complications of surgery and the anaesthetic were explained together with the specific complications of the particular procedure. Steps the patients could take to prepare for surgery for example by losing weight or increasing physical activity were described as well as the recovery process.

The trust informed us that the policy for consent was currently under review led by the trust wide Surgical Network Clinical Board. This review was examining the policy against national guidance
and the trust was seeking to standardise practice across all the sites in the trust. The trust had not audited consent. The trust told us the board would consider the report in September 2018.

Staff we spoke with had a good understanding of the Mental Capacity Act and were able to describe instances where capacity assessments would be relevant, making reference to appropriate legislation. Data provided by the trust showed that 93% of clinical staff had completed mandatory training in consent which was above the trust target of 85%.

We observed interactions between doctors and patients and saw that clinicians ensured that patients understood their procedures and had capacity to consent. Patient notes we examined contained evidence of discussions around consent. We also saw records of mental capacity assessments. We saw examples of clinical decisions made in patients best interests, if the patient did not have the mental capacity to consent.

There were consent and Deprivation Of Liberty (DoLS) policies available on the trust intranet and staff we spoke with knew how to locate them for reference. Staff understood their roles in relation to consent and capacity and understood concepts such as lawful and unlawful restraint and best interest decisions.

### Is the service caring?

**Compassionate care**

During our inspection we observed staff treating patients with compassion, they showed a genuinely kind and caring attitude. Staff told us that, although the wards were busy they tried to take time to show empathy and compassion and not rush patients.

The Friends and Family Test response rate for surgery at Bart’s Health NHS Trust was 15% which was worse than the England average of 25% from July 2017 to June 2018. However, the response rate for Whipps Cross Hospital was 20% which was better than the trust’s overall response rate.

A breakdown of response rate by site can be viewed below:

**Friends and family test response rate at Bart’s Health NHS Trust, by site.**
The trust provided us with information from the friends and family survey for the period April 2017 to March 2018. The figures showed that in March 2018, 73% of patients would recommend Poplar ward to friends and family, 50% would recommend Primrose ward, 73% would recommend Rowan ward, 90% would recommend Plane Tree ward, 89% would recommend Sage ward and 75% would recommend Sycamore ward. The response rates for the latest figures available in March 2018 however were very low in some cases as low as 6% or 7%. The trust had recently changed the way the information was collected. A new system had been introduced based on receiving patients’ response via text. The response rates averaged over the year April 2017 to April 2018 were higher for example Plane Tree was 59%, Sycamore 32%, Sage 40%, Primrose 23%, Poplar 10% and Rowan 22%. Staff on some wards were planning to re-introduce a paper based survey to gather feedback, as a temporary arrangement, until the new system was more effective.

Staff were encouraging patients to respond to the new system but told us this was taking time for patients to understand and respond following its introduction. We saw leaflets in a range of locations explaining the new system.

Plane Tree ward carried out their own patient satisfaction survey in addition to the friends and family test. They asked patients to complete and return a short questionnaire before they left the ward. We looked at a sample of 50 responses and saw the comments were almost all very positive.

We observed patient’s privacy and dignity was maintained during surgical procedures. Theatre staff ensured patients were covered up with a sheet or blanket. Leg and arm supports were in place and staff took care to protect vulnerable areas of tissue for example ankles and elbows. We observed patients' pressure areas were checked and their gown was changed prior to being transferred to the recovery area. Curtains were drawn around patients in recovery whilst they were transferred on to the recovery bed, again maintaining privacy and dignity.
Patients being offered tea and sandwiches in the day case recovery area. Staff on the day ward stayed with patients into the evening if necessary ensuring they were well enough to go home or arranged admission if they were unwell.

**Emotional support**

One patient we spoke with told us they felt treated with compassion and staff had provided emotional support when they could. They said they felt nurses did want to help but they were often too busy. Another patient told us they did not feel staff were listening to them.

One patient we spoke with had been in hospital for several months. They told us they felt treated with, “Immense respect by both medical staff and nurses”.

Theatre staff reassured patients as they waited for surgery and afterwards in the recovery area.

Theatre staff were aware this was an anxious time for patients who often felt vulnerable and required reassurance.

Clinical nurse specialists (CNSs) were available to provide additional emotional support for patients over and above the support provided by clinic and ward staff. CNSs were specialists in their field, able to provide more detailed information including contact details for support organisations.

Eye clinic liaison officers (ECLOs) provided ophthalmology patients with both emotional and practical support. ECLOs helped patients understand their diagnosis and deal with sight loss, for example, by discussing how patients could adjust to changes in their lives.

We observed nurses who provided practical and emotional support to talking to patients who had undergone stoma forming surgery.

Spiritual support was available for Muslim, Catholic and Hindu patients. There were prayer rooms and services held in the multi faith chaplaincy centre on site. There was access to the chaplaincy team 24 hours a day via a dedicated contact number.

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

Several patients told us they felt they waited too long for assistance from nursing staff. They said the nurses were very busy and they were reluctant to ask for assistance when they needed it.

Several patients and relatives also told us they were not told what was happening. One patient was due for discharge the previous week but nothing happened. They said the same happened the following day and that they had no idea why they were still in hospital. They were unsure whether this was related to their condition or something else. Another patient told us they had a needle phobia and fainted. They said the first time it happened staff had been understanding but were less supportive on the other occasions when it happened. They had been reassured however when staff gave them their test results, staff put them at their ease and discussed their treatment options.

We spoke with the relatives of one patient who told us they were able to stay to support their relative and how much they appreciated this. They described how involved they felt in the arrangements for discharge.

We spoke with 27 patients in total. Most were generally happy with the service they received. However, five patients raised concerns about communication of clinical decisions. For example, one patient we spoke with told us they had not spoken to their consultant for several days and they were unclear what was happening about their surgery. They said they felt ‘in limbo’. They said they wanted nursing staff to find out what was happening. Another patient told us they were
due to have a procedure that day but they did not know what was happening. They said they asked staff but they did not seem to know either. They said staff did not have the time to update and reassure them. On another occasion they were told they were going to theatre but then told they had to have a scan beforehand. They felt things were confused and had found this upsetting.

**Is the service responsive?**

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

The trust had recently engaged external consultants to develop a strategy for Whipps Cross hospital based on the needs of the local population. The service recognised the high number of frail elderly people living in the local community and the need to organise services to meet their needs. Whilst the strategy was being developed, the service continued to operate as a multi site general, acute specialty within the trust. The surgical division’s strategy described the pressures the service had experienced over the winter months when elective orthopaedic surgery was suspended because of the high number of medical and other emergency admissions. Managers recognised the need to work with GPs and other health and social care organisations to enable patients to be discharged more quickly and to improve the care of older people with dementia.

From April 2017 to March 2018, the average length of stay for all elective patients at Whipps Cross University Hospital was 3.7 days, which is lower compared to the England average of 3.9 days.

- Urology elective patients at Whipps Cross University Hospital was 2.8 days, which is higher compared to the England average of 2.5 days.
- Trauma and orthopaedics elective patients at Whipps Cross University Hospital was 5.3 days, which is higher compared to the England average of 3.9 days.
- General surgery elective patients at Whipps Cross University Hospital was 4.3 days, which is higher compared to the England average of 3.9 days. Managers told us the longer length of stay was due to the age and complexity of patients’ medical conditions.

The average length of stay for all non-elective patients at Whipps Cross University Hospital was 5.0 days, which is as expected compared to the England average of 4.9 days.

- General surgery non-elective patients at Whipps Cross University Hospital was 4.7 days,
which is higher compared to the England average of 3.8 days.

- Trauma and orthopaedics non-elective patients at Whipps Cross University Hospital was 9.9 days, which is higher compared to the England average of 8.8 days. This was due to a high number of older patients with more complex needs who often remained in hospital awaiting a residential home placement.

- Ear, nose and throat (ENT) non-elective patients at Whipps Cross University Hospital was 1.9 days, which is as expected compared to the England average of 2.2 days.

![Bar graph showing comparison between This site and England Average](image)

*Note: Top three specialties for specific site based on count of activity.*

*(Source: Hospital Episode Statistics)*

**Meeting people’s individual needs**

Theatre staff told us they used language line to support patients whose first language was not English or a face to face translator if they needed one. They told us they avoided using relatives to obtain consent but encouraged relatives to be present in recovery to support them if a patient had dementia or a learning disability. A dementia champion worked as part of the recovery team to support patients and help staff understand their needs.

Nursing staff in the pre-assessment service told us about the work they had carried out to identify the needs of people with a learning disability. This meant they could adjust their care if required, for example by placing the person first on an operating list, thereby reducing the person’s anxiety whilst they waited for their surgery. The service had developed a patient passport, which they asked patients’ and their carers to complete if they did not already have one. A patient passport is a document which contained information about the person who might have difficulty communicating information about themselves to the healthcare professional providing their treatment. An alert was added to the patients’ notes to direct staff to read the patient passport.

The pre-assessment unit was located adjacent to the scheduling team who organised patients’ admission which meant pre-admission staff could easily clarify questions about patients’ needs.

Pre-assessment staff used a pathway for identifying patients with anaemia so that they could be treated prior to surgery. Some patients undergoing major colo-rectal surgery with risk of a heart condition had cardio pulmonary exercise testing prior to surgery. Staff identified if a patient was likely to require a high dependency bed following surgery. A consultant anaesthetist identified patients with a risk by reviewing their case notes.

Pre-assessment staff also reviewed patients taking anti-coagulation therapy, adjusting their medicines prior to surgery.
Ward staff told us they tried to find a side room for patients with a learning disability but this was not always possible because the number of side rooms was limited. They told us they encouraged families to stay and contacted the learning disability team but sometimes they had to chase them for a response.

A surgical trauma list was carried out at weekend between 8am and 5pm by either a consultant or other senior doctor.

We saw incident reports about ward staff having difficulty obtaining assistance for patients during the night. For example, one patient needed IV fluids, anti-sickness and pain relief route on drug chard changed. Ward staff reported that they called the on call surgical SHO on 4 different occasions from 2300- 0700. The doctor was busy in A&E, arriving on the ward until 7.20 in the morning despite reporting the patient as being unwell.

An enhanced recovery nurse supported patients following colo-rectal surgery following national guidelines designed to help patients recover more quickly.

**Access and flow**

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

Over the two years, the percentage of cancelled operations at the trust showed a trend of decline, whilst Q2 2016/17 showed that of the 365 cancellations, 2% weren’t treated within 28 days, the remaining reporting periods have generally been worse than the England average.

**Percentage of patients whose operation was cancelled and were not treated within 28 days - Bart’s Health NHS Trust**

![Graph showing percentage of patients whose operation was cancelled and were not treated within 28 days](image)

**Cancelled Operations as a percentage of elective admissions - Bart’s Health NHS Trust**

![Graph showing cancelled operations as a percentage of elective admissions](image)
Over the two years, the percentage of cancelled operations, although they were higher, generally followed the trend of the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

Between March 2018 and August 2018, 587 patient’s surgery was cancelled on the day the operation was scheduled to take place. This represented 8.5% of all elective cases compared with 9% of cases in the period April 2017 to March 2018. The service’s cancelled operations as a percentage of elective cases booked was 1.4%, which was slightly better than the cancellation rate for the previous 12 months (1.8%). Of these 587 cancelled procedures, 383 were patient-initiated, with 140 recorded as patient ‘did not attend’ (DNA). There were 98 hospital-initiated cancellations for non-clinical reasons, which included: lack of time (22), lack of beds (37), another emergency priority (10), lack of staff (10) and equipment issues (10). The trust recorded that 106 procedures were cancelled for clinical reasons either because further tests or investigations were needed or the patient was unfit for surgery.

The Plane Tree day case unit provided care for planned and emergency patients. There was an emergency pathway whereby patients attending accident and emergency or the walk in centre could be admitted for surgery. The emergency co-ordinator contacted the unit at seven in the morning for patients who had attended A&E overnight. The unit was able to deal with up to six emergency cases a day by slotting them into the surgical lists running that day. Theatres were in operation throughout the night for surgical emergencies which could not wait until the next morning.

Some patients attending the Plane Tree day surgery unit were required to arrive at seven o’clock in the morning. However, their surgery might not take place until the afternoon which meant patients were fasting since the night before. Staff working on the unit acknowledged this was not a good patient journey but had been unable to encourage medical staff to change practice. The majority of patients due for surgery in the afternoon arrived at twelve o’clock.

We saw staff completed discharge plans which contained information about the assistance patients would need from the community nursing service and social services. The document also contained a checklist for the day of discharge covering the removal of intravenous catheters, medicines the person would need to take home and descriptions of any changes to the patient’s skin integrity. Staff on the ward were able to access information from the patient’s General Practitioner (GP) using a shared information system and make electronic referrals to community services.

At our previous inspection, we told the trust that they should improve admitted referral to treatment time (RTT) performance and reporting. As the trust had only started reporting RTT data nationally in April 2018, there was no data available for inclusion in the evidence appendix. After the inspection the trust provided us with admitted pathway, site specific, referral to treatment waiting times RTT data for all surgical specialities for the period September 2017 to July 2018. These showed that the overall RTT for July 2018 was 81.6%. This represented a slight improvement on the previous inspection when the figure was 79.7% in April 2018.

Trust data showed that RTT performance varied during the 11 month period between September 2017 and July 2018 in most specialties. Trauma and orthopaedics achieved 77.4% at out last inspection in April 2018 compared with 61% at the previous inspection but this had reduced slightly to 74.7% in July 2018, the most recent figures available. The picture was similar for general surgery achieving 73% in July 2018 when the April 2018 figure was 76%, an improvement from the previous 62%. Urology achieved 80.4% compared with 82.2% in April 2018 which was an
improvement on the previous figure of 64%. Ophthalmology was 83.4% in July compared with 84.3% in April 2018 an improvement on the previous 67%. ENT achieved 83.7 % which was similar to the April 2018 position (83.2%) also an improvement on 78% previously. The leadership team acknowledged further improvement was required to be compliant with national standards and this remained the top risk on the divisional risk register.

The division did not achieve the 85% target for the 62-day referral to treatment time target for cancer patients. Five breaches were recorded in June 2018.

Theatre utilisation rates had shown some improvement but were still below the trust’s target. Theatre utilisation rates for the period March 2018 to August 2018 across the 10 main theatres varied between 70% and 72% against the trust’s target of 85%. Performance had improved from our previous inspection but further improvement remained a high priority for the service.

For the period April 2018 to August 2018, 63 patients returned to theatre for further surgery, 15 in general surgery and 11 in trauma and orthopaedics.

The trust provided us with figures for delayed theatre lists and individual patient delays with reasons for the delays for the period April 2017 to April 2018. The trust recorded that 2,717 lists (67%) started late, affecting 1,257 (19%) of patients. This was an improvement on performance found at the previous inspection where 79% of lists started late between November 2016 and April 2017. For the five month period April 2018 to August 2018, 687 (13.4%) of patients experienced a delay before their surgery commenced. The main reasons were that the patient was not ready on the ward, the order of the list and changed and needed checking, incomplete consent, lack of equipment, medical or nursing staff not available, incomplete consent documentation or previous procedure taking longer than planned. At our previous inspection, the trust was not always recording the reasons for surgery being delayed. At this inspection we found the reasons for all delays were being recorded.

Between January 2018 and August 2018, 2528 (16%) of patients were discharged out of hours (between 8pm and 8am). This was higher than the figure provided by the trust for the period between April 2017 and December 2017 (13%). The proportion of patients discharged out of hours was similar each month ranging from 15% to 19% of patients.

The service captured information about the discharge process using an effective discharge dashboard. The report included the time patients were discharged and where discharges had been delayed. The service also monitored the proportion of patients re-admitted as emergencies in less than seven days of discharge. The numbers were small most weeks but we saw readmission rates of 6.7% during the week of 24.6.2018 and 6.1% on the week of 1.07.2018 on Poplar ward, 8.7% on Primrose ward on 17.06.2018, 7.5% on 10.06.2018 on Rowan wards and 7.1% on 20.05.2018 on Sycamore ward.

Call bell response times were observed during intentional rounding by wards managers and matrons but were not formally reviewed or documented.

**Learning from complaints and concerns**

From April 2017 to March 2018 there were 90 site level complaints about surgical services at Whipps Cross Hospital. The trust took an average of 47 days to investigate and close complaints, this is in line with their complaints policy, which states complaints should be completed between 10-60 days.

The top three wards with the most complaints were:
• Orthopaedic clinic: 17 complaints
• Plane Tree Centre: 16 complaints
• Sycamore ward: 12 complaints

The highest category of complaints related to diagnosis/treatment (36), the general themes from these complaints involved poor care provided to patients and poor communication from staff.

Further information provided by the trust showed that since April 2018 there have been a further 75 complaints relating to surgery. The majority related to:

• outpatients (35),
• 5 were about Poplar ward,
• 4 about Primrose ward,
• 1 about Sage ward,
• 4 about Sycamore ward,
• 4 about Plane Tree ward and 2 about Rowan ward

The majority of complaints were about problems over appointment times, the care received on the ward, the outcome of surgery and communications.
(Source: Routine Provider Information Request (RPIR) – Complaints tab)

From April 2017 to March 2018 there were 39 compliments given to Bart’s Health NHS Trust. No site or core service breakdown is available.
(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

The leadership structure of the surgical division was in the process of changing when we inspected. The changes were due to be implemented in October 2018. Previously, the surgical service was led by a site based leadership team which comprised a clinical director, associate director of nursing (ADoN) and two divisional general managers. Recent changes to the structure meant the clinical director now had leadership responsibility for the division of planned care (surgery and cancer). When we spoke with the clinical director about the changes they told us further work was required to develop the rest of the structure.

The trust was changing the structure across all the sites. The new operating model consisted of a group headquarters with responsibility for setting overall strategy and performance management. The group headquarters was overseen by the board with leadership from the executive group.

The individual hospital sites including Whipps Cross hospital were the key operational units within the trust’s group structure, with site managers responsible for the effective delivery of clinical services. A site managing director had overall leadership responsibility supported by the clinical directors and managers. Clinical networks developed more specialised clinical service plans. There were 30 clinical networks in total reporting to seven clinical boards for cancer services, cardiovascular, accident and emergency and trauma, surgery, women, children and medicine.
The networks reviewed variations in performance between sites and benchmarked the quality of services against similar services elsewhere.

A range of support services including pathology, imaging, pharmacy, therapies, outpatients and health records, clinical physics and research and development were managed together as part one structure providing services to all the sites in the trust.

There were a small number of “fully networked services” where clinical services across a number of sites were managed as a single unit. These included renal services, dental services, sexual health services and elements of cardiovascular services.

When we met with the leadership team they told us the service had been working hard to respond to the issues identified at our previous inspection. They had developed an action plan for the medicines issues and were monitoring progress. They acknowledged there was significant work required to make all the necessary improvements but felt they were making good progress. They also told us governance had also been strengthened with better representation from clinicians at meetings.

**Vision and strategy**

The trust’s overarching clinical service strategy was being developed between sites and the Bart’s Health clinical networks e.g. orthopaedics across sites. This would provide a clear sense of direction for sites and services for the next four years. The strategy aimed to tailor services more closely to the needs of the large, diverse population the trust served, reduce variation and improve productivity and quality. The strategy also sought to increase prevention and use clinical networks to facilitate improvements.

An integrated health, social care and wellbeing campus was being considered for the Whipps Cross site. This would involve new service models and pathways, improving the assessment and management of older, frail patients and developing a surgical assessment unit by 2020.

Managers told us services at Whipps Cross hospital were being reviewed as part of a strategy for the future development of the trust. The trust had recently commissioned an external consultancy firm to evaluate the options. The work was led by the surgical network board which was looking at surgical services across hospital sites and how services were organised at individual locations.

A local service strategy for the surgical division at Whipps Cross hospital was completed in October 2017. The strategy highlighted the challenges the service faced in providing the quality of care meeting standard of best practice. The key challenges included nursing recruitment and retention, the age of the estate and the scale of the equipment maintenance and replacement required.

**Culture**

Staff in theatre told us they felt well supported by their managers. They said managers carried out a back to the floor programme and were visible to staff. Theatre staff said they felt able to ask questions and challenge existing arrangements to make improvements. Some staff were undertaking an on-line leadership course supported by the trust.

Staff told us leadership of the service had improved with the appointment to vacant nurse manager posts. They said their managers were visible and supportive. However, some staff also told us team working was not always good on the wards with tensions between permanent and temporary staff and between nurses and healthcare assistants.

**Governance**
At our previous inspection we were not assured that there was sufficient management oversight of risk. The governance structure for surgery included departmental governance meetings, mortality and morbidity reviews, weekly governance reviews, quality and improvement meetings, clinical leads’ meetings and operational and senior nurses’ meetings. These groups reported to the surgery board.

At this inspection we reviewed the minutes of mortality and morbidity meetings, and clinical audit events. These showed complications of surgery and audit results were discussed. However, we noted it was not always possible to discuss particular cases because the relevant professionals were unable to attend the meeting.

There was now a governance lead within each specialty who was involved in setting regular meetings and engaging with colleagues.

The leadership team told us one important improvement was that they now had support from the governance team for clinical governance meetings which ensured the administration worked more effectively.

They also described how the clinical effectiveness unit now supported the audit programme, as a result audits were more visible. A member of staff now supported the team in submitting data and filling out action plans. Previously, without this support the programme was less effective.

There was an annual quality improvement meeting where junior doctors presented audit data and staff were encouraged and supported to complete their audits.

The trust provided us with copies of the minutes for the surgical division, safety and governance board meeting which showed that the board were concerned about the number of falls on surgical wards. Each ward was asked to review falls which had occurred and provide an account of how they had occurred. As a result of the concerns raised teaching was planned for staff and that all falls had been raised in the band 7 meetings and at safety briefings. When we spoke with one of the practice development nurses they told us about some of the review work and teaching which had been organised as a result.

Progress on investigations into the causes of pressure ulcers were also discussed. The surgical board also reviewed incidents, GP alerts, complaints, medicines incidents, safeguarding concerns and referrals monthly. Investigations into serious incidents were also discussed, compliance with NICE guidance including audits of compliance were also reviewed.

**Management of risk, issues and performance**

We saw the minutes of monthly, ward quality and safety meetings which showed staff discussed complaints, incidents such as falls and medicines errors, patient documentation, risk assessment, staffing and training. The service used quality and safety dashboards to monitor performance on the wards. The reports showed performance year to date and provided a comparison with the previous month which showed if the position had improved or deteriorated. There were performance measures for falls, pressure ulcers, incidents, complaints, hospital acquired infections, friends and family test feedback. Mandatory training compliance was also included together with harm free care measures. The dashboard provided information at a glance with easy to understand graphics which highlighted trends.

The risk register contained a total of 46 risks. The main risks which we identified were included on the risk register for example staffing levels and the need to replace equipment which was old or beyond repair. The minutes of leadership meetings showed risks on the risk register were reviewed monthly.
The trust was soon to be introducing a quality and safety trigger tool designed for health care settings to measure quality at ward level. Staff used a smart phone application, which meant they could capture information in the course of carrying out their duties. The application incorporated a RAG rated scoring system that helped identify actions to improve quality.

Whilst most wards met monthly for a few hours to review performance, staff on Sage ward met for a whole day in July 2018 to discuss safety and performance on the ward. Staff we spoke with told us this provided more time to discuss things in detail and helped with team development. The division provided cover for the wards to allow staff to be released.

The trust provided each division with a monthly performance report which was used to review performance against other services and against the trust’s key performance targets. The report included comparisons to last month year to date, and with the previous year. Improvements and deterioration in performance were also highlighted and could be tracked over time.

**Information management**

The trust was moving towards an electronic patient record system. The majority of clinical notes were held on the system. The trust’s IT system was linked to GP and community systems which meant staff at the hospital could access some information provided by primary care and could forward information about discharge to community teams. The majority of nursing information and assessments were still captured on paper records although electronic nurse records were being rolled out.

At our previous inspection the surgery risk register described the implementation of the electronic system as ‘piecemeal and not optimally managed’. There was variation in practice between clinical teams, for example with a mixture of hand written and electronic records for ward rounds and theatres notes which meant there was a risk staff might not be accessing the correct patient information. Managers told us this was still a risk but staff were aware of the importance of ensuring electronic information was accurate.

The trust’s IT system was linked to GP and community systems which meant staff at the hospital could access some information provided by primary care and could forward information about discharge to community teams.

**Engagement**

Staff we spoke with told us the appointment to vacant nurse manager posts had resulted in improved support and communication. Managers were more visible and staff felt more supported. The increased number of nursing posts on Poplar ward was particularly welcomed by staff and they spoke positively about improved recruitment.

Managers had developed ways of improving staff engagement. These included quarterly staff wellbeing fairs, consultant and junior doctors forums, an equality and inclusion forum, the appointment of network leads from across the trust and careers clinics. Journal clubs had been set up on the wards. Focus groups had also been set up when staff could meet with managers to discuss any issues affecting staff or to hear about developments. Nurse managers told us staff recruitment, morale and culture were their top priorities. They described how they wanted staff to feel more involved in highlighting issues and making quality improvements.

Some staff we spoke with were aware of these new engagement opportunities but some staff told us it was difficult to attend because they were too busy.

Managers told us about a patient panel which had been meeting monthly for over 15 years and were which was involved in work throughout the hospital.
The trust had recently introduced a text-based system for patient feedback. The response rates were low and ward managers told us they were working on the reintroduction of paper based questionnaires. Plane Tree ward were collecting patient questionnaires which resulted in a high response rate.

**Learning, continuous improvement and innovation**

A service improvement plan had been developed to address issues identified by the leadership team as affecting the quality of the service for example staffing levels and recruitment. The improvement plan also included issues identified on our previous inspections. The service provided us with an update on progress against their improvement plan for the period August 2018. The plan had a total of 58 actions which were being addressed. There were 24 actions where progress was not being achieved as planned. These included completing all the improvements to medicines management, setting up a surgical assessment unit, improving referral to treatment performance, recruitment and retention and improving the surgical pathway.

At our previous inspection a nurse had recently been appointed to lead a piece of work on enhanced recovery. At this inspection we discussed the work they had undertaken to date. The work focused on patients receiving colo-rectal surgery. They met with patients in clinic before their procedure and discussed changes they could make to their lifestyle to aid recovery. They saw patients following surgery to agree recovery goals and to encourage them to walk as soon as soon as they could. They also contacted patients after discharge to support and encourage them on the recovery pathway. This also helped ensure patients were not readmitted if problems could be resolved in the community. The work had only been underway for few months but they told us average length of stay had reduced from 10.5 days to 9.0 as a result.

Two practice development nurses had recently taken up post. We spoke with one of the practice development nurses about the challenges of the role. They described how they supervised newly qualified staff, provided staff training updates and provided practical training sessions for staff for example on topics such as tissue viability. They told us they would review patient documentation following staff training to check the lessons learned were embedded in practice.

The practice development nurses were working with ward managers to develop a training programme and work on team development.

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### Critical care

### Facts and data about this service

The critical care unit (the unit) at Whipps Cross Hospital consists of 17 beds; seven are funded for level 3 care, and 10 are funded for level 2 care. The High Dependency Unit (HDU) element of the department was opened in January 2017 and increased the bed base from nine beds to the current 17. The department is led by the clinical lead and matron, supported by the ward managers and accepted both elective and emergency admissions on agreement with the critical care consultant in charge.

There was 24-hour care seven days a week medical cover on the unit with 10 whole time equivalent (WTE) budgeted consultant intensivist posts for the departments’ rota and 97 WTE
clinical nursing posts. The service also had one WTE dedicated Intensive Care Audit and Research Centre (ICNARC) audit clerk allocated to the department. There was a follow up clinic available to patients post admission who meet specific criteria. The department sat within the wider surgical division and participates in weekly multidisciplinary team (MDT) meetings to discuss long term patients as well as monthly governance and mortality and morbidity (M&M) meetings which feeds into the surgical divisional board when appropriate.

(20180517 RPIR Acute - WXH Documents – Context)
The trust has 184 critical care beds. A breakdown of these beds by type is below.

Breakdown of critical care beds by type, Barts Health NHS Trust and England.

This trust

<table>
<thead>
<tr>
<th>Type</th>
<th>%</th>
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<tbody>
<tr>
<td>Neonatal</td>
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<td>Adult</td>
<td>65.6%</td>
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<tr>
<td>Pediatric</td>
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England

<table>
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<th>Type</th>
<th>%</th>
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</thead>
<tbody>
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<td>Adult</td>
<td>68.1%</td>
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<tr>
<td>Pediatric</td>
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(Source: NHS England)

Is the service safe?

Mandatory training

Whipps Cross Hospital set a target of 85% for completion of mandatory training.

The trust provided a breakdown of compliance for mandatory courses as of 4 June 2018 for nursing staff in critical care as shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/ No)</th>
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<tr>
<td>4 Harms - Catheter Acquired Infections</td>
<td>60</td>
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<td>4 Harms - Pressure Ulcer Prevention</td>
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<td>Clinical Documentation</td>
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<td>Working at Barts Health</td>
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<td>85%</td>
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<td>Infection Prevention and Control – Clinical</td>
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<td>98%</td>
<td>85%</td>
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<td>Information Governance</td>
<td>59</td>
<td>60</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical Gas Safety</td>
<td>59</td>
<td>60</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling - Patient Handling Practical</td>
<td>59</td>
<td>60</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>58</td>
<td>60</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>57</td>
<td>59</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation - Basic Life Support</td>
<td>54</td>
<td>60</td>
<td>90%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Nursing and midwifery staff exceeded the 85% completion target for all 27 mandatory training modules.
Staff we spoke with were aware they should keep their mandatory training up to date and could do so via the trust on-line system as well as through face to face training. Staff had protected time for this training.

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

**Safeguarding**

Whipps Cross Hospital set a target of 85% for completion of safeguarding training.

The trust provided a breakdown of compliance for safeguarding courses as of 4 June 2018 for nursing staff in critical care as shown below:
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained year to date (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>60</td>
<td>60</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>60</td>
<td>60</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 1</td>
<td>60</td>
<td>60</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>59</td>
<td>60</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Nursing and medical staff exceeded the 85% completion target for all four safeguarding training modules and included e-learning and face to face training.

Staff told us that patients living with a learning disability admitted to the unit received a disability passport which helped staff identify areas where patients may be at risk of harm. Staff would consult with the families and carers in order to maintain a consistent approach to their care.

The trust submitted data after the inspection for safeguarding training compliance for medical staff which showed medical staff exceeded the 85% completion target for all four safeguarding training modules. Data showed 95% completion rate for adult safeguarding (level 1 and 2) and 100% completion rate for children’s safeguarding (level 1 and 2).

All the staff we spoke with knew how to contact the trust safeguarding lead and gave examples of situations in which they would do so. Arrangements were in place to provide safeguarding intervention for patients at risk of, or who experienced, female genital mutilation. Staff demonstrated a clear understanding of how to access out of hours urgent crisis teams and when to escalate concerns to the trust’s safeguarding lead.

**Cleanliness, infection control and hygiene**

During our last inspection we found that doctors did not consistently wash their hands when entering the unit.

On this inspection, we observed all staff complying with hand hygiene practice consistently. During our observations, staff delivered clinical care or treatment using the aseptic non-touch technique correctly each time.

There were dispensers with hand sanitising gel situated around the unit including the main entrance to the units and inside rooms. Hand wash basins were non-touch and equipped with soap, disposable towels and sanitizer.

Staff complied with local infection control policies. We observed staff washing their hands, complying with the ‘bare below the elbows’ policy and using hand gel. We observed all staff using alcohol hand gel when entering and exiting the unit. We saw staff routinely decontaminate their hands before and after patient contact.

Signs at the entrance to the unit reminded visitors and staff to use the hand gel provided before entering and guidance was displayed in line with the World Health Organisation six steps to hand hygiene. We observed staff asking relatives and other staff to wash their hands on entering the unit.
Adequate supplies of personal protective equipment including gloves and aprons were available and we saw staff using these appropriately.

The unit completed a hand hygiene audit between April 2018 and August 2018 which showed 100% compliance with the saving lives standards.

The unit had an infection control policy dated November 2016 which laid out who was responsible for what actions in preventing and controlling infection.

We saw the unit’s approach to sepsis management via a document titled ‘initial management of the septic patient - a step wise approach’. This included early identification of sepsis, the sepsis six bundle and sepsis shock bundle.

Senior staff told us antimicrobial use was monitored closely in the unit through daily ward rounds by a consultant in microbiology (Monday to Friday) and also through ad hoc communications as clinically necessary at weekends and out of hours. During these rounds all antimicrobial prescriptions were reviewed and regimens were adjusted in accordance with clinical status and results of investigations with the consultant intensivist or the duty middle grade doctor. Multi-disciplinary meetings were held as necessary with specialist clinical teams and other clinicians.

Senior medical staff told us that due to the complexity of patients on the unit, guidelines would rarely fit the individual patient’s clinical features. The duration of antibiotic treatment when patients were first admitted to the unit were not agreed due to the complexity of each patient. However, as patients were approaching step-down, outstanding course durations were specified prior to transfer. Plans for stopping antibiotics were considered prior to weekends. Investigation and antibiotic treatment plans in the event of deterioration were prepared daily for each patient as necessary. Any implementation of escalation plans were reviewed on the following day and continued or reversed as appropriate, in the light of clinical status, results of microbiology and other investigations.

Between March 2018 and May 2018, the unit completed a retrospective (inpatient) sepsis audit on the documentation of sepsis 6 care bundles in patients who had sepsis and results showed that an overall 65% of patients received their antibiotics within an hour. The results also showed 57% of the audited forms documented oxygen as being given within an hour, 24% of the forms had no documentation to demonstrate whether oxygen had been given, 75% of the forms did not have a lactate documented and 57% of the 44 forms had fluid balance documented as being performed in one hour. Action had been agreed to improve these results which would form part of the quality improvement work around sepsis and the deteriorating patient. A re-audit was planned for July 2018. However, at the time of the inspection the results were not available.

Data provided by the trust as part of the Commissioning for Quality and Innovation (CQUIN) submission February 2018, showed 86% of patients deemed to have an infection, received their antibiotics within an hour.

Between August 2017 and August 2018, the unit experienced 21 blood stream infections, two unit acquired Methicillin-resistant staphylococcus aureus (MRSA), two unit acquired Clostridium Difficile (CDiff), 13 pre-admission MRSA’s and five (CDiff) with an infection.

We also saw ‘I am clean’ labels in use to indicate when equipment in storage was cleaned. We saw cleaning schedules which were up to date and we spoke with housekeeping staff.

All of the equipment we examined such as vital sign monitors, mobile computers and infusion pumps were visibly clean. Staff would clean their own equipment as part of their daily safety checks.
There were safe arrangements for the handling, storage and disposal of clinical waste. We saw waste was labelled, segregated and stored correctly. We saw sharps containers were available at each bed space and were correctly labelled and not over filled.

We saw disposable curtains were used around the cubicles across the units. These were clean and stain free with a date of first use indicated on them.

Between June 2018 and August 2018, the rate of unit-acquired bacteraemia was six and central line-associated blood-stream infections was zero.

The total patient days for the three month period was 1218, resulting in a bacteraemia rate of 4.9/1000 patient days.

**Environment and equipment**

At our last inspection we found staff did not always have access to reliable equipment. During this inspection we found this had improved as the unit had procured a variety of medical equipment such as: six non-invasive breathing machines, one kidney machine, a number of epidural pumps, patient bedside chairs and a patient touch screen computer.

There was one outstanding item which was an additional blood gas machine. This was required as there were limited blood gas machines on the Whipps Cross site and other clinical areas were using this machine from the unit. The service had mitigated this by purchasing other blood gas machines for the site. The unit was in the process of obtaining the funding from a charity for an additional blood gas machine for the unit.

During our observations of handovers, we saw nurses routinely carried out a safety check on each item of equipment, including breathing equipment. This was good practice and meant medical equipment was regularly checked to ensure it was functioning as needed.

Staff on each shift documented checks on emergency equipment, including resuscitation and airway trollies. We looked at the checklists for each trolley for the two months leading to our inspection and found staff had completed these consistently.

We saw evidence that the unit complied with the national standards for intensive care Health Building Note 04-02.

Both the intensive Care unit (ICU) and high dependency unit (HDU) were bright and well-spaced out, individual rooms were spacious and had natural light. Privacy and dignity was maintained when carrying out personalised care by the use of blinds within each cubicle.

A regular cycle of monthly fire risk assessments were undertaken within the critical care units. Fire assessment proformas were retained within the units and where actions was needed, the units received support from the fire officer and estates team.

We saw staff had been trained in the use of different types of equipment and training days provided by the nurse educators, were used to ensure staff had access to training on equipment.

Linen storage areas were tidy and there was sufficient clean linen available.

However, we were told by senior staff and we observed, pillows used for pressure relief were of poor quality. Staff told us they were ordering over 20 pillows per week as the pillows disintegrated quickly. Staff had to use more than one poor quality pillow when making sure patients had sufficient pressure relieving care, instead of using one pillow of good quality. Senior staff also told us that paper cups used for patients needing sips of water whilst recovering on the unit, were difficult to procure which meant staff paid for these out of their own money. During the inspection, senior staff informed us that concerns around both items had been placed on the risk register.
Assessing and responding to patient risk

At our last inspection we found there was no consultant intensivist cover for critically ill children. During this inspection we were told this had been addressed and was no longer of the risk register. We saw this had been taken off the risk register.

At our last inspection we found staff used an early warning system to monitor patients across the hospital, promoting early detection and intervention if a patient’s condition deteriorated and triggered the requirement of support from medical and nursing staff. During this inspection, staff did not use this system during the patients’ stay but would use it when preparing patients to be transferred back to the general wards.

Senior nursing staff told us patients in critical care had continuous patient monitoring and as such using the national early warning system was not appropriate.

During our inspection we observed two consultant-led ward rounds. These were well attended by the medical team, the nurse in charge and specialists appropriate to each patient. The ward round included a full, systematic review of the clinical needs of each patient and addressed their immediate risks and medical status as part of evidence of good, consistent team decision-making and review practices.

All clinical staff had up to date training on sepsis testing, treatment and risk management. This included the use of the national Sepsis 6 care pathway and the use of National Institute for Health and Care Excellence (NICE) guidance. The Sepsis Six is the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis. Sepsis training on the units was delivered as part of annual mandatory training for clinical staff.

At our last inspection we found the acute response team was not able to provide a 24-hour, seven-day service and plans to provide this cover did not seem sustainable. There was poor oversight of the acute response team as it was not managed within the department and division. The team’s activity was not monitored to ensure the team responded to all referrals promptly.

During this inspection we found the unit had an acute response team (ART) who responded to deteriorating patients in the hospital and provided advanced nursing support, including vascular access. All ART staff had completed their primary responder course and a medical lead had been appointed to develop and lead the ART.

ART staffing levels had increased from 4.6WTE to 5.6WTE but due to sickness additional support was used from the site management team at weekends and evenings where necessary. However, we saw plans were in place to continue to increase these staffing levels and rotate staff from the unit in the future.

Over the last two years data from ICNARC shows there had been a reduction in the percentage of high risk admissions which reflected the ART involvement at a much earlier point in the care of the unwell patient. Between April 2017 and March 2018, the ICNARC data also showed there had been a reduction in the number of patients with high risk sepsis admissions to the unit from the wards.

An audit of the ART activity between April 2018 and June 2018 by the medical team, showed 1,926 events, with the majority focusing on: tracheostomy care, clinical advice, clinical assessment, venepuncture and follow up post discharge from the unit.

Response times were audited based on the trusts escalation policy of a national early warning score (NEWS) score of five or above to respond within 30 minutes and a NEWS score of seven or above to respond within 15 minutes. Audit results for the period December 2017 to March 2018
showed an 88% response time for a NEWS score of five or above and 72% for the NEWS score of seven or above. The audit also showed that 60% of the patients seen had a NEWS score of five or above. This meant the other 40% of responses were for those patients with a NEWS score of less than five. Staff told us the majority of the 40% were due to staff needing clinical advice.

Physiotherapy staff undertook a risk assessment for rehabilitation needs following a critical illness and used a form to identify whether there were any risks to the patients’ recovery. If there were no risks identified at the first assessment then the assessment would be carried out if the patients’ condition deteriorated or was to be discharged home.

At our previous inspection we found that the reporting of actions from mortality and morbidity meetings were not consistently followed up. During this inspection we found the unit held monthly multi-professional mortality and morbidity meetings which were documented and included actions needed from individual cases.

We reviewed three sets of minutes from the mortality and morbidity meetings which were found to be comprehensive and included learning for both critical care staff and other surgical staff. There was a named member of staff allocated responsibility for disseminating information from these meetings.

**Nurse staffing**

Whipps Cross Hospital reported the following nurse staffing numbers for critical care in March and April 2018. The trusts fill rate was below 90% in March and April 2018.

<table>
<thead>
<tr>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care</td>
<td>59.1</td>
<td>76.4</td>
<td>77.3%</td>
<td>58.1</td>
<td>75.7</td>
<td>76.7%</td>
</tr>
</tbody>
</table>

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

Nurse staffing levels and nurse to patient ratios met the standards of the Faculty of Intensive Care Medicine (FICM) and the Intensive Care Society (ICS). This included a nurse to patient ratio of 1:1 for patients receiving level 3 care and two supernumerary nurses on shift at all times.

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

From May 2017 to April 2018 the unit reported a vacancy rate of 27.8% for nursing staff; this was higher than the trust target of 6.3%.

We asked senior staff about the high vacancy rate and were told, this was due to the opening of the new HDU in January 2017. Overall the staffing establishment for the unit increased from 58.62 WTE to 104 WTE of which 88.98 WTE were nursing posts. Prior to the increase in establishment there were 6 WTE vacancies.

These vacancies were within the band 5 service line and the unit had continuous band 5 vacancies advertised both externally and internally on the NHS jobs website and internally. The unit had a full establishment of assistant practitioner posts and band 7 posts.
Senior staff had been overseas twice as part of a recruitment drive for critical care. One international nurse started in post with four more expected in September 2018 and four still awaiting start dates.

Two staff members were due to return from secondment for nurse training in September 2018 and would fill Band 5 posts. The unit had assistant practitioners who were registered nurses in their own countries and staff were supporting them to obtain their Nursing and Midwifery Council pin numbers. Once these had been obtained the assistant practitioners would then also fill Band 5 posts that were created through staff turnover.

The matron, clinical educators and HDU manager were undertaking the objective structured clinical examination (OSCE) training to further assist overseas staff in preparation for their assessments.

From May 2017 to April 2018 Whipps Cross Hospital reported a turnover rate of 22.2% for nursing staff in critical care, this was higher than the trusts target of 13%.

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

Senior nursing staff told us the high turnover rate was reviewed and the reason for leaving had either been due to re-location because of the cost of living in London or because this was their first experience of critical care and they found that this was not the speciality for them.

We were told by senior nursing staff they had already begun to see a reduction in turnover rate to 16% in August 2018.

The unit had tried to reduce the high turnover by offering a number of incentives such as the opportunity for staff to act up as band 7, to increase job satisfaction and maintain motivation. The unit had created a band 4 post to give assistant practitioners the opportunity to progress. Job roles had been reviewed and revised to increase both job interest, efficiency and financial effectiveness. For example the units’ administration assistant now combined the administration role with the audit of the units' performance.

From May 2017 to April 2018 Whipps Cross Hospital reported a sickness rate of 2% for nursing and midwifery staff in critical care, this was lower than the trusts target of 3%.

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

From May 2017 to April 2018 Whipps Cross Hospital had a total of 2,694 nursing staff shifts. A breakdown of bank and agency usage and unfilled shifts is shown below:

<table>
<thead>
<tr>
<th>Bank and agency</th>
<th>Number of shifts (% of total shifts)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank</td>
<td>2,269 (84.2%)</td>
</tr>
<tr>
<td>Agency</td>
<td>195 (7.2%)</td>
</tr>
<tr>
<td>Not filled</td>
<td>166 (6.2%)</td>
</tr>
</tbody>
</table>

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

**Medical staffing**

From May 2017 to April 2018 Whipps Cross Hospital reported a turnover rate of 0% for medical and dental staff in critical care, this was lower than the trusts target of 13%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)
From May 2017 to April 2018 Whipps Cross Hospital reported a sickness rate of 0.3% for medical and dental staff in critical care, this was lower than the trusts target of 3%.

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

From January to December 2017, Whipps Cross Hospital did not report any locum or agency usage for critical care.

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

The unit had an establishment of 10 consultants wtes in critical care which sat within the anaesthetic department budget. There were 69.54 wte allocated to that budget with 65.84 wte in post, which represented a substantive fill rate of 95%. At the time of our inspection there was one consultant on sick leave and a vacancy of one consultant. The vacant post was due to be filled by a locum consultant in November 2018. The remaining eight consultants worked extra shifts to ensure the unit met the correct level of cover for the Faculty of Intensive Care Medicine (FICM) and the Intensive Care Society (ICS) standards.

During the week the ICU consultant cover was 08.30 until 08.30 the next day. The HDU consultant cover was 08.30 until the evening handover to the ICU consultant at 17.30.

Trainees worked a standard day from 08.30 until 17.00 or a long day of 08.30 until 21.30 which was usually one ICU, ST3 (specialist trainee: third year) or above, with competencies in airway management and one HDU CT2+ (core trainee 2 years plus). This was usually in blocks of four week days, Monday to Thursday and three weekend days, Friday to Sunday.

Trainees covered the night shift from 20.30 until 09.30 with usually one ICU, ST3 or above with competencies in airway management and one HDU, CT2+. This was also in blocks of four week nights Monday to Thursday and three weekend nights Friday to Sunday.

At weekends the ICU consultant covered both ICU & HDU from Friday until Monday morning. The trainee doctors cover was the same as the weekday cover.

During out of hours on weekdays and at weekends the ratio of consultants to patients was 1:17. This was worse than the faculty of Intensive care medicine (FICM) guidance ratio of 1:15. The out of hours ratio of junior doctors to patients was 1:8, which was the same as the FICM guidance.

Trainee doctors we spoke with said ‘they never had problems with requesting leave, and if there ever was an emergency cover required such as in sickness, it was usually provided internally by ICU or anaesthetic trainees’.

During our last inspection in 2016 we found the consultant daytime working pattern was not consistent with the FICM recommendations for continuity of care. On this inspection, we found this remained unchanged. This resulted in morning handovers being comprehensive, structured but lengthy.

Senior medical staff explained this rota suited the patients’ needs better and put the emphasis on the importance of handover and managing patients risks appropriately. There was no evidence to show patients care was compromised due to this type of rota and no incident reports relating to substandard handover communication.
The unit had audited the consultant presence at the daily handover and results showed the handover was robust and the transfer of information maintained the integrity of clinical decision making.

The two handovers we observed were attended by two matrons, two consultants, three medical students, the night consultant and six junior doctors. At handover nursing staff would be involved with their individual patient. Nursing staff told us they felt the handover was more in depth and made them feel more empowered to give their view of the patients’ progress.

Data provided by the trust showed a compliance of 76% of patients reviewed by a consultant within 12 hours. Senior staff told us there was further work to be undertaken with data completeness as there were between 14% and 20% of patients where the information was unavailable. This meant the unit’s performance may be better than currently quoted. There was an action plan in place to nominate a champion from the consultant staff to review the data capture process.

**Records**

We looked at nine patient records and found a consistent standard of risk assessment and documented nurse and therapies observations. This included waterlow scores, moving and handling, venous thromboembolism and infection risk.

Waterlow scoring is a tool used to estimate the risk of a patient developing a pressure sore.

Staff completed daily progress notes for each patient and included a review of their care bundles, resuscitation status and communication with family members. Staff had clearly documented allergies in prescribing documents.

From the notes we saw evidence of twice daily multi-disciplinary input, clinical observations, risk assessments, evidence of discussion with the patient and families, specialist nurse inputs, types of devices being used and checked, types of invasive techniques and operations.

We reviewed a set of notes which showed a complete and safe world health organisation (WHO) handovers following the patient from the operating theatre, to the recovery area and from recovery to the high dependency unit. The WHO check list is a tool for the relevant clinical teams to improve the safety of surgery for reducing deaths.

The unit carried out an audit in January 2018 of admission documentation, which resulted in the development and use of a new admission proforma. The proforma included a record of medications, relevant legal information, and social history, lifestyle, language and communications, observations and examinations, diagnosis, treatment plans, morning and evening consultant input, night round updates and family discussion summaries.

The units’ documentation performance was automatically audited as part of the ICNARC data entry. Between May 2017 and March 2018 the data showed the unit was 100% compliant in 23 out of 29 areas of data completeness.

**Medicines**

The unit had a dedicated pharmacist who visited the ward daily, checking drug charts and providing advice. The pharmacist cross referenced to the British National Formulary to ensure medication prescribing was up to date. We observed the pharmacist providing advice to clinicians about dosages and supply while we were on the units.

At the last inspection we found medication stock items were ordered by the ward nurses using the stock list which was then sent to pharmacy. Required drugs were sent back to the unit on the
same day. During this inspection the hospital was in the process of implementing a ‘top up’ system for medications across the site. Technicians visited the unit three times a week and topped up the medicines. However, this system was causing problems with staff as the level of medicines did not reflect the usage and there were short falls for those medicines most used.

If medication was needed through the night there was an on call service at the Royal London site. This meant staff would have to wait up to four hours for medication if there was no stock on the Whipps Cross site. Medicines would be couriered across which delayed giving patients their medication in a timely manner.

Staff monitored medicines and fridge storage temperatures. These were within a safe range and checks were recorded. All medicines including intravenous fluids were securely stored and staff monitored and recorded medicine storage temperatures daily.

Some prescription medicines were controlled under the Misuse of Drugs legislation 2001 and called controlled drugs (CDs). We examined the CD cupboards and found that storage was appropriate with no other items in the cupboards. Balance checks were carried out twice daily. CDs were managed appropriately in line with relevant guidelines.

At the last inspection, the CD audit undertaken in April 2016 noted that frequently (84 times) there was some missing information in CD records for example drug name, form, or strength. Occasionally entries were put in the wrong column (eight times) or balance was calculated wrongly (16 cases). The audit also found that drugs and the register were stored correctly, and daily balance checks were undertaken and any discrepancies investigated immediately. During this inspection, the quarterly CD audit for April 2018 to June 2018 showed a significant improvement with both units rated as outstanding by the pharmacy team.

The pharmacy team also undertook a medicines audit covering 24 areas such as medication storage, fridge temperatures where drugs were stored and delivery of drugs. This showed that both units were compliant with medication management and were rated as good for the management of CDs.

The pharmacy team did not meet the FICM guidance of 24/7 cover as there was no on site cover overnight and at weekends.

We reviewed 10 prescription charts were fully completed and any allergies were documented in the patients’ record.

Incidents

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

From August 2017 to July 2018, the trust reported no incidents classified as never events for critical care at Whipps Cross Hospital.

(Source: NHS Improvement - STEIS)

In accordance with the Serious Incident Framework 2015, the trust did not report any serious incidents (SIs) in critical care which met the reporting criteria set by NHS England from August 2017 to July 2018.
At our last inspection we found staff did not always record actions taken or have any learning points from incidents. During this inspection we found this had improved as a number of actions recorded and taken after an incident had occurred. Senior staff alongside other critical care staff told us that the trust allowed the unit to conduct their own root cause analysis (RCA) as the unit completed them comprehensively.

We found reliable systems and processes to keep people safe and safeguarded from abuse. Staff used an electronic reporting system to record incidents. Staff were aware of how to report incidents and staff told us that they received feedback in a timely manner.

There was a good reporting culture within the service. Staff we spoke with fully understood their responsibilities to report incidents and near misses.

Between March 2018 and August 2018, the service experienced 150 critical incidents. Incidents were categorised into five main areas; airways and ventilation (11), drugs and therapeutics (47), procedures, lines and equipment (9), patient mix and environment (49) and unit management (26).

Staff told us about a problem with pressure ulcers due to the use of a non-invasive face mask. This had been identified as a risk and a ‘rotational policy has been implemented to ensure face masks were changed to nasal masks at regular intervals. This resulted in a reduction of pressure ulcers in that area.

The unit completed an audit of its incidents relating to tracheostomy care which resulted in a more in-depth categorisation of tracheostomy incidents being developed which would highlight more specific issues relating to tracheostomy care.

During the inspection, we saw a patient who had experienced an incident which resulted in no harm. We saw the patient had been informed about the incident immediately and an apology was made to the patient. The notes reflected the staff actions and the patient told us that he had been well informed and was very complimentary about the unit staff.

This showed that staff followed to duty of candour guidance. The duty of candour sates that every very healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress, staff must apologise to the patient (or, where appropriate, the patient's advocate, carer or family).


We saw the unit had a number of check lists and safety guidance in relation to the National Safety Standards for Invasive Procedures (NatSSIPs) such as the insertion of tracheostomy tubes, central venous lines, chest drains, pleural drainage and intubation.

There were trust-wide NatSSips meetings where progress was monitored against the trust’s implementation plan. Staff attended these meetings when necessary.

**Safety thermometer**

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.
Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 20 new pressure ulcers, one fall with harm and five new catheter urinary tract infections from June 2017 to June 2018.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Barts Health NHS Trust**

1. **Total Pressure ulcers**
   - (20)

2. **Total Falls**
   - (1)

3. **Total CUTIs**
   - (5)

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

(Source: NHS Digital)

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**Is the service effective?**

**Evidence-based care and treatment**

At our last inspection we found there was limited evidence of relevant audit activity and where audits were carried out learning was not always shared with staff. During this inspection we found information about the outcomes of patients’ care and treatment were routinely collected and monitored.

The unit demonstrated a comprehensive approach to delivering evidence-based care. There was a specific member of staff responsible for ensuring data returns for the intensive care national audit and research centre (ICNARC) were up to date. The unit carried out local audits to benchmark standards of care and treatment.
Doctors provided care and treatment in line with standards endorsed by the faculty of intensive care medicines (FICM). All the clinical staff we spoke with demonstrated how they accessed clinical policies and standard operating procedures using electronic access. This included National Institute of Health and Care Excellence (NICE) guidance and reference material.

The unit participated in a number of clinical audits based on national and local guidance. Some of these were joint audits across the hospital site and included critical care, emergency care, acute medicine, respiratory medicine, general surgery. For example, this group looked at the care of patients needing non-invasive ventilation outside of the unit. The audit showed issues around poor documentation and resulted in a number of actions to improve the outcomes. This was to be re-audited once the actions had been implemented.

Other examples of NICE audits were: critical illness rehabilitation which showed 100% compliance with the clinical standards. Clinical staff were encouraged to develop audits that would establish standards of care in the unit and drive improvements.

A retrospective audit at eighteen months post intensive care follow up showed there were a high number of patients who had experienced delirium. The unit were now discussing a new intervention for delirium prevention and would re-audit once implemented.

The unit participated in other quality improvement initiatives such as national research, studies which could be used to improve information about patients and their outcomes. An example was the prevalence of Candida auris in patients admitted to Intensive Care Units (ICUs) in England. The results of this showed there was no candida auris in any of the samples submitted from the unit. Candida auris is a type of fungus which causes severe illnesses in some hospitalised patients.

Nurses and assistant practitioners adopted link roles to specialise in certain areas, such as pressure area care, infection control and end of life care. Link nurses attended meetings and training with specialist teams and used critical care meetings and training days to deliver up to date information and guidance.

Staff used national Sepsis 6 and NICE guidance to assess for sepsis and to provide treatment. There was an up to date local sepsis policy in place that reflected national best practice and had been updated to accommodate national changes.

The pharmacy and microbiology teams maintained an up to date database of antimicrobial and antibiotic prescribing guidelines on a mobile phone application, which clinicians could access at any time. This meant staff had continual up to date access to trust guidance and policies.

The unit was part of the north east and north central London adult critical care network, which included undergoing network peer reviews to benchmark standards of practice. A peer review had taken place in September 2017 which resulted in a number of recommendations which the unit were in the processes of addressing such as the nurse staffing levels.

The units’ audit against the rehabilitation targets in an acute critical care unit; clinical guideline 83 (CG83) showed in April 2018 the units’ compliance was 100%.

**Nutrition and hydration**

The unit had plans to re-audit of fluid balance documentation for patients on critical care but this was to take place in December 2018.
At the last inspection there was one 0.6 WTE dietician provision for the critical care unit. This post was now full time and one dietitian responded to referrals from the units’ team. The dietitian would access the clinical record system each morning to review and assess all patients.

The dieticians saw most patients in critical care and prioritised those who required naso-gastric feeding and total parenteral nutrition. Total parenteral nutrition is a method of feeding that bypasses the gastrointestinal tract. Fluids are given into a vein to provide most of the nutrients the body needs. The method is used when a person cannot or should not receive feedings or fluids by mouth.

We saw an example of a menu available to patients, it included vegetarian and gluten free options as well as pureed food items suitable for patients requiring a soft diet. Patients were offered food when able to eat and we observed they had free access to drinks, including fresh water available next to their bed. There were also menus for patients from religious backgrounds. Patients we spoke with said they were happy with the quality and frequency of food and said they had access to snacks out of hours.

We saw there was consistent input from speech and language therapists and dieticians. Staff from each team worked together to assess each patient’s dietary needs, including risks for malnutrition and dehydration. Where patients had complex comorbidities, dieticians worked with critical care nurses to ensure nutritional needs were assessed and met. Staff used evidence based assessment tools to assess patients’ nutrition such as the malnutrition universal scoring tool (MUST).

**Pain relief**

Staff assessed pain and prescribed pain medicine in line with the Core Standards for Pain Management Services Faculty of Pain Management (2015). We saw that patients’ pain assessments were carried out by staff correctly and patients told us they had access to pain control medication when required.

In June 2018 the trust undertook a pain audit across the hospital site but it was unclear whether the unit took part in this audit. (DR104 - surgery)

The assessment of delirium, sedation and pain were undertaken as part of the daily nursing assessment on the unit. We saw nationally recognised scoring tools were used for assessing pain, delirium and sedation.

Nursing staff told us if a patient required medical intervention there were two non-consultant grade doctors would could be approached 24 hours a day.

**Patient outcomes**

The trust has four units which contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered and patient mortality could be benchmarked against similar units nationwide. We used data from the 2016/17 Annual Report. Any available quarterly data should be considered alongside this annual data.

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

At our last inspection we found ICNARC data for April 2015 to December 2015 suggested the unit had higher than expected mortality levels (compared to similar units nationally). Senior staff were not fully aware of the latest ICNARC clinical audit data results. During this inspection we found the expected mortality rates had improved (1.2) and was slightly worse than the national average of 1.1.
During the last CQC inspection there was no protocol for taking patients off ventilation and rehabilitation for long term patients. On this inspection we found this had improved as staff had developed an approach with three options. The first option weaned patients off ventilation using an endotracheal tube. The second option was used if the patient failed to be weaned off using the first approach. A tracheostomy tube would be used and respiration would be tailored to meet the patients’ specific needs. The third option was used for very specific patients and was supported by an external provider and their outreach team.

For the long-term rehabilitation patients, the team used NICE Clinical guidance (CG) 83 paperwork. The original NICE CG83 guideline required the full paperwork completed within 24-48 hours of admission but a revised version as of September 2017 (NICE QS158) showed that it could be too early to detect. This revision allowed staff up to four days to complete the assessments. The physiotherapists took the lead for this on behalf of the multi-disciplinary team (MDT). The CG158 was placed in the medical notes folder for each patient.

The MDT completed a recent audit to see if the unit was compliant with the older standard (24-48 hours) which showed 92% of critical care patients had a completed NICE CG83 (82% on ITU vs 100% on HDU). If assessed against the four-day standard the unit was 100% compliant. The team were continuing to undertake audits and were currently conducting an audit to see how long the therapy time offered is for HDU long term patients.

The unit provided monthly follow-up clinics for patients who had been ventilated during their inpatient stay or who had been an inpatient for longer than three days. The clinic provided patients with an opportunity to reflect on their experiences and memories through the use of patient’s diaries, as a method of improving their ability to cope with the psychological impact.

For the Intensive Care Unit at Whipps Cross University Hospital, the risk adjusted hospital mortality ratio was 1.2 in 2016/17. This was within expected range and remained unchanged from the figure in the 2015/16 annual report.

<table>
<thead>
<tr>
<th>Number of cases</th>
<th>Metric</th>
<th>2015/16</th>
<th>2016/17</th>
<th>National aggregate</th>
<th>Asp Standard</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>566 admissions</td>
<td>Risk-adjusted hospital mortality ratio (all patients)</td>
<td>1.2</td>
<td>1.2</td>
<td>1.0</td>
<td>none</td>
<td>Within expected range</td>
</tr>
</tbody>
</table>

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

ICNARC data showed between April 2017 and March 2018 unplanned readmission rates to the unit within 48 hrs of discharge, to a ward, was 0.6% which was better than the national average of 1.1%. This demonstrates the intended outcome for patients was being achieved.

A team of five physiotherapists provided rehabilitation to patients in line with NICE CG83, which relates to rehabilitation after critical illness. Although the staffing levels met the Faculty of Intensive Care Medicine and Intensive Care Society standards, this was not the case when a therapist was on leave or training. Additionally, the senior physiotherapist was the only permanent member of
the team and the junior physiotherapists were in rotational posts. This meant not all patients received an assessment within 24 hours of admission, which was not in line with London standards. In addition, the physiotherapy staffing levels and skill mix meant the team could not get involved in tracheostomy care and weaning.

Competent staff

From April 2017 to March 2018, six members of medical staff were eligible to receive an appraisal, and they achieved 83% completion rate against a trust target of 90% (five members of staff received an appraisal). Consultant appraisals were completed annually in line with their job plans and we found a positive attitude towards the learning and development opportunities presented by appraisals during our discussions. Clinical supervision for nursing staff was given on a monthly basis via team leaders.

The unit met the requirement of a minimum of 50% of registered nursing staff to be in possession of a post registration award in critical care nursing.

Senior staff told us regular appraisals gave staff the opportunity to highlight areas of interest so that they could assign roles accordingly. Staff had been able to expand their roles through attendance at follow up clinics, shadowing matron and link nurse roles.

The continued development of the ART to become a critical care outreach team (CCOT) would also provide opportunities for staff to develop another range of skills and to experience a different role.

The hospital did not provide a core service breakdown for medical staff; therefore, we were unable to include any appraisal completion rates.

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

However, nursing staff we spoke with told us they had received their annual appraisal. The unit was supported by clinical educators and a shift co-ordinator who were supernumerary as per ICS guidelines. Staff provided examples of other training such as advanced tracheostomy care.

The unit was engaged in on-going audit on compliance of staff’s education portfolios. All members of the MDT were engaged in teaching and training with personal development plans were in place to support learning opportunities. Staff who had previously only worked on an ICU now had the opportunity to work on an HDU and were given opportunities to manage the HDU as part of their development.

The unit had two nurse educators (NE) who led the units’ introduction to critical care nursing programme for new staff and had significantly increased the overall access to training. During the induction and probationary periods the NEs provided one to one support and ad-hoc bedside teaching to staff. During this period new staff worker on a supernumerary basis, which the NE could extend if needed. New staff completed basic competencies within three months and then began specific intensive care competencies. This structure meant nurses had access to training and development at an appropriate pace and also meant the unit was more aligned with similar units for the training of band five staff nurses.

We saw education programmes for new nursing staff and those progressing through their critical training were comprehensive. Topics included orientation, documentation, clinical competencies, wound care, the management of pain and insertion of chest drains. Staff told us this training was thorough and rigorous.
Junior medical staff told us their induction was adequate for their needs and included a tour of the unit and introductions to the staff.

The unit had recruited 17 assistant practitioners who once trained had the skills and experience in critical care. Assistant practitioners had the opportunity to advance their skills with the support from the units’ staff and nurse educators. Career progression was clear and supported the continuation of motivating staff. Assistant practitioners we spoke with felt they were part of the units’ team and felt valued and supported.

The unit shared learning across all the trust sites and within the local critical care network. The unit used band 7 study days to enable senior staff to discuss issues with their peers and to learn as a group. There was a dedicated teaching slot every Wednesday afternoon which was used to examine practice, teach new skills and for staff to feedback their own learning to their colleagues. Topics included; sepsis, airway management, nutrition, cardiac arrest, liver disease, psychology in the ICU, renal replacement therapy and radiology for ICUs.

Each member of the ART had a sub-speciality interest such as: sepsis, tracheostomy care, respiratory support, NEWS and acute kidney injury in order to support staff across the site.

**Multidisciplinary working**

Staff told us they felt the weekly MDT meetings were of benefit. Staff had protected time for these meetings they felt they could make comments as they discussed each patient.

The critical care team worked with the pharmacist, physiotherapists, nutritional team, speech and language therapists and microbiologists on a daily basis to plan all aspects of patient care.

Formal MDT meetings were held every Wednesday on the unit to discuss any patient issues or problems. By the end of the MDT meeting, there was a clear and concise plan set in place for each patient. The MDT discussion was then documented in the patient’s notes by the consultant holding the meeting. As part of MDT working the speech and language therapist attended the weekly units’ MDT meeting and the tracheostomy ward round. This picked up patients on the unit and step down wards to ensure continuity of care in a safe and effective way.

Staff frequently liaised with other trust teams such as the safeguarding, learning disability and social work teams. Staff told us they worked closely with the integrated discharge team plan for complex discharges and to ensure that patients and family needs were met.

**Seven-day services**

At our last inspection we found the unit was failing to comply with a number of the ‘London quality standards’ for adult critical care. Not all patients were seen and reviewed by the consultant in clinical charge of the unit at least twice a day, seven days a week. During this inspection this was still the case but these figures were being reviewed due to lack of data. Senior staff told us 20% of the data was missing.

An audit into compliance with ICU consultant admission review and ward round standards had been undertaken but the report had not been completed at the time of our inspection. This would be completed by the end of October 2018 and reported through the units quality and safety committee and then through the surgical divisional board meeting in January 2019.

The onsite hospital pharmacist provided five days a week support. Weekend cover was available on Saturdays and Sundays from 10am to 2pm and mostly over the phone but they would also visit the unit if requested. During out of hours there was access to the on call pharmacist at The London Hospital via a bleep (weekdays 5pm to 9am and weekends 2pm to 10am).
Microbiologists and radiologists were available Monday to Friday with on-call services available out of hours. Physiotherapy, speech and language therapists and pharmacy provided seven-day cover using an on-call system. This included chest physiotherapists who provided on-demand specialist therapy. The dietetics team was unable to provide a seven-day service due to short staffing.

Staff on the unit could access the trusts mental health team via the telephone when needed.

There was 1.0 wte band 7 speech and language therapy cover for the unit on the Whipps Cross site. This was currently covered by a job share. When fully staffed, the team provided speech and language therapy intervention to the unit Monday to Friday 08:30-16:30. The team aimed to respond to referrals within 24 hours and prioritise patients accordingly. Information provided by the team showed they used a prioritisation scale to ensure patients were seen in a timely manner. Similarly, dietetics services were only provided 8.30am to 4.30 pm Monday to Friday.

Some services such as computered tomography (CT) scanning and ultrasound services were available 24 hours a day seven days a week. The service had access to a magnetic resonance imaging (MRI) on site Monday to Friday 08:00-20:00 whilst out of hours; the trust provided a service for spinal pathways through one of the other trust’s team.

**Health promotion**

Patients and their relatives had access to the units’ dietitian to discuss their nutritional and health promotion needs during their stay on the unit.

Patients had additional opportunities to discuss their health when they attended the follow up clinics, such as stopping smoking and obesity.

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

Staff we spoke with were aware of the Deprivation of Liberty Safeguards (DoLS) legislation and gave good examples of what constituted a DoLS. Staff told us if a patient lacked capacity to make a decision a best interest meeting would be called.

We reviewed the clinical notes of patients with reduced mental capacity or those who had been cared for with a ventilator to identify if staff had applied for a DoLS authorisation. In each case we found staff had carried out appropriate mental capacity assessments as well as best interest assessments with the trusts mental health team. Where a patient had been cared for on a ventilator for a significant period without a DoLS authorisation, they had acted in line with FICM guidelines for life-saving care.

The unit had a sedation policy and used a nationally recognised sedation scoring tool. We saw this tool in use at the time of our inspection. The unit also used a nationally recognised delirium scoring tool.

The hospital site had not conducted a consent audit.

The trust policy for consent was currently under review by the trust wide Surgical Network Clinical Board. This review will look to review national guidance and align cross site processes. The working party were due to report their findings and proposals at their Board meeting in September 2018. At the time of the inspection these results were not available to us.

The unit did not provide data to confirm training in MCA and DoLS took place.
Is the service caring?

**Compassionate care**

Between February 2018 and July 2018, the unit’s results for its Friends and Family test showed 72% of patients would recommend others to be a patients on the unit. However, there was a 6% response rate.

Relatives we spoke with said they were happy with the care their relatives had received on the unit. One relative told us the medical team involved them in their care planning and consent was always sought when carrying out tests and treatments.

Patients we spoke with told us they were extremely happy with their care and the response from nursing staff was timely.

We observed patients being cared for with respect and dignity. The use of curtains was used to ensure patients’ privacy and dignity were maintained.

**Emotional support**

Where patients and their families received life-changing diagnoses, the unit offered families support in a number of ways. These included access to the psychological support practitioner, opportunity to speak with any member of the nursing staff, matron and medical teams. There was involvement of specialist teams such as palliative care, spiritual support and involvement of social services, housing services, and drug and alcohol support services when required.

All of the services were offered to patients and their families as part of the on-going care that they receive whilst within the unit.

The unit had a follow-up team, which included a psychology nurse practitioner. The team used patient diaries which provided patients with emotional support if they needed it following discharge.

Staff had the training and resources to provide emotional support to patients and their relatives following significant mental health events, including self-harm and attempted suicide.

The unit had established visiting hours to reduce disturbance and distress to patients. For example, visiting times on the intensive care unit (ICU) were from 16.00 to 20.00 and on the high dependency unit (HDU) 15.00 to 20.00. However, where family members or patients were distressed or deteriorating, the nurse in charge could relax the times and allow visitors at times to suit patients.

The unit also had an end of life link nurse and a chaplaincy service for patients to use when necessary.

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

Relatives told us staff were in constant communication with their patients and relatives. Information about calls from relatives and visits by relatives were documented at the back of the unit chart. This information was included in the daily handover.

When treatment was being withdrawn for those patients at the end of life, a doctor or a nurse in charge of the patients’ care could make a referral to the specialist nurse for organ donations (SNOD). The SNOD team were the first point of contact with patients’ families when raising the topic of organ donation as this has been shown to improve the consistence of approach and information shared. When the SNOD team approached families, they distributed a donor family
information pack which encompassed the support needed during this process as during conversations a great deal of information will have been shared.

In some instances, the organ donation team would also consult with the coroner as to whether they can make the approach. We saw at the morning handover, where appropriate, deprivation of liberty (DoLS) were discussed along with do not attempt cardiopulmonary resuscitation (DNACPR) and organ donation. Families were involved in these conversations and were handled professionally and with respect.

Is the service responsive?

Service delivery to meet the needs of local people

The unit took part in a local Critical Care Network which included 15 local critical care units. The aim of the network was to provide benchmarking against national quality standards.

At the last inspection we found between July 2015 and June 2016 the unit admitted 639 patients in total of which 521 were unscheduled admissions. This showed that 20% of the units’ admissions were elective patients and had an effect on service planning. At this inspection we found between May 2017 and May 2018 the unit admitted 962 patients in total of which approximately 193 (20%) were planned admissions. This was a similar performance to 2016.

The unit had a critical care admission and discharge policy to ensure that critical care beds were utilised appropriately in accordance with the guidelines set out in the National Framework Document (Comprehensive Critical Care: A Review of Adult Critical Care Services).

Staff were proactive in liaising with the specialist nurse for organ donation (SN-OD) to identify potential organ donors. Between June 2018 and August 2018 there were 18 patients eligible for organ donation. However, senior staff told us this data may not be precise as there was an issue with data collection. The unit had been part of providing two organ donations over the last 12 months.

Patients staying on the unit for three days or more had access to an intensive care unit (ICU) follow-up clinic.

These clinics were held monthly to review the patient’s physical and mental rehabilitation and to assess if any further interventions were needed to improve their outcomes. Patients’ diaries were used to enable them to get a more in-depth experience of their stay on the unit. Consultants, critical care nurses and a psychological support practitioner would attend these clinics monthly.

Meeting people’s individual needs

At our last inspection in July 2016, we found there were mixed-sex accommodation breaches on the unit owing to the lack of capacity, which service leads had not highlighted as a risk. During this inspection we found this was still the case which meant the unit was non-compliant with the agreed National Policy for preventing mixed sex accommodation breaches (2015) Between March 2018 and August 2018 there were 70 mixed sex breaches. Staff told us this was due to the patients being fit for transfer to a ward but there was a lack of receiving ward capacity. This had been noted on the units’ risk register.

Patients living with a disability or sensory loss were identified via the trusts patient administration system. Where their condition was recorded, flagged and shared where necessary. This allowed clinical teams to access this information and the ability for the team to tailor their interactions with each individual patient. This included use of touch and alphabet boards. Where the team required
more support and advice, the trust learning disabilities team would be contacted for additional assistance.

The unit had its own information leaflet for family and friends which included the unit’s philosophy, visiting times, contact details, infection control prevention, patient diaries, access to spiritual support and a map of the hospital site.

The unit had information leaflets for family and friends about a variety of conditions such as a guide for family and friends about delirium. This included what delirium was, causes and signs of delirium and how families and friend could help if their relatives experienced delirium.

At our last inspection we found there were no designated facilities for relatives to stay overnight. On this inspection we found this had improved as where possible, the unit allocated side rooms for patients living with a learning disability and made as many adjustments as possible to make patients comfortable. Staff would also move patients to a side room so that relatives can stay if necessary and regular refreshments were offered throughout the day and night. The unit provided reclining chairs and fold up beds for relatives who want to stay overnight with their relative. Where side rooms were not available, the unit allowed family members and carers to stay within the unit and provide them with reclining chairs and fold up bed frame and mattress to the used at the bedside.

Alternatively, the unit provided a list of hotels that were within a 10 minutes’ drive from hospital. Relatives were also given reduced parking fees when their relatives were being nursed on the unit.

Patients living with a learning disability had a learning passport and where this was not present; the team would get the patients carers involved in completing the passport. The details within the passport were used to frame their care and to accommodate the needs of the patients and their carers.

The clinical team identified patient’s needs as part of the discharge process from the unit to a ward. This included liaising with district nurses and community physiotherapists to support patients who would find daily activities challenging. Doctors included this information in discharge summary reports for GPs and provided patients with information on how to access other types of care. The follow-up clinic team supported patients to reintegrate into their community and to access community services.

Staff maintained patients’ dignity by using screens when carrying out care and using side rooms when possible. Translation services were available through an external company which was accessed by telephone with details displayed for staff.

Information leaflets in several languages most relevant to the unit’s local population were provided in the visitor’s waiting rooms.

For people who were because of obesity unable to use the standard equipment, we saw equipment was shared between ICU and HDU. Staff told us if a chair or bed was required these were obtained from the equipment library. If a bed was not available, the unit could hire beds and delivery would be within a couple of hours.

The unit had a learning disability link nurse and a dementia champion.

If the unit was caring for patients with living with dementia, they would also have access to the trusts dementia nurses.
Access and flow

At our last inspection we found bed occupancy levels for the ICU were consistently higher than the national average.

During this inspection data we found there had been little change to the bed occupancy rates. Trust data between May 2017 to May 2018 showed the unit had seen a stable trend in monthly bed occupancy rates ranging from 86% to 94%. This was generally higher (worse) than the England average.

**Adult critical care Bed occupancy rates, Barts Health NHS Trust.**

![Graph showing bed occupancy rates](image)

Note data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

(Source: NHS England)

At our last inspection we found that due to lack of bed capacity, the unit was not meeting several professional standards for patient care as required by the faculty of intensive care medicine (FICM) standards. Patients were waiting more than four hours to be admitted to the unit and sometimes cared for outside the unit by staff without intensive care training. During this inspection we found that no patients were cared for outside of the unit by staff without intensive care training. However, we found bed capacity was still a concern due to the patient flow issues within the trust. Between February 2018 and August 2018, a total of 16 operations were cancelled due to the lack of beds on the unit. Senior staff told us this was due to the lack of beds as patients were waiting to be transferred out onto the other wards.

The trust had daily bed flow meetings to help nurses on the unit improve flow across the hospital. Safety huddles took place at 11am each morning across the trust site. Issues discussed included the top three risks for the site, an update from the emergency department, ward updates, radiology updates, any safeguarding issues and planned discharges.

Since our last inspection in 2016 the unit had increased its bed capacity by eight beds and was now a 17-bedded unit. This included increasing its nurse staffing levels by fifty WTEs and expanding nursing competencies to include caring for patients on an ICU and HDU. During our inspection we saw recruitment was in the final stages of completion. This transition had been led by the units’ senior staff and their leadership and inclusiveness should be applauded. Staff told us about the managers’ approach to developing new roles and new ways of working and gave positive comments about this transition.
There were 3,285 available bed days for the unit. The percentage of bed days occupied by patients with discharge delayed more than 8 hours was 1.5%. This compares to the national aggregate of 4.9%. This meant that the unit was not in the worst 5% of units. The figure in the 2015/16 annual report was 2.6%.

<table>
<thead>
<tr>
<th>Number of cases</th>
<th>Metric</th>
<th>2015/16</th>
<th>2016/17</th>
<th>National aggregate</th>
<th>Asp Standard</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>3,285</td>
<td>Crude delayed discharge (% bed-days occupied by patients with discharge delayed &gt;8 hours)</td>
<td>2.6%</td>
<td>1.5%</td>
<td>4.9%</td>
<td>0%</td>
<td>Not in the worst 5% of units</td>
</tr>
</tbody>
</table>

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

The FICM standards state that discharge from the ICU should occur between 7am and 10pm as discharges overnight have been linked with high mortality. Data provided by ICNARC showed the unit had improved on this standard. Between April 2016 and March 2017 the unit’s performance was on average 4% with the current performance for April 2017 to March 2018 standing at 1.7%. This was better than the national average of 2%.

At the last inspection the service was not meeting the FICM standards for delayed discharges over four hours. During this inspection, we found this remained unchanged and had been noted on the unit’s risk register.

The core standards for intensive care units state that discharge from an intensive care unit to a general ward should occur within four hours of the decision. Between September 2017 and August 2018 there was an average of 58% delayed discharges over four hours from the decision to transfer to the wards. This ranged between 35% and 81% and did not meet the standard.

ICNARC data for April 2017 to March 2018 also showed delayed discharges over eight hours was 10.5% which was worse than the national average of 4.9%. Delayed discharges over 24 hours were 6.1% which was worse than the national standard of 3%. Senior medical staff told us this was due to the lack of beds in the main wards.

When determining whether a patient needed an elective critical care bed post-surgery, senior staff told us that during the pre-operative assessment process, it was determined whether a patient required a critical care bed post operatively.

This information was then captured within the electronic assessment record which was held on the trusts patient administration system.

The trusts scheduling department was also notified of the requirement and which type of bed was required, for example, level 2 or level 3. The scheduling team would then place an entry into the critical care admission diary.
This information was also shared with the operating theatres team including the anaesthetist in charge of the operating list that the patient has been allocated.

In line with departments’ admission and discharge policy, the consultant anaesthetist in charge of the operating theatre list would check the availability of the bed with the critical care co-ordinator on the day of surgery and in advance of start of the procedure.

If there was limited capacity, a review was undertaken to identify potential discharges and requested ward beds in order to accommodate the elective cases.

The number of booked cases and critical care capacity were discussed at the early morning bed meeting to allow for planning.

There were 614 admissions to the unit, of which 0.3% had a non-clinical transfer out of the unit. This was within expected range. The figure in the 2015/16 annual report was 0.6%.

<table>
<thead>
<tr>
<th>Number of cases</th>
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<th>Comparison</th>
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</thead>
<tbody>
<tr>
<td>614 admissions</td>
<td>Crude non-clinical transfers</td>
<td>0.6%</td>
<td>0.3%</td>
<td>0.4%</td>
<td>0%</td>
<td>Within expected range</td>
</tr>
</tbody>
</table>

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

At our last inspection we found that due to bed pressures patients were sometimes transferred out of the unit for non-clinical reasons and many patients were transferred out overnight contrary to professional standards. The figure in the 2015/16 annual report was 1.9%. During this inspection we found that 3.1% of admissions were non delayed, out-of-hours discharges to the ward. These are discharges which took place between 10:00pm and 6:59am. Although this was within expected range, the figure had increased in comparison to 2015/16 figure.

<table>
<thead>
<tr>
<th>Number of cases</th>
<th>Metric</th>
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<th>2016/17</th>
<th>National aggregate</th>
<th>Asp Standard</th>
<th>Comparison</th>
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<tbody>
<tr>
<td>451 admissions</td>
<td>Crude, non-delayed, out-of-hours discharge to ward proportion</td>
<td>1.9%</td>
<td>3.1%</td>
<td>1.9%</td>
<td>0%</td>
<td>Within expected range</td>
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</table>

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

Learning from complaints and concerns

From April 2017 to March 2018 there were seven complaints about critical care services at Whipps Cross Hospital. The trust took an average of 64 days to investigate and close complaints. This was not in line with the trust’s complaints policy, which states complaints should be
completed between 10-60 days. Three out of seven complaints related to diagnosis/treatment.

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

The unit had low numbers of complaints which reflected the services' responsiveness and proactive approach to local resolution.

Although the unit received two complaints between March 2018 and August 2018, the response times had improved and were in line with the trust's policy for both of the complaints. One complaint related to a hospital acquired pressure ulcer and the other to staff attitude. The unit completed a review of the medical and nursing notes and apologies were made to both relatives and patients. Both complaints had been shared with the service to share learning.

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

Is the service well-led?

Leadership

The unit was part of the surgical services division and was managed through the department of anaesthesia and critical care. Responsibility and accountability for quality, safety and operational effectiveness division was managed through a triumvirate structure with an accountable clinical director, associate director of nursing and general managers.

The clinical board and network membership included multi-disciplinary representatives from trust sites (clinical and managerial), strategy, research and education. Strategy leads and a clinical board research director were aligned to each board. Each network was led by a clinical network director. A support and assurance framework had been developed by the senior team and implemented to ensure that clinical boards and networks could achieve their objectives.

A lead consultant and a matron led clinical care in the critical care unit and a business manager was responsible for non-clinical staff. We spoke with 30 staff in various roles in the unit about the leadership structure. Staff spoke positively about the leadership of the unit and said there had been notable and significant improvements since our last inspection.

Medical staff told us there was better leadership which resulted in improved tracking of actions from meetings, better delegation of actions to other staff and improved timings of meetings so more staff could attend.

Vision and strategy

At our last inspection we found there was no documented long-term strategy for the division and staff had poor awareness of the leadership’s plans for the department. During this inspection we found this had improved as the unit had a strategy which could be found at the entrance to both the intensive care unit (ICU) and high dependency unit (HDU).

The critical care strategy formed part of surgery division’s strategy and included developing stronger working relationships trust wide, transitioning the acute response team (ART) into the unit and developing a critical care outreach team. The strategy also included continuing to work closely with partners across the local health and social care systems and the further development of the hospital site plans.

Management of the ART was now led by a clinician with a specialism in respiratory care which we were told had improved decision making and progress with the development of the ART.
The units' leadership team had an open door policy and openly supported discussion, development and involvement in the strategy. The strategy was developed with external partners with a focus on the frail elderly. Senior staff told us all staff groups had the opportunity to review and contribute to the strategy in varying ways. Critical care nurses reviewed and commented on the strategy at various opportunities whilst consultants and doctors reviewed and contributed during their monthly business meetings. The unit's senior leadership team circulated the strategy to all staff by email.

**Culture**

At our last inspection there was a positive culture on the unit as we found staff were friendly and open and felt confident raising concerns. They were positive about local leadership on the unit. During this inspection we found staff continued to be positive. Staff supported one another and remained proud to work in the unit. Staff we spoke with told us they felt valued and respected.

The unit provided all staff with the development they needed, including appraisals and career development pathways, opportunities to develop as a member for the ART and shadowing more senior nursing staff.

Staff told us they felt comfortable in raising their concerns and were asked their opinions about their patients. The in-depth ward rounds gave nursing staff the opportunity to inform medical staff about their patients in more detail.

**Governance**

The critical care clinical lead and matron shared the responsibility for governance, budget planning, staff management, recruitment and retention and staff development, cost containment, equipment lease and purchase. They acted as the link with the surgical divisional board, corporate trust management and other regional bodies.

The unit held monthly clinical governance meetings led by the unit's clinical lead with support from the matron and general manager. The minutes from these meetings included set agenda items such as incidents, complaints, clinical audit and risk management.

Consultants attended monthly morbidity and mortality meetings and invitations to the meeting included all of the critical care team. The team reviewed each patient death at the meeting and included staff at all grades in discussions of the events leading to their death as a strategy to identify opportunities for learning.

Weekly safety meetings also took place on the unit to keep the profile of risk and governance as a priority.

We saw the trust had a duty of candour policy dated May 2016, Staff we spoke with were aware of this policy.

We also saw the trust had a patient information leaflet telling them about the duty of candour which relatives could access in the waiting rooms. This leaflet discussed areas such as being open and transparent when things went wrong and what support groups were available such as bereavement services and the patient advice and liaison services.

We saw duty of candour issues were discussed as part of the surgical division safety and governance board meetings. Other issues were discussed such as; complaints, critical incidents and risk issues.
Management of risk, issues and performance

At our last inspection we found the risk register did not fully document all risks identified across the unit and senior divisional leaders had limited awareness of key challenges, risks, and serious incidents which occurred on the critical care unit.

During this inspection we found this had improved as the risk register was more comprehensive and was part of the surgical divisions risk register. The main risks included recruitment and retention, mixed sex breaches, delayed discharges and procurement of equipment.

We saw the minutes of monthly quality and safety meetings which showed staff discussed complaints, incidents such as falls and medicines errors, patient documentation, risk assessment, staffing and training.

There were performance measures for falls, pressure ulcers, incidents, complaints, hospital acquired infections, friends and family test feedback.

The minutes of leadership meetings showed risks on the risk register were reviewed monthly.

Staff we spoke with were aware of the risk register and its contents. The results of the monthly sepsis audits were monitored via the Infection Prevention and Control Committee which reported by exception to the quality and safety committee. The quality and safety committee then reported by exception to the hospital management board.

Information management

There were computer stations with intranet and internet access available on both units for staff to use.

There were computers throughout the unit to access patient information including test results, diagnostics and records systems. Staff were able to demonstrate how they accessed information on the trust’s electronic system.

There were information boards in staff rooms which provided information on monthly safety and governance indicators, patient experience briefing, new guidelines, new staff welcome, ward messages and thank you messages.

The unit was developing a business case for software to allow the development of an outreach database for the ART and was readvertising for the post for a clinical link for organ donation, which will be responsible for ensuring data completeness and a more consistent approach to capturing this information.

An electronic discharge letter was sent to the patient’s GP once the patient was discharged from the unit. Further information would also be sent to the GP following the patient’s follow up appointment in the clinic. This letter would highlight any ongoing issues or problems the patient may still be experiencing.

The unit identified there were issues of data capture such as information relating to: time to be reviewed by a consultant within 12 hours, organ donation referral rates and data capture for the ART.

Engagement

The unit participated in NHS Friends and Family Test and undertook family satisfaction surveys and the feedback provided by patients and their families was positive.

The unit had an established follow-up clinic for patients that had been cared for on the unit and was part of the critical care rehabilitation process under NICE guidance. This clinic gave previous
patients the opportunity to obtain detailed information about their critical care stay and to fill in any
gaps in their memory. It also provided the opportunity to obtain referrals for any outstanding needs
that patients had following discharge from hospital. We maintain patient diaries which families
contribute to and this has also become a source of feedback.

Patient diaries were used to assist and engage patients to gain more of an insight to their care.
The unit had its own psychological support practitioner who would attend the monthly follow up
clinics. The psychological support practitioner worked closely with the team gaining feedback from
patients who had stayed on the unit.

As part of the learning process the clinic provides feedback which is summarised and displayed for
staff.

There were feedback cards were used to gain feedback from relatives in the waiting rooms and
these were also given to patients on discharge from the unit. Information leaflets in the visitors’
waiting rooms were provided in several languages.

Staff told us families would often seek advice and help from staff though informal conversations
and this also helped to secure the assistance they needed.

**Learning, continuous improvement and innovation**

The unit had an Adult Post Anaesthesia Care Policy dated January 2017 which showed the unit
had implemented the Association of Anaesthetists of Great Britain and Ireland guidelines on
immediate post-anaesthesia recovery. These ensured patients were cared for and transferred to
the unit following national guidance.

Staff from other areas of the hospital were invited to attend the unit’s teaching sessions on areas
such as tracheostomy care and staff also took the opportunity to use teaching from other
areas such as an offer from the Margaret Centre to help with training for the use of pumps. The
unit had an end of life link nurse who would present training sessions on care of the dying patient.

The service participated in a number of clinical research studies which ensured nursing and
medical practice was up to date and evidenced based.

The senior team should be commended for their positive and inclusive leadership skills resulting in
the successful transition of staff to an integrated ICU and HDU with a reduction in nurse
vacancies.

The leadership team maintained focus and motivation of their staff through this transition: staff
were positive about their new ways of working.
Outpatient services at Bart’s Health NHS Trust is provided at all five hospital sites: The Royal London Hospital, Whipps Cross Hospital, St Bartholomew’s Hospital, Mile End Hospital and Newham University Hospital. The trust saw around 1.48 million outpatient attendances in 2017/18.

Outpatient services across the sites are managed via a mixed operating model: Clinical Support Services (CSS) administer the new appointment centres, clinic reception, nursing, medical records and phlebotomy for the majority of services at The Royal London Hospital and Whipps Cross Hospital, with some areas managed by the sites.

St Bartholomew’s Hospital and Newham University Hospital manage the majority of their new patient bookings with CSS providing reception of clinics and medical records. This model is under review with an aim to offer a standardised site based operating model for outpatient services across the trust. A team manage outpatient services across the sites with around 500 front line booking, reception, nursing, phlebotomy and medical records staff, who are site based but managed by the central team.

While CSS manage large elements of the booking and reception functions, responsibility for referral to treatment time and income generation sits with the hospital sites. A key focus for 2018/19 is the national requirement for all trusts to stop accepting paper referrals from GPs, and instead accept bookings only via the Electronic Referral Service (ERS). The trust is due to go live with this process July-September 2018.

Source: (Provider Information Return RPIR Acute Context tab)

In August 2018, outpatients services moved from the remit of CSS to the emergency care and medicine (ECAM) division, managed directly in the hospital. The division of outpatients and medical records maintains overall oversight of the service operation and non-clinical aspects, such as centralised referrals. Outpatients services were provided across 86 specialties and services and the hospital provided an average of 1057 appointments per month.

Total number of first and follow up appointments compared to England

The trust had 1,358,950 first and follow up outpatient appointments from April 2017 to March 2018. The graph below represents how this compares to other trusts.
Number of appointments by site

The following table shows the number of outpatient appointments by site, a total for the trust and the total for England, from April 2017 to March 2018.

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Number of Spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Royal London Hospital</td>
<td>765,685</td>
</tr>
<tr>
<td>Whipps Cross University Hospital</td>
<td>521,004</td>
</tr>
<tr>
<td>St Bartholomew's Hospital</td>
<td>316,882</td>
</tr>
<tr>
<td>Newham University Hospital</td>
<td>274,495</td>
</tr>
<tr>
<td>Bart’s and The London Outreach Clinics</td>
<td>42,432</td>
</tr>
<tr>
<td>This trust</td>
<td>2,099,264</td>
</tr>
<tr>
<td>England</td>
<td>105,566,870</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics)

The chart below shows the percentage breakdown of the type of outpatient appointments from April 2017 to March 2018.

Number of appointments at Bart’s Health NHS Trust from April 2017 to March 2018 by site and type of appointment
From January 2018 to June 2018 staff carried out 96,172 phlebotomy procedures in outpatients and inpatient wards.

**Is the service safe?**

**Mandatory training**

The trust did not provide figures for the completion of mandatory training for staff in outpatients. They told us this was because each specialty service held their own records, which could not be analysed centrally. This meant there was no overall assurance of the compliance of outpatients staff with mandatory training requirements.

The trust had a 95% standard for the completion of mandatory training. The July 2018 nurse and healthcare support worker (HCSW) meeting summarised training compliance amongst outpatient nurses, administration and management. The minutes identified 18 training modules with overall compliance of 93%, which reflected a three-month downward trend. This was an average figure and a range from 80% completion for fire safety to 95% for equality and diversity. An operations and governance meeting in August 2018 identified mandatory training completion for nurses, administrators and managers as 98%, 93% for the health records team and 99% for phlebotomy.

Results from the 2018 staff survey indicated a need to facilitate more protected time for staff to complete mandatory training.

Staff told us they received protected time for mandatory training updates and they could schedule their own courses using the online booking system.

**Safeguarding**

The trust did not provide figures for the completion of safeguarding training for staff in outpatients. They told us this was because each specialty service held their own records, which could not be analysed centrally. This meant there was no overall assurance of the compliance of outpatients staff with the trust’s 95% standard for safeguarding training completion.
We identified training completion rates for nurses, HCSWs, managers and administrators in July 2018 from team meeting minutes. This noted 92% completion of safeguarding adults level 1, 95% completion of safeguarding children level 1 and 80% completion of safeguarding children level 3.

The medical records team vetted requests for copies of the medical records of patients with a known safeguarding risk and worked with clinical teams to ensure information sharing requests did not compromise their safety.

All the staff we spoke with demonstrated a sound working knowledge of the principles of safeguarding and could explain local referral and escalation procedures for patients they considered to be at risk. A safeguarding lead was in post for the hospital and provided an on-call service. Out of hours, staff had access to urgent referral pathways to community safeguarding teams.

Staff demonstrated fast and appropriate action when they became aware of a safeguarding need. For example, a nurse acted immediately when a patient disclosed information of domestic abuse during an unrelated clinical assessment. They involved the safeguarding team, the patient’s GP and the police, which ultimately meant the patient was protected from further harm. The member of staff completed a detailed incident report and shared this with their colleagues for learning.

Staff followed the trust’s established policy on female genital mutilation (FGM) including the urgent referral of patients at risk of harm.

**Cleanliness, infection control and hygiene**

All clinical areas were fitted with antibacterial hand gel dispensers and areas to wash hands with soap and hot water. Signs were prominently placed to advise patients and visitors to use the facilities. Cleaning schedules were available in each clinical area and all examples we checked were up to date.

From January 2018 to June 2018, outpatient and phlebotomy staff demonstrated consistently high standards of hand hygiene practice including the use of the aseptic non-touch technique (ANTT). Infection control staff monitored this through monthly hand hygiene audits, which demonstrated 100% compliance during this period in each month except for June 2018 in which surgical outpatients achieved 98%. In all months, services performed better than the trust standard of 95%.

The hospital used scores from the annual patient-led assessment of the care environment (PLACE) as an additional measure of cleanliness. The hospital had performed consistently well in this measure and achieved 99% in 2017 and over 99% in 2018, exceeding the national average.

Infection control training was mandatory for both clinical and non-clinical staff and in July 2018 nurses, HCSWs, administrators and managers met the 95% completion rate.

During most of our clinical observations staff demonstrated good standards of infection prevention and control in line with trust policy. This included adhering to the bare below the elbow standard, frequent hand washing and use of antibacterial hand gel. However, this was not always the case in non-clinical settings. For example, we observed one clinical member of staff in the eye treatment centre used their mobile phone whilst using the toilet. They had not closed the door and this was visible to anyone passing, including patients, as the toilet was shared. The member of staff did not wash their hands after this and returned to the clinical area. This presented a significant infection control risk and lack of adherence to infection control principles.

Tuberculosis (TB) clinical nurse specialists (CNSs) provided a dedicated service in the chest clinic. There were several risks relating to infection prevention and control in this service that had not been addressed by the TB team or by the site infection control leads. We raised this as a
significant concern with the senior nursing team, who prepared a standard operating procedure with the TB team to ensure practice did not compromise safety. Although this reflected a planned improvement in practice, there was evidence staff had previously identified this as a risk in February 2018 but had not taken action. TB CNSs we spoke with during our inspection did not demonstrate awareness of this risk and said they had not worked with the infection control team to limit the risks.

We checked each outpatient area for compliance with the Department of Health and Social Care (DH) Health Building Note 00/09 in relation to infection control in the built environment. The chest clinic environment was fully compliant with this HBN, including the sinks. Staff documented regular flushing of sinks that were rarely used to reduce the risk of a Legionella outbreak.

The ear, nose and throat (ENT) team demonstrated consistent standards of decontamination for naso endoscopes in line with best practice. This include separate dirty and clean rooms, a good decontamination flow and a manual back-up system if the ultraviolet (UV) decontamination machine failed. Staff validated scopes and copied this into patient notes, which meant they could continually track each scope. The service had a drying machine that could safely store scopes for up to seven days before they would need another decontamination.

**Environment and equipment**

Emergency planning and fire safety were mandatory training modules and the trust set a 95% minimum completion rate. In July 2018 91% of nurses, HCSWs, administrators and managers had completed emergency planning training and 80% had completed fire safety training.

Emergency resuscitation equipment was available in all clinical areas and outpatient clinics, including oxygen and emergency medicine. Staff documented daily checks when clinical areas were in use. We reviewed the documented safety records for all equipment in the three months leading to our inspection and found consistent standards of checks and recording.

Eight members of staff had undertaken enhanced fire training in outpatients. However, the trust was unable to map these individuals to specific clinics or outpatient buildings. This meant we could not confirm that each building or area had a designated fire safety lead. We were not assured staff always had a good working knowledge of local fire safety and evacuation procedures. For example, one manager said they were unsure about fire drills, practices or training in their area. Another manager was unable to identify all evacuation routes from their usual area of work. During our inspection main outpatients was evacuated due to a fire alarm evacuation. The evacuation was unorganised and poorly managed in the areas our inspectors were present. Staff and patients huddled around exit doors and there were no visible fire wardens or control staff. Staff did not direct patients to rendezvous points and there was no coordinated effort to ensure people around the doors moved away from the building.

The chest clinic had carried out an unannounced mock evacuation exercise in September 2018. A senior nurse said the evacuation went to plan and staff carried this out safely and in line with their training.

Results from the 2018 PLACE results indicated patient assessors rated the condition, appearance and maintenance of the environment highly. The result for this measure, at 93%, was comparable to the national average of 94% and reflected an improvement from the 88% result in 2017.

A matron and lead nurse had assessed the outpatients building for risks relating to patients with self-harm tendencies. They identified a number of risks, such as ligature points in unsupervised areas and found control measures were appropriate for them.
Some of the estate presented staff with significant challenges in keeping clinics safe and fit for purpose. During our inspection the roof of the chest clinic had developed a leak, which resulted in the closure of a patient waiting room. The heating system had failed, which meant waiting areas and clinical rooms were very cold. Staff had not provided patients, including those with vulnerable immune systems, with blankets or heaters to keep them warm. We spoke with the service delivery manager and nurse in charge about this and we were not assured there was an appropriate escalation plan in place. In the eye treatment centre, three patient toilets were out of use. The alternative toilet was shared between staff and patients. Although investment in the estate was a key part of the trust’s strategy, there was limited evidence staff in individual clinics could respond to patient needs when there were failures in equipment or the estate. For example, in October 2018 the access standards team rescheduled 146 cancer appointments due to the failure of a CT scanner. Although the team tried to reschedule patients to the trust’s other sites, their ability to do so was restricted due to the lack of capacity of other services to carry out kidney function and blood tests.

Senior staff identified old and unserviceable dictation equipment and broken label printers as a key challenge in the service. However, the outpatients service was transitioning to use a new dictation system and new label printers had been ordered.

The trust had carried out the most recent fire risk assessments under the Regulatory Reform (Fire Safety) Order 2005 in May 2018. The assessments found 43 doors that needed to be upgraded to meet standards relating to heat and smoke seals, which could prevent a fire spreading. The assessments also found that five-year IEE electrical safety testing had not been kept up to date although this had restarted. The risk assessments also found emergency lighting testing was not carried out in line with British Standard 5266 and that 1050 units had failed the most recent discharge test in November 2015. The risk assessment action plans attributed repairs and urgent safety testing to the estates team but did not include a date schedule or evidence of completion.

We checked each outpatient area for compliance with the DH HBN 00/10 in relation to flooring. The chest clinic was fully compliant, with coving fitted at the edges of floors to prevent the build-up of bacteria. The reception area in the Gillian Hanson Centre for Diabetes and Endocrinology was carpeted and therefore not compliant with the HBN.

Hazardous waste audits in the chest clinic were fully completed and up to date and reflected consistently good standards of practice. This included segregated waste streaming and secure disposal in line with the requirements of the Hazardous Waste (England and Wales) Regulations 2005.

**Assessing and responding to patient risk**

The trust did not maintain a record of the level of resuscitation competency training of junior doctors. Instead educational supervisors carried out an annual review of clinical progress (ARCP), which included confirmation each doctor held training to a level appropriate for their role.

In September 2018 53% of outpatient nurses had completed immediate life support (ILS) training and 47% had completed advanced life support (ALS) training. All nurses had paediatric life support, 71% had completed paediatric ILS and 55% had completed paediatric ALS.

The trust did not carry out sepsis audits in outpatients and was not able to provide details of staff training rates for sepsis.

Senior staff in the chest clinic and respiratory service had developed training with clinicians to better identify high risk patients and offer them priority appointments. This was part of broader work to improve the service, which also included a more reliable spirometry follow-up process.
Staff in the chest clinic had demonstrated rapid action when an asthmatic patient had rapidly and unexpectedly deteriorated during an outpatient appointment. The nurse had called the respiratory consultant and rapid response team and the medical specialist registrar had attended. The team’s fast action meant the patient was quickly transferred to the emergency department.

Staff did not routinely call patients who experienced extended delays in referral appointments and managers said this would usually be the responsibility of individual consultants. However, we did not find evidence this routinely took place. This meant services could not maintain a regular understanding of patient’s needs or risks while they were waiting for delayed appointments. Some service managers, such as in the eye treatment centre, liaised directly with consultants to ask if some waits were appropriate based on known patient risks. Where consultants considered a wait to be risky or inappropriate, the manager brought the appointment forward. The appointments booking service team submitted an incident report where patients called to say their condition was worsening while they were waiting for an appointment but said they did not routinely receive a response to this.

The phlebotomy team used electronic coding to track sample tubes and four positive identification confirmation processes, which ensured results were always attributed accurately to the correct patient.

Staff in the diabetes and endocrinology service had acted on a Supply Disruption Alert from the Department of Health and Social Care that enabled them to extend the useful life of EpiPens in certain situations.

Senior staff had identified that the dermatology service could not meet demand and had applied to the trust to temporarily divert new referrals. This reflected a backlog of 488 patients who had waited more than 22 weeks for an initial appointment. The authorising body responsible for this had declined the request and senior staff were attempting to resolve the situation with increased recruitment.

### Nurse staffing

Whipps Cross Hospital did not provide planned vs actual staffing data for nursing staff within outpatient services.

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

Each specialty managed staffing within its remit and the trust was not able to provide an overview for outpatients.

Whipps Cross Hospital did not provide vacancy data for nursing and midwifery staff within outpatients services.

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

We asked staff in each clinical area or specialty about vacancies in the absence of data from the trust. The nursing teams in the eye treatment centre and chest clinic had no vacancies. Vacancies in other specialties ranged from two to four nurses.

Whipps Cross Hospital did not provide turnover data for nursing and midwifery staff within outpatients services.
Whipps Cross Hospital did not provide sickness data for nursing and midwifery staff within outpatients services.

Staff told us sickness rates had decreased in the previous two years and they felt their teams were generally more stable.

Whipps Cross Hospital did not provide bank and agency staff data for nursing and midwifery staff within outpatients services.

A team of 17 phlebotomists provided services across outpatients specialties, with the exception of the chest clinic where the specialist team carried out their own procedures. This was a reduction of 50% since November 2017, when 17 staff were redeployed to the community. The phlebotomy manager arranged training for any clinical staff to help take pressure off the phlebotomists and had secured funding for an additional three staff.

Senior teams were recruiting specialist nurses to address the increase in demand and difficulties in recruiting medical staff, such as a diabetes clinical nurse specialist.

The workforce had stabilised following the completion of a merger between trusts that was underway during our last inspection. Ward managers and senior managers said their teams were more cohesive and attrition had reduced.

A registered nurse, a HCSW and a receptionist were responsible for the operation of paediatric outpatients. The nurse post was rotational and individuals worked in the clinic for six months before moving to another area. The HCA and receptionist posts were permanent and enabled consistency in service delivery. Nurses based on Acorn ward, the paediatric inpatient ward, provided support on request during peak times.

A lead physiotherapist, eight physiotherapists and two rotational physiotherapists provided the outpatient musculoskeletal (MSK) service, with support from three physiotherapy assistants. An MSK lead, and three occupational therapists provided the hand therapy service.

**Medical staffing**

Whipps Cross Hospital did not provide planned vs actual staffing data for medical and dental staff within outpatient services.

Whipps Cross Hospital did not provide vacancy data for medical and dental staff within outpatients services.
Services were impacted by the lack of consultant or medical cover. For example, a GP who provided additional capacity in the respiratory service had left the service and managers were recruiting for nurse specialists who could provide the service instead. However, recruitment was on-going with varying degrees of success. For example, ophthalmology had recruited three new consultants and urology had recruited two specialist trainees and a consultant to cover maternity leave. Gastroenterology had a 37% vacancy rate for consultants and this was entered on the service risk register as a high risk. The vacancies had increased waiting times and led to breaches of the 52-week wait referral to treatment time (RTT) limit.

Whipps Cross Hospital did not provide turnover data for medical and dental staff within outpatients services.

Whipps Cross Hospital did not provide sickness data for medical and dental staff within outpatients services.

Whipps Cross Hospital did not provide locum and agency staff data for medical and dental staff within outpatients services.

Most clinics were consultant-led, such as consultants in chronic obstructive pulmonary disease (COPD), sleep apnoea and lung cancer in the respiratory service.

The dermatology service could not meet demand and senior staff highlighted this as a significant risk. The team had been unsuccessful in recruiting to a locum post and instead had established an agreement for two consultants working in the community to provide 0.6 whole time equivalent (WTE) cover in the dermatology clinic.

A team of twelve consultants and a clinic lead provided the ophthalmology service although this was not enough to meet demand and the service referred simple cases to other clinics in the trust.

A full-time consultant in the respiratory service had left the trust and a consultant working 0.4WTE was increasing their hours to try and meet demand.

The urology service was short-staffed due to long-term leave but had recruited an additional stoma specialist.

Four consultants and four specialist registrars led care and treatment in the diabetes service, and one consultant and one registrar additionally provided cover for acute services.

The service had a standard operating procedure for recruiting locum consultants. This included a structured induction procedure that ensured consultants had access to trust computer systems, policies and standards.
Where the trust was unable to recruit to permanent posts, they identified interim solutions with locum doctors. For example, the trust had backfilled a vacant gastroenterology consultant post with a long-term locum doctor.

**Records**

The trust did not carry out audits of patient records in outpatients. This meant there was no system in place to assess the quality of medical records and the adherence of staff to General Medical Council standards.

Staff saw patients if their notes were not available in time for their appointment and used temporary notes to document findings and observations, which the medical records team added to permanent notes.

Services were in the process of implementing electronic records and were at varying stages of this. Paediatric outpatients had piloted a new electronic vetting system for referrals under an NHS Digital project. Sexual health and HIV services were fully electronic. This meant the infectious disease consultant and specialist registrar, who led HIV care at the hospital, had access to patients records from wherever they usually received care in the trust. For example, the team had access to the medical records of HIV positive patients who were seen for other conditions in the rheumatology and neurology clinics, which meant they could provide a multidisciplinary treatment service with other colleagues. The HIV pharmacist had access to this system, which enabled clinicians to review prescriptions continually.

Reception staff said they felt record management had been improved since our last inspection, with better access and controls in place and more secure storage in each clinic.

We spoke with medical records staff, who worked to targets for the availability of notes. Routine notes were supplied within 72 hours of a request and urgent or cancer two week wait notes were available within 24 hours. From January 2018 to June 2018 note availability was 99%, which met the trust standard of 98%. Where the team could not track notes, they submitted an incident report, which triggered an investigation.

Some AHPs said the clinical note-taking system in place was not fit for purpose. For example, they recorded notes on paper that were not readily accessible to medical colleagues. One therapist said, “We write paper notes and file them away and no-one ever reads them. Community teams can’t access them and medical staff never ask for them.” While staff raised this as a concern for patient safety they also said it reflected significant time on their behalf that could be spent in consultation with patients.

We looked at seven patient records in the chest clinic. In each case medical entries were legibly written, dated and signed. Nurses had documented care bundles and clear treatment plans were noted although with details of the patient’s history and reason for referral.

**Medicines**

Medicine management was a mandatory training module for all clinical staff. In July 2018 91% of nurses and HCSWs were up to date with this training.

The pharmacy team carried out an annual safe and secure handling of medicines audit in each clinical area. The governance pharmacist published the outcomes of the 2017 audit in March 2018 and made recommendations to the medicine safety and management committees. The main areas of non-compliance with trust policy were lack of allergy posters in clinical areas, expired signature lists and gaps in the temperature recording of fridges used to store medicines. The audit included main outpatients, the chest clinic and outpatient urology. The audit found staff did not
always store ampoules in their original box in the chest clinic or outpatient urology, which was against best practice. The chest clinic and main outpatients did not display allergy posters and did not have an up to date signature list of nurses able to prescribe medicines. The pathology laboratory was the only area relating to outpatients with full compliance against trust medicine management standards.

The pharmacy department carried out a monthly audit of compliance with FP10 management standards. FP10 refers to a medicine documentation process that enables nurse prescribers or pharmacist prescribers to dispense medicines without the need for a doctor’s signature or authorisation. The most recent audit results available were from August 2018 and had taken place in 22 outpatients services and clinics. The audit assessed compliance against eight standards and overall found consistent standards. Fifteen areas met all eight standards, including use of an FP10 log, serial number logs and the ability to track which prescriber issued the FP10. Six services or clinics did not meet the requirements for legible and tidy logs and the ophthalmology service was not always able to track which patients had received an FP10 prescription. During our inspection we looked at the storage of FP10s in five clinical areas, including paediatric outpatients. In each case documentation was stored in a locked cupboard with controlled access.

An antimicrobial pharmacist led an antimicrobial stewardship programme based on the guidance of the UK Five Year Antimicrobial Resistance Strategy, which included total antibiotic usage as a key performance and safety measure in outpatients. However, the trust was not confident of the accuracy of their data and was unable to supply this.

Staff maintained a daily record of temperature checks of ambient storage areas and medicine fridges in the chest clinic along with daily documented checks of glucometer machines.

A serious incident in the diabetes service in 2017 had led to improved communication standards and liaison between junior doctors, consultants and pharmacy staff. This meant insulin prescribing was more consistently monitored and controlled.

**Incidents**

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

From August 2017 to July 2018, the trust reported no incidents that were further classified as never events for outpatient services at Whipps Cross Hospital.

(Source: NHS Improvement - STEIS)

A never event occurred after the above data was submitted to us, in September 2018. This related to a breach of confidentiality and treatment delivered to the wrong patient due to a failure to follow trust procedures. All of the staff we spoke with were aware of this, including a receptionist who demonstrated a detailed understanding of the need for positive patient identification. Senior staff had implemented new standards for the identification of patients prior to the delivery of care and we observed staff adhere to these during all our observations.

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents in outpatient services at Whipps Cross Hospital which met the reporting criteria set by NHS England from August 2017 to July 2018.

Clinical incidents were recorded in the monthly divisional quality and safety dashboard. However, it was not evident incidents were reported or monitored in outpatients in a way that ensured senior
staff maintained ownership and oversight. For example, there was one incident recorded for outpatients in the data the trust supplied for March 2018, May 2018 and June 2018. The incident related to a patient who injured themselves in their wheelchair when they did not use the brake properly. This incident was reported in June 2018 and remained awaiting review when the trust supplied the data to us in October 2018. Allied health professionals said they were not always confident incidents were investigated or acted upon. For example, one therapist said they submitted an incident report whenever their clinic ran late but the only response they ever received was a standardised e-mail from a manager. Service specialties entered incidents under their name, such as ‘diabetes and endocrinology’, but it was not possible to identify if the trust had a clear indication of incidents relating specifically to outpatients.

Non-clinical incidents were recorded in an outpatients incident tracker. From September 2017 to October 2018 staff recorded 647 incidents, of which 98% resulted in no harm and 2% resulted in low harm. Of the 11 incidents reported with low harm, nine related to minor injuries, or allegations of such, sustained by staff. The incidents related to minor injuries from handling broken fixtures or equipment, or in one case from straining while handling documents without following moving and handling good practice. Two incidents related to patients who slipped or tripped in outpatients, neither of which could have been prevented by staff or the trust. Most incidents, 94%, related to outpatient services prior to the move of the service from CSS to ECAM. Of the remaining incidents, 5% related to health records and 1% of incidents related to phlebotomy. Of the incidents attributed to outpatients services, 85% were submitted by staff in relation to delayed clinics or problems with appointments. In most cases staff documented they apologised to patients and kept them informed although significant, excessive demand on services meant senior staff had not been able to reduce the risk of similar incidents recurring.

An overdue incident was included in the incident report list for June 2018. The incident had been reported in April 2018 in the dermatology clinic and the member of staff noted it was difficult and confusing to assign an incident manager due to the number of options available on the reporting system. The reporter noted this was a psychological barrier to the reporting of incidents. However, the status of this incident was still pending in October 2018. An allied health professional also said the allocation of incidents for investigation was complicated and said the investigation of an incident involving both the main outpatients clinic and the musculoskeletal (MSK) service had been delayed because the complex accountability system meant staff did not know who should investigate it.

Senior staff identified learning from the 2018 staff survey that included the need to develop a culture of incident-reporting and to develop a feedback system for the outcomes of incidents. For example, a third of respondents reported seeing an error or near miss in the previous month that could have harmed patients and only 50% said they felt the trust would address concerns about unsafe clinical practice.

Investigation of incidents was a mandatory training topic. Although the trust was unable to provide a completion figure for outpatients overall, or for medical staff, in July 2018 94% of nurses, HCSWs, administrators and managers had completed the training.

Most staff we spoke with said they felt incident reporting had improved since our last inspection in July 2017. However, they also told us they did not always receive feedback or a discussion about the outcome. We spoke with senior staff about this and received varied responses. One manager said staff in their team always received a formal response, even if there was no formal learning from it. Another manager said they did not always reply to incidents formally but would speak with staff and discuss it with them. Staff in phlebotomy said feedback was given occasionally.
The respiratory CNS ensured all incidents reported in their service were raised and discussed at clinical safety meetings with the lead consultant. A diabetes incident group, led by CNSs, met periodically and reviewed incidents in the specialty on a trust-wide level to identify learning and opportunities for improved practice.

It was not evident that incident reports always led to improvements in the service. For example, one incident was reported when a patient’s appointment had to be cancelled when they arrived on site because staff could not access the trust’s telephone interpretation provider. The patient did not understand enough English for staff to safely carry out the appointment. Staff rebooked the appointment for two months’ later and cancelled it again on the day because planned interpretation was unavailable and the patient waited another eight weeks to be seen. There were no resulting changes to how staff could access language interpretation as a result.

There was limited evidence that sharing of learning outcomes was robust or common practice. For example, clinic managers we spoke with had some awareness of a serious incident in gynaecology outpatients involving a retained instrument but could not identify the details or key outcomes.

**Safety thermometer**

Staff in the renal haemodialysis unit audited patient safety using the national Saving Lives catheter care bundles. From September 2017 to August 2018 renal units performed consistently well, with 100% compliance against bundle standards for both catheter insertion and continuing care.

**Is the service effective?**

**Evidence-based care and treatment**

Outpatients did not have an overall audit plan. Instead all clinical services which provided care in outpatients had their own specialty plans, some of which included the outpatient department.

Staff adhered to national best practice and clinical guidance from the National Institute of Health and Care Excellence (NICE) and monitored this within their specialist area.

The tuberculosis (TB) service operated from the chest clinic was not fully compliant with NICE national guidance 33 relating to the safe management and care of patients. We escalated this to the senior team after our inspection, who implemented improved standards of working in line with national guidance with the TB team. This included the Royal College of Nursing Tuberculosis Case Management and Cohort Review for Health Professionals 2017.

An audit of speech and language therapy (SaLT) documentation between December 2017 and May 2018 found it was not common practice for therapists to document outcome measures for patients. This meant when patients attended outpatients for on-going condition management, there was no measure of their planned outcomes and goals in relation to SaLT-led activities such as swallowing. The audit lead had initiated a new project to address this, which would include a benchmarking exercise against other trusts and SaLT teams and introduction of a new care protocols.

Allied health professionals were involved in a series of national audits to benchmark or establish care against NICE standards and guidance. In 2018/19 the audit plan included an evaluation of the physiotherapy management of fragility hip fracture patients and two audits to improve the care of patients living with diabetes who are pregnant or at risk of Coeliac disease. Therapist teams
carried out audits within their specialties. For example, the SaLT team was reviewing care pathways for patients living with aphasia and a physiotherapist was auditing care against national bronchiectasis guidelines.

The respiratory service had not contributed to national audits, such as the chronic obstructive pulmonary disease (COPD) audit in six months due to short staffing. However, a senior nurse had presented a business case to employ a dedicated CNS who would lead on audits. The trust had accepted the business case and planned to appoint a new nurse. A consultant carried out an ongoing non-invasive ventilation (NIV) audit and presented the results at the respiratory governance meetings. The audit aimed to improve care and outcomes for patients.

Staff delivered care for COPD in line with British Thoracic Society guidance, including through the use of lung function tests, nurse-led assessments and the implementation of a care bundle.

**Nutrition and hydration**

The hospital measured patient satisfaction with food using the annual patient-led assessment of the care environment (PLACE). Results demonstrated a gradual improvement in results year-on-year between 2013 and 2018. The most recent score was 95%, which was better than the national average of 90%.

The multidisciplinary team was research-active and participating in a study to explore how to better support patients who received clinically assisted nutrition and hydration due to long-term conditions such as frailty and Parkinson’s. The research included consideration of best interest decision-making processes that often impacted how staff could ensure patients received adequate nutrition and hydration.

A dietician was based in paediatric outpatients weekly and provided reviews for patients with an appointment and had capacity for same-day referrals from other clinics.

**Pain relief**

Two consultants led a pain management clinic that operated weekly. Staff in other services managed pain on an individual basis with patients for example through referrals back to the patient’s GP and liaison with the specialist pain team.

A community pain service was prominently advertised in the therapies department and staff referred patients to the service who experienced pain as part of everyday life.

Clinical staff in paediatric outpatients kept a stock of oral paracetamol to be give as-needed (PRN). Where a patient’s pain was uncontrolled by this, a consultant would refer the patient to the paediatric emergency department.

**Patient outcomes**

The outpatient therapies team used a musculoskeletal (MSK) referral and treatment pathway that helped to triage patients at an early stage to one of six services: local physiotherapy; physiotherapy telephone triage; pain team; trauma and orthopaedic rheumatology; carpal tunnel clinic and rheumatology. An extended scope physiotherapist or band 7 physiotherapist triaged each referral.

There was limited communication between consultants and GPs. Senior staff said there were no pathways of care between consultants and GPs, which meant GPs did not routinely have access to specialist advice. In addition, GPs did not have full access to the electronic records system, which meant they could not access medical photographs taken by services in the hospital.
The diabetes team worked regularly with community and acute medicine colleagues and used learning from complex cases to improve patient outcomes. For example, the diabetes CNS team worked with the learning disability nurse, a dietician and a care home manager worked together to improve the long-term health of a patient who had experienced multiple hospital admissions for diabetic ketoacidosis.

**Competent staff**

Whipps Cross Hospital did not provide any appraisal data for staff within outpatients services.

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

We asked the trust to provide anonymised samples of appraisals so that we could check them for effectiveness and to corroborate what staff told us during the inspection. However, they were unable to do so. This meant we were not assured that when appraisals took place they were effective and fit for purpose.

Arrangements for appraisals and clinical supervision varied between specialties. The phlebotomy manager led appraisals in their team and 100% of their staff had completed an appraisal within the previous 12 months or had one planned within a 12 months period. A respiratory CNS led appraisals and one-to-one supervisions in the chest clinic and 100% of nurses and HCAs were up to date.

Results from the staff survey in 2018 identified a need for a more consistent approach to supervision and appraisal processes. Senior staff identified four themes to develop in this area, including establishing clearer roles and responsibilities in the appraisal process to help staff identify their contribution and achievements.

The trust asked staff about their experience of appraisals in the 2018 staff survey, which indicated 28% had not had an appraisal in the previous year.

Leadership vacancies in the allied health professionals’ teams meant staff did not have access to consistent or regular supervision or appraisals. One therapist we spoke with said they had not been offered an appraisal in over two years and another said they were expected to carry out a self-appraisal. However, as there was no-one to provide a peer review or senior oversight of this, they had stopped doing it. Although physiotherapists said they could access funding for masters-level study and training up to one year ahead, other therapists said they were not given access to this. For example, one member of staff had paid for their own re-accreditation despite this being a prerequisite of their role.

Outpatients services did not have a dedicated nurse education team and staff had varying perceptions of access to competency and professional development. For example, some staff said matrons were responsible for nurse education in their specialties but most staff we spoke with said they did not know how to access additional training. The service manager for the eye treatment centre used bi-monthly meetings with colleagues across the specialties to identify educational opportunities for their teams. For example, nurses in the eye treatment centre were undertaking training to enable them to administer eye injections and more complex day surgery cases, which would increase capacity.

A respiratory CNS led training in this service and provided sessions and opportunities for all staff to ensure they maintained professional competency and developed their skills. For example, a physiology training session had been delivered and include spirometry and smoking cessation.
Diabetes CNSs worked with staff across the hospital, particularly with junior doctors, to raise awareness of diabetes and insulin management. The team networked with a national specialist diabetes organisation, organised consultant education days and delivered case presentations to colleagues.

All staff undertook a corporate induction on joining the hospital followed by a series of local or specialist inductions depending on their area of work. International nurses recruited to their first UK post undertook additional supernumerary training and support to achieve the Nursing and Midwifery Council observed structured clinical examination (OSCE). The induction policy included temporary and locum staff, who were required to complete a corporate induction followed by supervision in their clinical specialty.

The ear, nose and throat (ENT) service provided care for patients with a tracheostomy and a dedicated healthcare assistant had completed a tracheostomy care course. This enabled them to clean the tracheostomy and to prepare simple dressings.

In clinics led predominantly by bank staff, the senior team ensured they engaged with regular training to maintain their skills and confidence. For example, the nursing team in paediatric outpatients was mainly led by bank staff. The team undertook regular simulation and ‘turbo’ training, which was used to target specific areas of knowledge, such as sepsis. Staff spoke positively of this approach and said the highly intensive, one-hour turbo sessions were focused, detailed and helped them to rapidly increase their knowledge. Simulation training was based on previous incidents to help staff develop management and communication skills. For example, one recent simulated exercise involved the sudden collapse of a child who could not speak English. Staff in paediatric outpatients spoke highly of the matron who they said was trying to secure funding for four nurses to undertake postgraduate study and for others to access a specialist clinical paediatric course offered by a children’s hospital.

**Multidisciplinary working**

A team of allied health professionals provided therapies services to outpatients and in the community. A community neurotherapy team provided care to patients after a stroke as part of the networked stroke care service.

AHPs said they had frequent opportunities to meet with inpatient colleagues to share learning and development. However, some therapists said they felt isolated from colleagues within outpatients and said their workload meant they did not have the opportunity to approach medical colleagues for support or to plan coordinated care.

Individual specialties arranged multidisciplinary team meetings within the service. For example, the chest clinic team met monthly and managers facilitated this to encourage staff to raise concerns and to identify areas of good practice. The senior team used this meeting to review incidents, complaints and other performance markers. Colleagues from respiratory inpatients routinely joined this meeting to discuss case reviews and patient pathways.

The respiratory service held a monthly meeting with the palliative care team to review patients and make new referrals during this meeting.

The multidisciplinary HIV team convened monthly, with representation from each of the trust’s sites, and included the tuberculosis (TB) leads to review patients living with both conditions. TB clinical nurse specialists (CNSs) led care planning for patients who were also HIV positive and worked with the multidisciplinary team to coordinate care. Outpatients specialities worked with the HIV service to promote opportunistic screening during appointments, including routine screening alongside colposcopy (a medical diagnostic procedure) and in the dermatology clinic. Sexual
Clinical and non-clinical teams had improved opportunities for multidisciplinary working through monthly combined meetings. The meetings helped teams with different roles to understand their responsibilities more clearly and identify opportunities for more streamlined working.

Allied health professionals provided multiple services with low levels of cover as everyone could work multiple roles. For example, one therapist provided dedicated cover as an extended scope physiotherapist (ESP) in an orthopaedic clinic, a musculoskeletal (MSK) clinic, a hand clinic and a GP community clinic. The ESP had access to a specialist registrar and a consultant in the hand clinic but problems with the referral process from GPs meant patients did not always undergo a consultant review first. This caused delays as it meant the ESP had to arrange for them to be seen by a consultant at a future date.

An appointment service manager, two supervisors and 34 call handlers and scanners provided the dedicated appointment booking service. This team had been instrumental in the successful implementation of the new electronic referral system (e-RS). A supervisor and five call handlers were dedicated to the two week wait appointment system.

Respiratory consultants worked with a psychologist who would sit in on patient sessions to help understand the causes of asthma, particularly in patients with a complex presentation. A trust-wide difficult asthma multidisciplinary team meeting was held weekly and the local team joined this to review patients.

**Seven-day services**

The availability of services outside of Monday to Friday daytimes depended on commissioning arrangements. To address capacity issues, ophthalmology and cardiology offered clinics every weekend and trauma orthopaedic clinics ran on Tuesday and Thursday evenings. Gastroenterology and rheumatology services offered sporadic out of hours clinics when staff were available to address additional demand.

The pharmacy team provided a seven-day service with an on-call provision for evening clinics. An external provider operated an outpatient dispensary that was open Monday to Saturday.

**Health promotion**

Printed health promotion material was readily available in clinical areas and was issued by trust teams and by specialist external organisations. This included signposting to talking therapies services, smoking cessation, health and wellbeing workshops and a wide range of support for people living with cancer. The service maintained an annual plan of visits from external organisations to promote their services and health promotion interventions. In 2018 Healthwatch from two local boroughs carried out eight events and other events included World Orthoptic Day, diabetes awareness, emotional support for older people, eczema support and a living well team.

A patient had commented in survey feedback for the ear, nose and throat (ENT) clinic in September 2018 that they appreciated staff efforts to help them improve their health through a patient-centred approach.
Specialist teams organised a range of annual health promotion events for staff and visitors, including for World Sepsis Day, World AIDS Day and HIV Testing Week.

The diabetes service offered a weekly drop-in support service for patients newly-diagnosed with type 1 diabetes. A nurse in this service had developed a support group for patients living with type 2 diabetes, which had been transferred to a community provider and remained readily accessible to clinic patients.

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

The trust was not able to supply training completion data for consent, the Mental Capacity Act (2005) (MCA) or the Deprivation of Liberty Safeguards (DoLS) as this was delivered at specialty service level. Clinical staff we spoke with said they had completed this training during their induction but it had not been repeated or refreshed.

The dementia and delirium team saw patients from all specialties and prepared treatment plans for those with complex needs. Doctors screened all patients over the age of 75 for dementia and delirium using established cognitive screening tools.

All of the staff we spoke with demonstrated understanding of the MCA and DoLS, including local escalation and referral processes.

There was limited evidence of consent in a sample of seven patient records we looked at in the chest clinic. Although a clinician had noted they had obtained informed consent in each case, there was no documented evidence of how this was obtained or why the patient had not signed their consent.

During our observation of a spirometry appointment the physiologist discussed consent with the patient and ensured they fully understood the procedure before they continued.

**Is the service caring?**

**Compassionate care**

Each specialty monitored narrative patient feedback gathered from the NHS Friends and Family Test. We looked at a sample of feedback for six specialties in September 2018. In this sample patients provided generally positive feedback on their experience with staff. For example, one patient in the orthopaedic and fracture clinic said staff had been, “…Very friendly and welcoming”, and one patient noted that staff in the plaster room had been, “…superb.” One patient noted the ear, nose and throat (ENT) service was “excellent” and another patient said their doctor had been, “…A good listener and communicator.” Six patients noted staff in the gastroenterology clinic had been friendly and comments included, “Everything great” and “Excellent care.” Feedback was similarly positive in the gynaecology clinic and one patient noted, “Very professional…sympathetic kind doctor and staff.” Patients in haematology commented on the crowded waiting room but said staff were, “…very kind” and noted, “The service was excellent.”

Feedback for the pain clinic was very positive. One patient noted, “I am very pleased with doctors”, another wrote, “Very thorough and honest” and one patient said, “I could not ask for more care, kindness.”

We spoke with three patients in the Gillian Hanson Centre for Diabetes and Endocrinology who all spoke very highly of the care they received. One patient said, “I’m treated with the highest levels of care.”
An allied health professional noted concerns about privacy and dignity in the hand clinic. They said the environment layout meant patients were seen in an open area that impacted on dignified care. Clinics displayed patient feedback in waiting areas, which demonstrated how positively patients felt about the standard of care they received. In outpatient areas A and B displayed quotes noted patients found staff to be, “…Very attentive, caring” and, “…Sympathetic, kind and professional.”

**Emotional support**

Bereavement services were available in the hospital and prominently advertised in outpatients areas.

The chaplaincy offered a 24-hour, seven day a week service and a faith centre provided access to prayer materials from multiple religions and in a range of different languages.

An improving access to psychological therapies (IAPT) walk-in service for anxiety was available for patients attending the diabetes service.

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

We spoke with a patient who attended outpatient appointments frequently. They told us the service was consistently good and staff always reviewed with them what the plan for the session was. They said, “It’s nice they (staff) don’t just assume I understand everything even though I’m here all the time, I like to be kept involved and updated.”

Staff told patients how and when they would receive test results before they left their appointment and each patient received their next appointment, before they left the hospital. Patients had the option to receive copies of letters staff sent to their GP.

The hospital had implemented the objectives of the Academy of Royal Colleges Guidance for Taking Responsibility: Accountable Clinicians and Informed Patients (2014). This included continuity of care for outpatients, such as remaining with the same consultant for the duration of their treatment. Where patients moved between inpatient and outpatient services, consultants liaised directly to ensure patients understood their treatment. Outpatient appointment letters stated the name of the consultant in charge of every clinic appointment and the nurse in charge displayed the name of each consultant in outpatient clinic waiting areas.

In the annual patient-led assessment of the care environment (PLACE), outpatients scored poorly in the measure for privacy, dignity and wellbeing, with a 77% result compared to the national average of 84%.

One patient said they had felt enabled to ask questions of staff in the ENT service but did not feel they had been answered. For example, one patient said staff, “…did not give clear or certain answers and left me with some uncertainty.” Feedback from patients who used the pain clinic was more positive. One patient noted, “[Doctor] was thorough in his approach. He explained all aspects of treatments available and took his time to ensure I [understood] exactly what he suggested.”

Female and male chaperones were available in each clinic and posters advertising this service were on display. Patients could request this on the day of their appointment and trained staff were always available.

Staff in the Gillian Hanson Centre signposted patients to advocacy services that could help them with long-term condition support.

We observed a patient undergoing spirometry testing. The physiologist demonstrated excellent awareness of the patient’s need for understanding and explained each step clearly and patiently.
They carried out a practice run first, explained why three good quality breaths were needed and explained to the patient what to expect next.

Patients we spoke with said they knew who to contact if they had worries or concerns after they left the hospital.

**Is the service responsive?**

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

From April 2017 to March 2018, Whipps Cross Hospital’s did not attend rate was higher than the England average.

The senior leadership team had expanded services based on local demand and by sharing recruitment of new staff with the rest of the trust. This included more availability of gastroenterology and ear, nose and throat (ENT) clinics and the development of a new community-based rheumatology service. This included a virtual rheumatology clinic, a virtual chronic kidney disease (CKD) clinic and a community dermatology clinic, which the services implemented to improve access and reduce waiting times. Services did not routinely collect data to identify impact on waiting lists, other than maintaining a record of the number of patients seen.

As part of a strategy to improve access and reduce pressure on the hospital for clinical appointments, consultants carried out joint community clinics with GPs. This helped to train community and primary care doctors in the specialties, such as dermatology and diabetes, to increase capacity and reduce waiting times. During shared clinics consultants and GPs had joint access to patient records, arranged in advance with the medical records service to ensure patient information was available.

From January 2018 to June 2018 staff ran 614 ad-hoc clinics across medical specialties, which reflected the demands on the service and efforts by individual teams to increase capacity.

Outpatient therapies teams provided a physiotherapist-led musculoskeletal (MSK) secondary care service and an occupational therapist-led hand therapy service. Both had been developed following increasing demand from the local population.

The sexual health service had moved from Whipps Cross Hospital to the Sir Ludwig Guttmann Health and Wellbeing Centre in May 2018 and combined with the HIV service. The team offered a dedicated smear clinic and on-site microscopy and had a specialist pharmacist and a phlebotomy team.

This was a networked service and the new centre meant the consultant-led team had significantly increased capacity and scope of care and a dedicated HIV service remained in place in the hospital. An infectious disease consultant and specialist registrar provided a weekly HIV clinic in the hospital, which included medical inpatients where needed. The restructure meant staff had introduced broader services for the local population, including emergency coil fitting and an expanded gynaecology and scanning service.

The hospital had introduced a walk-in clinic for survivors of female genital mutilation (FGM). This was a multidisciplinary service provided by a gynaecologist, a midwife and an FGM sample-taker. The team facilitated access to psychology services and provided interpreters.

The eye treatment centre provided adult and paediatric outpatients services, an urgent and emergency eye service and a surgical day-case unit with pre-operative assessment. Senior staff said there was a very high demand on the service and they were increasing specialist clinics.
based on trends in local population health. This included additional retinal services and glaucoma clinics.

The chest clinic and respiratory service offered a sleep study clinic for home service users. This service was at risk due to the age of the machines, which were 11 years old and had passed their planned life. Staff had entered this on the service risk register although there had been no action to date, which meant the service would cease if the machines became unuseable.

The ear, nose and throat (ENT) team had adapted the service in line with changes in the presentation of the local population. For example, the service operated an emergency clinic from 10am to 12.30pm Monday to Friday, which patients could access through a referral from the emergency department. Clinicians in this clinic were able to carry out nose manipulations for patients who had been assaulted. On a Thursday the service operated a ‘one stop’ clinic that provided care for patients within the specialty with any level of need and typically saw 110 patients.

The eye treatment centre had multiple services and reception desks but signage in the building was not clear. There was no easy-to-read or high-visibility signage in place. During our observations patients routinely presented to the incorrect reception desk for their service and had to be redirected. We spoke with three patients who said they found the centre confusing and relied on staff to identify where they should be waiting. This centre did not have dedicated waiting space for wheelchair users, who we saw had to wait in corridors to be seen.

In most clinical areas, waiting environment facilities were limited. Most areas did not have a drinks machine, magazines for patients or a children’s play area. However, toilets were readily available and waiting rooms had sufficient numbers of seats.

Volunteers were based at the entrance to main outpatients to help patients navigate the department and find their appointment.

Meeting people’s individual needs

Some outpatient reception areas were readily accessible without controlled access. A security team was available on site and staff told us they responded quickly to any situations in which they needed support. We observed positive examples of interactions between patients, relatives, parents and reception staff. This included where patients presented late for an appointment and were clearly upset or anxious. Reception staff were required to complete conflict resolution training and 98% were up to date at the time of our inspection. This was significantly better than the trust target of 85%.

None of the outpatients areas had been adapted to the national dementia friendly standard. The eye treatment centre service manager identified this as a priority along with wider improvements for patients living with dementia or presenting with reduced mental capacity. They also said there were gaps in dementia training for clinical teams and this reduced the service’s ability to meet patient’s needs. Staff offered a forget-me-not to each patient living with dementia, reflecting national standards and the trust’s patient engagement strategy, and prepared a personalised care plan.

A dementia champion nurse had been in post in the eye treatment centre for two years although it was not evident this had led to improvements in the environment. The trust told us outpatients routinely offered appointment slots for patients in a dementia friendly environment wherever possible and patients with high levels of sensitivity to noise could be seen in the Connaught Day centre and less busy clinics. However, staff told us they did not know of dedicated dementia friendly areas in outpatients although they could provide quiet waiting space on request.
The appointments service provided known carers with the contact details of the nurse in charge of the clinic so they could make contact ahead of an appointment to arrange adjustments to make the patient more comfortable. This service was offered as part of the trust carer’s policy, which helped patients access appointments more flexibly. We spoke with seven patients who said they were generally happy with the appointment-making process.

Staff had developed links with patient support organisations to help those with complex needs maintain their health and access care flexibly, such as in hospital and in the community.

In the annual patient-led assessment of the care environment (PLACE), scores in the dementia and disability domains improved between 2017 and 2018, from 52% in 2017 for dementia to 64% in 2018 and from 61% in 2017 for disability to 71% in 2018. However, neither score met the national averages of 79% for dementia and 84% for disability and the results in 2017 demonstrated a significant deterioration from 2016.

The learning disabilities (LD) nurse specialist had prepared an information guide for children, young people and adults visiting the hospital for appointments and who were living with an LD or autism. This helped people to understand what they could expect in the department; what adjustments could be made for access and communication and how to ask for help. The guide included who to contact if they wanted to raise concerns, make a complaint or a compliment.

The LD lead nurse attended appointments with patients with complex needs and supported specialists in delivering care. This promoted better health outcomes as patients were at high risk of self-neglect. The nurse worked with patients and their families or carers to complete a hospital passport that included details of how they liked to be cared for and what they disliked about hospital. This helped staff to plan appointments to be less distressing for patients.

The phlebotomy team had developed adapted approaches to taking blood samples from patients with an LD. This included distraction techniques, using more private spaces and offering more time so patients did not feel rushed. The phlebotomy manager said the service had a high success rate of taking blood from patients with an LD and liaised with the LD nurse in more complex cases.

During our inspection a patient living with an LD waiting in an outpatient waiting area became agitated and distressed. Staff acted quickly to support the patient, offering a quieter waiting area and ensuring the consultant saw them as their next patient.

Specialist services had the freedom to develop their own ways of working to meet the needs of their patients. For example, a haematology consultant had improved access to the service by offering digital engagement opportunities to patients. The HIV service had developed a pharmacy-led condition management service. This enabled HIV positive patients whose condition was stable on medicine, plan to receive ongoing medicine management from the pharmacy team and have an annual consultant review. The diabetes service had implemented remote clinics using video chat software, which enabled patients to access clinical staff without the need to attend the hospital.

Paediatric outpatients was delivered in a dedicated clinic with separate access from the main building. It included a play area for younger children with a range of toys, which staff could also use for distraction. Staff had access to sensory tools and toys from Acorn ward, which they arranged to have in advance of patients attending.

The nurse in charge of each clinic maintained a noticeboard of clinic delays. We saw nurses updated the boards whenever there was a change in waiting times.

Most waiting areas were accessible by wheelchair and each clinic had bariatric chairs. Patients using the pain clinic had identified the chairs were too low to be comfortably used and these
caused them discomfort. The team had discussed this and initiated an audit to identify a more suitable alternative.

Staff approach to the use of translation and interpretation services varied between clinics and specialties. For example, interpretation services were readily advertised in the Gillian Hanson Centre for Diabetes and Endocrinology but not in most other areas. Staff in the chest clinic had straightforward access to telephone interpreters in each clinical room but staff in main outpatients said they rarely had time to access interpreters. Allied health professionals we spoke with said they relied on patients to bring a relative who could translate for them or to notify the clinic in advance. They said the use of a telephone translation service was not practical as it delayed the clinic and was not useful for physical assessments.

Outpatients areas used the national Accessible Information Standard and provided easy-to-read literature for patients. Staff had access to communication support materials, including for Makaton, on the trust intranet. The trust had an advocacy service that provided access to information in Braille and to British Sign Language interpreters for patients. As part of this work the trust had introduced new name badges for staff that were more easily readable for patients with reduced vision.

The trust had reviewed the patient information policy and introduced a new process for the quality of information released. This process involved a review by the patient information review group who would liaise with the patient readership panel to assess the information for content, language and accessibility. The review group then checked the information against the Plain English Campaign Standards. The trust was in the process of implementing a new process for patient mail, including appointment letters. This would enable the system to generate letters in different formats when patients’ needs were registered. For example, the system could send information in Braille and large-print. This was an on-going project to ensure all specialties would be included in this.

AHPs were working with a gender identity clinic to deliver transgender support work, on an outpatient and community basis. This work was funded through a charity and reflected an innovative drive to extended therapies services to a community that lacked structured support.

Staff adapted their services to meet individual needs. For example, patients with mobility needs who used hospital transport were seen as a priority in clinics. Staff used a discreet pink sticker on their appointment letter to indicate to reception staff that the person needed mobility support, which could include being escorted back to their transport. During our observations of a clinic we observed staff write down information and instructions to a patient with hearing loss who did not use a hearing aid. This demonstrated attention to detail and meant the patient could better express themselves. In another observation a HCA skilfully used appropriate distraction techniques to engage with a patient living with a severe learning disability.

Staff adapted services to meet patient’s religious and cultural needs. For example, staff arranged for female clinical staff to carry out assessments for a patient who did not want to be examined by a male doctor and another patient who needed alternatives to contraception due to their religious belief.

**Access and flow**

Staff offered patients a choice of two appointments for each appointment, including next day appointments where the need was urgent.

The trust performed better than the 93% operational standard for people being seen within two
weeks of an urgent GP referral. The performance over time is shown in the graph below.

**Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers), Bart’s Health NHS Trust**

(Source: NHS England – Cancer Waits)

The trust performed better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat). The performance over time is shown in the graph below.

**Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers), Bart’s Health NHS Trust**

(Source: NHS England – Cancer Waits)

The trust performed better than the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral, with the exception of quarter 1 in 2017/18. The performance over time is shown in the graph below.

**Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment, Bart’s Health NHS Trust**
The trust supplied more recent data on cancer waiting times after our inspection. From August 2018 to October 2018, the hospital saw 95% of patients within the two-week wait target and 99% of patients started their first treatment within 31 days. Compliance with the 62-day wait targets was more variable and during this period only 70% of patients met this standard for treatment although 90% met the 62-day standard for a consultant-led upgrade of care.

Outpatients overall had a waiting list of 4450 patients in a backlog awaiting new or follow-up appointments.

Compliance with the national 18-week standard for referral to treatment times (RTTs) varied between services. The diabetes and endocrinology service saw 100% of patients within 14 weeks. Dermatology had an average 24 weeks wait and met the RTT standard in 70% of cases. The trust was actively recruiting two new dermatologists to address this. Ophthalmology met the RTT standard in 84% of cases. Gastroenterology, ophthalmology, respiratory and urology reported an average 22 week wait in October 2018 with the following numbers of patients waiting for an appointment:

- Dermatology: 499 patients.
- Ophthalmology: 525 patients.
- Respiratory: 547 patients.
- Urology 674 patients.

The ophthalmology service had significantly reduced the waiting list, by 1175 patients between October 2017 and October 2018.

From September 2017 to August 2018, services reported 243 breaches of the 52-week wait standard, which reflected 1% of the 23,227 patients referred. Trauma and orthopaedics experienced 12 52-week wait breaches in August 2018 and 27% of patients waited more than 18 weeks for an appointment. This was reflective of capacity issues and demand pressures on outpatient surgery services, which achieved 81% compliance with the RTT 18-week target in August 2018. Anaesthetics, paediatric endocrinology, paediatric diabetic medicine, paediatric medical oncology, general medicine, medical oncology, geriatric medicine and clinical oncology each achieved 100% compliance with the 18-week target in both May 2018 and August 2018.

Managers used weekly access tracking of RTTs and patient tracking lists (PTLs) to monitor trends. In August 2018 paediatric clinical haematology, paediatric urology, paediatric audiological medicines and paediatric dermatology were under particular pressure, with 27% of patients waiting more than 18 weeks to be seen.
Each service increased capacity where the availability of clinicians enabled this. For example, the urology service offered four additional evening clinics in October 2018, gastroenterology added eight clinics in September 2018 and rheumatology offered one remote video clinic per month. The urology service had recently implemented Saturday clinics following the recruitment of two clinical nurse specialists. However, there were no robust plans to improve access and managers cited slow consultant recruitment and lack of clinical space as significant, ongoing barriers to this. Use of technology to hold virtual clinics was very limited. Staff in the sleep clinic said they had planned to initiate virtual clinics but this had not yet started and they had no timescale for implementation. RTT training was mandatory for all non-clinical outpatient’s staff and compliance in September 2018 was 100%.

RTT compliance in the eye treatment centre had improved from 60% to 80% from January 2018 to October 2018 as a result of more efficient care pathways and better use of community services. However, the senior team acknowledged this would not increase to the national standard of 92% unless they could find more clinical space and recruit more doctors, both of which limited capacity.

The chart below shows the ‘did not attend’ rate over time.

**Proportion of patients who did not attend appointment, Bart’s Health NHS Trust**

![Graph showing 'did not attend' rate over time](image)

(Source: Hospital Episode Statistics)

Staff reported when patients did not attend (DNA) planned appointments. The DNA rate remained between 12% and 16% between June 2017 and July 2018 for new patients and between 12% and 13% for follow up appointments against a divisional target of 10%. Services varied in their follow-up to DNA patients. We saw evidence staff in the diabetes and endocrinology service followed up 100% of DNA patients. The appointments booking team sent text message reminders to patients to attempt to reduce the DNA rate and senior staff said offering the option of two appointment dates also helped to reduce this.

From January 2018 to July 2018 the administration team answered 94% of calls within 60 seconds, which was better than the trust standard of 90%. In each month the average queue time for each call was 16 seconds, which was significantly better than the trust standard of one minute.

As part of the national NHS Paper Switch-off Programme, outpatient services had gradually moved towards a wholly electronic referral service (e-RS), which had been fully implemented in October 2018. The trust had worked with local providers to encourage them to begin using e-RS before the full implementation date, which led to a steady increase in the number of referral
bookings made through this system, from 2959 in April 2018 to 3349 in July 2018. From January 2018 to July 2018 78% of new patient referrals were registered within five days of receipt, which was worse than the trust standard of 90%. In the same period the hospital was able to meet the first choice of appointment slot for 84% of patients.

The service maintained an overall record of the number of patients waiting for an appointment on the appointment service issue (ASI) list. Patients were added to this list when they were unable to make an appointment using the electronic referral system (e-RS). The number of patients on the ASI who had waited over 22 days for an appointment was consistently high and reflected the majority of patients on the list. For example, in August 2018, 77% of patients on the ASI had waited longer than 22 days on the list. However, between August 2018 and October 2018 there was a steady decrease in the overall number of patients on the ASI, from 4471 patients to 3566 patients, which reflected the implementation of the e-RS system.

From October 2017 to October 2018 the hospital cancelled 18% of planned appointments. This was an average figure and varied widely from no cancellations in old age psychiatry or rehabilitation to 3% in diabetes and endocrinology to an 81% cancellation rate in dietetics. However, these figures were influenced by very low numbers in some cases, including clinics that saw only one patient during the period. In clinics with more than 3000 patients the average cancellation rate was 19%, reflecting a range from 3% in occupational therapy to 46% in endocrinology. The average number of days between the appointment being cancelled and the next appointment being scheduled was 37, reflecting a range from nine days for occupation therapy to 83 days for neurology and pain management.

From January 2018 to July 2018, the hospital cancelled an average of 23% of appointments. An average of 1312 patients per month had their appointments cancelled more than once, reflecting a range from 854 patients in January 2018 to 2163 patients in June 2018. In this period 11% of appointments cancelled by the trust, 262 individual appointments, were at short notice. Senior staff said this was for a variety of reasons.

From August 2017 to August 2018, clinicians cancelled 4158 appointments with more than six weeks’ notice, 50% of which were due to annual leave and 20% of which were due to reasons categorised as ‘other’ by the trust. The trust did not define what this could include. In the same period 432 appointments were cancelled with less than six weeks’ notice, 28% of which were due to annual leave and 40% of which were due to reasons categorised as ‘other’ by the trust. During this period an average of 33% of patients were affected by non-availability of clinicians.

In response to high numbers of patient cancellations or patients who did not attend (DNAs), the eye treatment centre typically overbooked each clinic to reduce the risk of wasting appointments. However, this meant they often had to reduce the list size themselves if no patients had cancelled in advance. Senior staff said this was typically up to four patients per day.

General surgery and urology outpatients teams used a recovery action plan (RAP) to address pressures on the service. The RAP involved weekly monitoring and monthly updates by an accountable improvement team, including an operational lead and a responsible manager. The RAP aimed to move the service towards 92% achievement of the 18-week RTT target, which would bring it in line with the national standard. The latest version of the RAP included an increase in clinics to reduce waiting times, data reviews to ensure waiting lists were accurate and short-term capacity improvement plans. All nine on-going actions were on target at the time of our inspection.

The appointments booking system used for follow-up appointments was not linked to consultant availability. For example, follow up appointments were booked up to one year in advance but
consultant rotas were scheduled only six weeks in advance. This led to cancellations with six weeks’ notice when rotas could not be matched to bookings. Senior staff said pressures on the service meant they did not meet the 28-day standard for rebooking cancelled appointments. There were no plans in place to address this.

There was no system in place to track and monitor clinic delays or to monitor trends over time. Patient narrative feedback collected from the NHS Friends and Family Test in September 2018 indicated waiting times were a challenge for services. In feedback for six specialist clinics, patients described significant delays in some instances although they noted this had not impacted the quality of care. The trust told us senior staff were expected to complete an incident report when their clinic was delayed. From September 2017 to August 2018 staff submitted 520 incident reports relating to delays. Of this, 96% of reports related to the overrunning or late finish of a clinic and reflected delays from 30 minutes to over two hours and 4% of the incident reports related to delayed clinic start times. Each delay ranged from 20 minutes to 80 minutes and staff attributed them to a range of causes, including the late arrival of staff, late arrival of patient records and IT failures. In each case staff documented how they kept patients up to date and arranged for car park extensions vouchers. As there were no formal criteria we were unable to identify the proportion of total delays the reports reflected.

The service delivery manager for respiratory outpatients was responsible for improving RTT performance, which showed a gradual improvement in 2018, from 77% compliance with the 18-week wait in July 2018 to 83% in October 2018. This reflected a reduction of 103 patients on the waiting list. The manager had identified some clinics that were not operating to capacity, which resulted in extended waits for appointments. They had addressed this by ensuring each clinic was fully booked and by working with clinicians to develop a wider range of care pathways. They had implemented a new system for booking follow-ups, which meant patients were given a confirmed date and time for their next appointment before they left the clinic. Where patients called the service to make an appointment, staff used a policy to offer two different date options. This was part of a strategy to reduce the number of patients who did not attend.

Service managers met with the nursing teams in their clinics each day before patients arrived to plan the service ahead. This enabled them to identify challenges with staffing or capacity and mitigate it accordingly.

From May 2018 to July 2018 the phlebotomy service reported four incidents relating service suspension or significant delays due to a lack of capacity in the service or overcrowding in the waiting room. Incident investigations found significant gaps in cover, such as one shift in which five phlebotomists were available to cover 24 medical and surgical wards. There was some evidence the senior team were able to address issues, such as the reinstatement of an extra one hour of cover in a phlebotomy clinic.

The senior team responsible for dermatology had carried out an audit with community colleagues to identify opportunities to transfer patients to secondary care to reduce waiting times. In a sample of 100 patients they found 69 individuals could be safely treated in the community. The team was acting on this to establish referral criteria and a coherent programme for community-based care.

**Learning from complaints and concerns**

The trust did not supply any data relating to complaints ahead of our inspection. After our inspection we asked the trust for data and found 92 complaints or patient advice and liaison service (PALS) concerns had been received between September 2017 and October 2018. In the same period four formal compliments were received. Of the complaints, 36% related to phlebotomy services, 49% related to outpatient bookings or services prior to the move of the
service from CSS to ECAM and 15% of complaints related to health records. All complaints related to administration, appointments, bookings or results and not to clinical issues, which were tracked by each specialty service separately.

We asked the trust to supply us with details of the investigation and outcomes of complaints received between October 2017 and October 2018. The trust supplied three complaint investigations, one each from October 2017, March 2018 and August 2018. Administration errors, communication problems and failure to follow trust procedures were present in two complaints per topic. In each case a senior member of staff had apologised, completed an investigation and detailed to the complainant the action taken and lessons learned. They demonstrated how they had involved staff in investigations and explained to complainants what they had put in place to correct the mistake. All three complaints predated the move of outpatients services from clinical support services (CSS) to the hospital site. However, they involved staff, clinics and/or processes that were still in place and reflected the use of the trust complaints process.

The patient advice and liaison service (PALS) operated Monday to Friday from 9.30am to 4.30pm and patients could make contact by phone, e-mail or by visiting the office. The PALS service was supplementary to serious complaints investigated by divisional staff. Between August 2017 and August 2018, the PALS team handled 548 complaints relating to appointments.

Service managers and senior nurses managed complaints on an individual basis as they arose in the clinics. The eye treatment centre service manager said they had experienced a significant drop in the number of patients asking to speak to them on the day of appointments about delays, which reflected better information systems for patients. Receptionists we spoke with in three clinical areas said they felt the number of patients presenting to complain had decreased in the previous two years and that the general atmosphere for patients in waiting areas was more positive. A phlebotomy supervisor said they had never received feedback on complaints made to the service, which they found frustrating because they could not use this information to improve the service.

Each clinical area had a complaints poster or leaflets available that outlined the complaints policy. This included an introduction to the PALS team, their role and how to contact them.

Some AHPs maintained a written record of verbal compliments given to them from patients and their relatives. For example, one relative told a therapist, “[Patient] hasn’t smiled so much for ages as when he saw you last week” and a patient said, “I’m so happy I can speak well enough to nag my husband again!”

**Is the service well-led?**

**Leadership**

Outpatient services had moved from an external community base into the hospital in August 2018. A temporary general manager for outpatients was in post and reported to the deputy director for performance. A permanent general manager was due to take up the post in November 2018 and recruitment was on-going for an overall service manager.

Outpatients had a long-standing service manager vacancy and interviews were taking place shortly after our inspection. Doctors told us this reduced the interface between clinicians and operational managers and had a negative overall impact on morale. The deputy director of operations was acting as a general manager pending recruitment to that post. This reflected on-going instability in the senior teams, which had also been evident during our inspections in July 2016 and May 2017.
A lead physiotherapist was responsible for the outpatient musculoskeletal (MSK) service with two band seven physiotherapists providing team lead support. The MSK lead physiotherapist was responsible for the hand therapy service but staff told us they had no supervisory role. One therapist said they had never received clinical supervision and that there was no defined leadership structure in place.

Outpatients, medical records and phlebotomy were organised into a service group with service managers for each and further leadership for each clinical specialty.

Results from the 2018 staff survey indicated staff were dissatisfied with leadership in a number of areas. For example, just over half of respondents said they were satisfied with support from their line manager and 40% of staff said managers could not be counted on to help with difficult tasks. Other feedback about leadership indicated a need for managers to value their teams more readily and involve them in decision-making and with feedback.

There was evidence in the minutes of team meetings that managers followed up on concerns or challenges raised by staff. For example, reception teams noted problems in correctly transferring patient calls and in receiving medical records in packs too heavy for them to lift. In response supervisors liaised with the switchboard manager and the medical records team to identify solutions.

There had been no head of therapies or AHP clinical lead in post for outpatients for over 18 months. Senior therapies staff told us a general service manager was supporting the team as an interim measure and a professional lead for speech and language therapy (SaLT) provided senior oversight. However, the professional lead was based cross-site and therapists we spoke with said it could be difficult to obtain support.

The heads of therapies for medical inpatients provided support to the outpatients physiotherapy musculoskeletal service (MSK) through monthly support and operational meetings due to the level of pressure and demand on the service.

A part time assistant service delivery manager and a deputy operations director led the clinic and service managers for each specialty. Managers we spoke with described the leadership team as visible and approachable and said they felt well supported.

Reception staff we spoke with said they felt well supported by their managers and were confident in raising issues and making suggestions.

The senior team on Acord ward, an inpatient paediatric facility, maintained overall responsibility for paediatric outpatients. The lead nurse post had been vacant due to sickness for an extended period and nurses from elsewhere in the hospital provided daily lead nurse cover on a bank basis. Staff in the clinic told us this worked well because it provided consistent, stable leadership and enabled nurses from other specialties to gain experience in a different area.

**Vision and strategy**

The trust had a vision and clinical services strategy to guide development and improvement into the future, which incorporated the outpatients transformation strategy. Senior clinicians said the trust had increased its focus on outpatients in the previous two years and they felt strategies to improve the integration of services was working well. One senior leader said the outpatients transformation strategy was succeeding in bringing in new ways of working that would increase capacity and improve patient experience.

The strategy was based on 10 key plans, including the introduction of ‘hot’ clinics, a referral assessment service and a site-based operating model. This was an overall strategy and each
specialty was working towards their own future plans. For example, senior staff in the eye treatment centre were planning to network the service to increase capacity and ensure they could adapt to rapidly increasing demand. Although the transformation plan reflected the key needs of outpatients, there was limited knowledge of it amongst managers. The plan was included in the trust’s development strategy but the outpatients interim general manager was unaware of it.

As well as the overarching strategy for outpatients, specialties had developed their own vision and plans for the future. This included increased remote clinics in rheumatology, the recruitment of an additional clinical nurse specialist for chronic obstructive pulmonary disease in respiratory and the implementation of electronic patient records in diabetes.

In the 2018 staff survey, 40% of respondents said they did not have shared team objectives in their usual area of work.

The trust had established an improvement board to manage the integration of outpatient services fully into the site. The board was overseeing the implementation of a programme to ensure outpatients team maintained insight and involvement during the post-transition period and to help staff identify goals and future service strategy.

Sexual health services had a vision to create two centres of excellence, which was reflected in the move of the service out of the hospital and the merging of sexual health and HIV into a single service. The future strategy was focused on research-led care and expanding services.

**Culture**

Staff scored the hospital poorly in the 2018 staff survey in relation to working environment and culture. For example, only 53% said they would recommend outpatients as a place to work and the senior team identified themes of bullying and harassment both within staff teams and from patients and visitors.

Staff in most areas told us they felt there had been improvements in the working environment and culture. In the chest clinic staff said there had been facilitated work to improve relations between clinical and non-clinical teams, which had resulted in a more positive place to work. Staff in the eye treatment centre said there had been a general reduction in the number of disgruntled staff and they felt their team was more coherent and settled. One member of staff said, “It feel more structured now. Everyone knows the direction we want to go in.” This was reflected in the trust’s recognition of the improved working culture with an award.

All staff clearly understand the principles of the duty of candour although recognition of the name of this was variable.

**Governance**

Outpatients services were provided within the emergency care and medicine (ECAM) division following a move in August 2018 from the customer support services (CSS) division. This meant outpatients governance processes were aligned with ECAM, including the use of a monthly dashboard to monitor and track key governance identifiers such as risks, incidents and the risk register.

Individual teams and service areas led their operation and governance meetings. We looked at a sample of three sets of meeting minutes for the outpatients services, health records service and for the nursing team. It was not evident from the minutes of the nursing meeting that governance involved patient and performance outcomes all of the time or was effective. For example, in July 2018 staff noted that most complaints had been about waiting times with some complaints about the phlebotomy service. The minutes also noted the number of incident reports submitted in the
previous month. There was no evidence of an exploration of the incidents and complaints and no identification of themes.

The monthly divisional quality, safety and governance meeting for ECAM included specialties delivered through outpatients services. We looked at the minutes of meetings from April 2018 to July 2018 and found the meetings were focused on inpatient activity, with little representation for outpatients. Where the teams considered serious incidents in outpatients there was little demonstrable action to progress the investigation. For example, a serious incident in the dermatology clinic was noted in June 2018 to need more information following a SIRMAP review. There was demonstrable uncertainty in the meeting about the nature of the incident or about the information SIRMAP wanted and there was no update one month later. This demonstrated gaps in communication between different components of the governance system.

We looked at the minutes of board and governance meetings from May 2018 to July 2018 and found a range of appropriate staff attended them with links to most major clinical specialties. There was a clear focus on performance and service development and challenges in delivery were documented and followed up.

Staff said governance processes and structures had undergone significant improvement. For example, the eye treatment centre team had changed the times of governance meetings to better meet the availability of key staff. This meant more staff had the opportunity to discuss incidents, complaints and other performance issues. The new schedule meant senior clinical staff joined the meeting, which had not previously been possible.

Recruitment to the appointments booking team was almost complete and the appointment service manager said reliance on bank staff had significantly reduced.

We looked at the minutes of respiratory governance meetings for the five months leading to our inspection. In each meeting staff had discussed clinical incidents, both specialist and trust-wide, as well as a morbidity and mortality review of any deaths in the service. Staff in the meeting routinely discussed patient feedback, risks and complaints. A diabetes governance team met monthly and discussed similar issues.

Management of risk, issues and performance

Specialty services used the ECAM risk register to record risks to their service. The latest risk register available was dated June 2018 and noted three risks to services in outpatients. One risk was categorised as high and related to a 37% consultant vacancy rate in gastroenterology. Two risks were categorised as medium and related to the clinical environment and facilities in the chest clinic and the risks presented to patients who present with tuberculosis (TB) and a chronic nurse shortage in the Gillian Hanson Centre for Diabetes and Endocrinology. There was no evidence of senior oversight of these risks or of progress toward a resolution. Period review dates had been added against each risk but it was not evident what action had been taken to progress the risk nor why there were extended delays in resolution. As of October 2018, there had been no documented updates for the medium-level risks since February 2018 and no update for the high-level risk between July 2017 and October 2018.

There were two outpatients risks entered on the corporate risk register. One risk, originally entered in September 2016, related to a lack of capacity that led to extensive waiting lists. The second risk had been entered in October 2014 and related to the poor condition of the environment. This related to low temperatures that affected frail or elderly patients and deteriorating décor, which impacted patient experience. We have identified the outpatients environment as a key area for improvement in every inspection since 2013 but there has been very limited progress.
Recruitment remained on the risk register for most specialties and the trust was carrying out an international recruitment project to address this. We found varying levels of knowledge from senior staff with regards to service risk registers. For example, one service manager did not know what was on the risk register for their specialty and could not tell us what the key governance issues were that the senior team was addressing. Senior staff in the eye treatment centre had identified the age of the retinal laser equipment as a key risk and the trust had approved plans to rent new equipment to address the risk temporarily.

Outpatient services used a monthly dashboard to monitor performance and trends in key elements of the service, including the did not attend rate, the appointment slot issues (ASI) list, cancellation rate and hand hygiene compliance of clinical staff. We looked at the dashboard for the period January 2018 to July 2018 and saw key performance indicators in most measures met or exceeded trust standards. However, where outpatient teams did not meet trust standards there was limited documented input from senior staff about work to address it. For example, the hospital did not meet the trust minimum threshold that 85% of patients referred from the electronic referral system (e-SR) be registered within five working days. However, there was no narrative in the dashboard to highlight work to address it. There was a note that the senior team planned to increase capacity to address the increasingly large ASI but this was not reflected in findings during our inspection.

Senior booking and administration staff met weekly in an ‘access standards’ meeting to review ASIs, two-week waits for cancer referrals and performance against national targets. We looked at the minutes of 12 meetings that took place between July 2018 and October 2018 and found they were well attended with a consistently detailed review of the contributing factors to extended waits for appointments or breaches of national targets. The team reviewed data to ensure patients were referred accurately and appropriately and liaised with the referrers when this was not the case. For example, during a meeting in September 2018 the team found a coding error in how patients with breast asymptomatic cancer were being referred, which had resulted in unnecessary delays to their appointments. The team corrected this and implemented monitoring although a senior member of the team we spoke with said they felt feedback from more senior staff was rarely forthcoming.

Staff had the opportunity to raise issues and concerns through team meetings. For example, in the nurse and healthcare support worker meeting in July 2018, staff raised concerns about low staffing levels in surgical outpatients and about the need to work early to prepare their clinical areas due to short staffing. Other staff described challenges in obtaining resources for their clinics, including diabetic biscuits, and the challenge presented when some doctors would not screen patients for meticillin-resistant Staphylococcus aureus (MRSA). The minutes indicated variable evidence of feedback from the senior team and in some instances the matron agreed to work towards a resolution. For example, it was documented that a matron would address the issue of screening for MRSA with doctors who said this was a nurse’s responsibility.

The outpatients improvement board recognised the high rate of ASIs and clinic managers were working together to validate the data, which would check it for accuracy, and to increase capacity. For example, in August 2018 managers facilitated 105 ad-hoc clinics to help reduce waiting lists.

Allied health professionals were not consistently represented at quality and safety board meetings due to the absence of a stable leadership post or team. However, the heads of therapies for inpatients provided support where needed.
The clinical support services division held the risk register for therapies services. The general service manager represented the risks at board level, which reflected three key areas: a lack of space in outpatients; a lack of serviceable computer terminals and staff vacancies.

Although performance in some areas had improved through additional weekend and ad-hoc clinics, these relied on the goodwill of staff to offer additional hours of work. For example, the ophthalmology service offered outpatients clinics every Saturday. However, this was based on the goodwill of consultants and senior staff said they could not ensure the extended service would continue indefinitely.

Clinic and service managers met monthly to review capacity, demand and progress on future plans. Clinic managers attended weekly central appointment huddles to plan extra clinics and identify lessons learned from the previous week. Receptionists attended monthly meetings with team leaders and service managers and said they were listened to when discussing concerns or complaints. The paediatric outpatients team held planning and service huddles every three weeks and more frequently when the service was caring for child at risk.

The tuberculosis (TB) clinical nurse specialists (CNSs) provided patient reviews on an outpatient basis in the chest clinic. We found the risks of this service were not properly managed and the service was not compliant with national guidance that would help to contain infection control risks. This was because patients with an active TB infection were not separated from patients who had a compromised or vulnerable immune system and facilities were not available to provide a negative pressure clinical area. This had been entered in the divisional risk register in February 2017 and it was recognised redevelopment of the chest clinic was needed to ensure the safe could continue to be provided safely. The risk had been reviewed in February 2018 with no documented updates or actions.

The service did not audit waiting times, which meant it was not possible to identify the length of time patients with a positive TB infection spent with other patients vulnerable to infection. We escalated this to the senior trust team and a TB CNS, the clinical lead nurse for infection prevention and the senior quality improvement manager produced a formal risk assessment to review the risk of TB cross-infection. The risk assessment implemented new standards of practice, which involved an initial CNS-led patient assessment followed by a deferral of treatment in the chest clinic if this was clinically appropriate and would reduce the risk of harm to other patients.

An MSK health and safety group had carried out a full risk assessment of the clinical environment and service processes. The group found patients sometimes arrived unexpectedly on stretchers, which was a safety risk in the environment. As a result, they changed the service information available to other referrers and updated the referral criteria.

AHPs said the trust had introduced an improved lone working policy that protected them from risks, which had previously been an issue. This included a buddy system whenever staff were in clinics or departments alone.

Management of the lack of capacity in SaLT was consistently lacking. For example, the service had been without a clinical lead for over 18 months and a professional lead for this team worked cross-site and provided intermittent support. The SaLT team had two members of staff but one individual would be unavailable for several months. The trust had not backfilled this post, which meant if the remaining SaLT took leave or was unwell the SaLT service cease.
Information management

Outpatient services had moved to a new digital information system managed on-site. This meant communication with patients was more reliable, letters included more information about appointments and a new text message service had been introduced.

Senior clinicians responsible for the HIV service managed the records of HIV positive patients in line with their responsibilities under the Venereal Diseases Regulations (1974).

The medical records team handled subject access requests (SARs) under the requirements of the General Data Protection Regulation (GDPR), with which they were fully compliant.

From September 2017 to October 2018 staff reported 18 incidents attributable to the mishandling of medical records, including 16 instances of data breaches where a patient inadvertently accessed someone else’s’ notes or where the notes of other patients were contained in the same file. Two incidents related to misplaced notes where staff had been unable to locate patient documents.

Although information management in the appointments service had improved with the introduction of the e-RS system, staff identified challenges in managing information when it was shared between teams. For example, the appointments team had a service standard to process referrals within five working days. Where this was not possible, the manager transferred the referral to the administration team in the relevant medical specialty. However, the referral would not be accessible to both teams at the same time, which meant they could not coordinate appointments together and could not both respond to patient or referrer queries.

Staff could use the trust intranet to access policies and documentation and most staff we spoke with said there were generally enough computers available. However, they said the IT infrastructure was often unreliable and caused delays to clinics and recording of patient details. There were examples of clinics running over one hour late in the incident reporting system due to computers failing to start. Staff said that when the IT system failed, the IT department were easy to reach and very helpful but the age of a lot of the equipment meant help was often limited.

someone else’s was a mandatory training topic for all staff. The trust was unable to provide us with an up to date figure of completion rates for this training although staff we spoke with said they undertook regular refreshers. The senior team had provided colleagues with more detailed information on the importance of information governance and data security following a never event that resulted from the failure to correctly identify a patient.

Engagement

The senior team had introduced a suggestion box that enabled staff to leave feedback and suggestions anonymously. This was an initiative following the results of the staff survey to increase the ways staff could provide feedback.

Leadership triumvirates had action plans to improve staff well-being through more consistent, substantive engagement. For example, during a recent heat wave staff worked under very challenging conditions. Managers supported staff by ensuring they had a continuous stock of cold bottled water and installed temporary air conditioning units around the hospital.

Outpatients teams had access to an annual programme of planned and ad-hoc engagement events organised by the trust and by specialist teams. Events for 2018 included staff survey results briefings, quality improvement events, engagement with the trust’s charitable organisation and discussions of political events that were causing staff anxiety.
Outpatients departments participated in the annual patient-led assessment of the care environment (PLACE), which the trust used to track year-on-year performance using results from patient engagement. Results in all six measures demonstrated improvement between 2017 and 2018 although five out of six measures did not meet the national average. This meant we were not assured staff effectively used patient feedback to improve services.

Senior staff planned to significantly increase engagement with their teams following the results of the 2018 staff survey. This included sports days, subsidised fitness classes and more opportunities to promote health and wellbeing as well as new processes to recognise and reward exceptional work. The hospital also planned to introduce suggestion boxes and questionnaires to embed a more routine, ongoing approach to collecting feedback as a strategy to maintain a constant check on how staff were feeling. Senior teams also planned a series of ‘In your shoes’ events that would enable staff to work together in a shadowing capacity to help them understand each other’s roles and responsibilities. This would improve understanding between different staff teams and groups as it would help them to better understand the key pressures and challenges they each worked under.

Following the movement of outpatients into the hospital, the patient panel had initiated a plan to co-design an improvement programme based on patient feedback with Healthwatch services. The initial planning for this programme was underway at the time of our inspection and the initial phase was due for completion in November 2018.

The sexual health and HIV service had an active patient forum that met monthly and contributed to service changes and improvements. For example, the forum had identified problems in reaching the service by phone at key times. To address this the service leads had increased administration staff levels during peak times and were developing a centralised call system to better manage capacity and demand.

Some clinical areas displayed a ‘you said, we did’ board to demonstrate changes the service had made in response to feedback from patients. For example, the eye treatment centre had introduced an additional HCA post in the walk-in service, installed a vending machine in the waiting area and stated they now played music in waiting areas. However, there was no music playing in any of the waiting areas during our inspection. The therapies department had a you said, we did information display although this was blank during our inspection. Feedback in outpatient clinics A and B indicated the trauma and orthopaedics team had improved communication with the emergency department to facilitate more accurate referrals and administration staff had improved the accuracy of information given out with regards to clinic locations.

**Learning, continuous improvement and innovation**

Outpatient teams were proactive in identifying methods to improve engagement with patients and their overall availability. For example, staff were progressing a project to introduce remote appointments and consultations using digital video software.

The rheumatology team had developed a digital smart phone app for patients to access for support between clinical appointments, for which the trust issued an innovation award.

The trust had recognised a number of wards and individuals for exceptional standards of work and innovative contributions. This included recognition of a sister in outpatients for their work to support colleagues. A nurse in the eye treatment centre had been recognised with a Health Service Journal Award for their clinical contribution to patient care.
The occupational therapy MSK team had implemented a single point of access triage service that meant therapists could see patients from the Waltham Forest area and triage them according to the details in the referral. The team had developed the process over 18 months to reduce misused orthopaedic, rheumatology and pain consultant appointments for patients who did not need invasive treatment. This also resulted in an overall improvement of the management of patients who had on-going MSK needs.

The hospital had introduced a walk-in clinic for survivors of female genital mutilation (FGM). This was a multidisciplinary service provided by a gynaecologist, a midwife and an FGM sample-taker. The team facilitated access to psychology services and provided interpreters.

### Diagnostic imaging

### Facts and data about this service

Bart’s Health has the largest imaging department in England. It is organised as a networked service and provides a comprehensive range of imaging modalities across five hospital sites (The Royal London Hospital, Mile End Hospital, St. Bartholomew’s Hospital, Whipps Cross Hospital and Newham University Hospital). The main services provided are x-rays, fluoroscopy, magnetic resonance imaging (MRI), computerised tomography (CT), ultrasound, breast services (including Mammography), interventional radiology, nuclear medicine / PET CT and radiopharmacy. Bart’s Health Imaging provides a range of specialist services such as a twenty-four hours a day, seven days a week service in interventional Radiology and MRI as well as Paediatric Imaging in dedicated facilities at The Royal London Hospital.

(Source: Provider Information Return RPIR – Acute context tab)

The imaging service at Whipps Cross Hospital provides general and interventional radiology, magnetic resonance imaging (MRI) and computerised tomography (CT) scanning and a nuclear medicine department. There were 158,572 imaging tests undertaken across all modalities and neuro-imaging department between August 2017 and July 2018.

There is a walk-in direct access service for GP referrals for x-ray. The department provides a service to an average of 150 patients a day from GPs and outpatients and performs more than 23,000 GP requested examinations per year. The imaging service supports the accident and emergency department through the provision of x-ray and CT scanning 24 hours a day.

### Is the service safe?

### Mandatory training

The service provided mandatory safety training in key skills to all staff. Staff we spoke with were clear about their mandatory training requirements and there was a system in place which ensured staff and their line managers were notified when mandatory training updates or refreshers were
required. Staff explained that they were given protected time to complete all their mandatory training. This included recent training in the new updated Ionising Radiation (Medical Exposure) Regulations IR(ME)R introduced in early 2018.

Data submitted by the trust following the inspection showed levels of compliance with mandatory training where the trust standard was 85%. The trust did not provide mandatory training compliance data by module but instead grouped the performance of staff groups together. This meant it was not possible to determine which mandatory training modules had the lowest compliance.

<table>
<thead>
<tr>
<th>Category</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and dental</td>
<td>94%</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>98%</td>
</tr>
<tr>
<td>Allied health professionals</td>
<td>96%</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>100%</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>94%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>96%</strong></td>
</tr>
</tbody>
</table>

Mandatory training covered a range of subjects including moving and handling; basic life support; infection prevention and control; medical gases safety and equality and diversity.

Sonographers in the ultrasound department led in specific mandatory training areas to ensure colleagues were up to date. We saw there was an overall 96% compliance with mandatory training completion.

**Safeguarding**

The trust submitted mandatory training data following this inspection for all members of the diagnostics department. This showed there was 100% compliance with safeguarding adults levels 1 and 2; as well as 100% compliance for safeguarding children levels I and 2. The data also identified 100% compliance for allied health professionals in safeguarding children level 3.

Staff understood their role in identifying and reporting safeguarding concerns to keep patients safe. They understood how to protect patients from avoidable harm and abuse. The trust had policies to guide staff on protecting vulnerable adults and children and staff knew how and when to raise a concern.

Staff told us they learned about female genital mutilation as part of their safeguarding online training. A member of staff told us they acted on behalf of one patient they were concerned about; they said the hospital safeguarding team were swift and supportive in their response.

There were processes in place to ensure the right person got the right radiological scan at the right time. The Society and College of Radiographers (SCoR) recommends a ‘pause and check’ process for radiographers before and after an exposure is carried out. The computerised tomography (CT) questionnaire covered all aspects of this process. It prompted the radiographer to do three checks of patient identity (right test; right patient; right time) as well as confirm the
pregnancy status of female patients. Safety notices were in place and the procedure for dealing with consent was centralised on the trust intranet to maintain consistency in approach to the issue.

The World Health Organisation (WHO) Surgical Safety Checklist is designed to allow time to pause and check prior to and during any procedure. The trust checklist included team brief, sign in, time out, sign out, documentation and debrief. Data submitted following this inspection showed there was 100% compliance with all aspects of the checklist between July 2017 and July 2018.

**Cleanliness, infection control and hygiene**

All the imaging rooms and waiting areas we visited were visibly clean and there were hand sanitiser units throughout the department. We observed staff in the clinical areas were ‘bare below the elbow’ in accordance with the national institute for clinical excellence (NICE) guidance. Posters in waiting areas and other communal areas advised patients and visitors to disinfect their hands using cleaning products provided. There were adequate supplies of personal protective equipment (PPE) including gloves and apron dispensers available for use when required.

Environmental cleaning was provided by contract cleaners and was completed at regular intervals. Departmental staff were happy with the level of service they received. We saw daily cleaning schedules were completed and up-to-date. We found clinical and patient waiting areas were visibly clean and free from dust and debris.

The trust provided data that showed hand hygiene audits took place regularly. The monthly audit data showed general compliance levels with good hand washing practice were between 90% and 100% staff compliance in all modalities between July 2017 and July 2018. Staff explained how standards of cleanliness and hygiene were maintained. We saw evidence that equipment was labelled as clean.

Staff said when treating patients who had a communicable infection such as tuberculosis, flu or scabies, all attempts were made to ensure their investigation was prioritised to reduce time spent with other patients. Where possible, appointments were booked for quieter times within the departments, usually at the beginning or end of the clinic. Patient times in treatment rooms were minimised to reduce the risks of cross infection. Staff understood the trust infection control policy and explained the correct cleaning requirements in such circumstances. Staff wore personal protective equipment including gloves and gowns where necessary.

Staff segregated waste products into hazardous and general waste bags. Bins were not overfilled and regularly removed from the departments. Sharps bins were assembled correctly and safely used, with restricted openings which minimised risk of access to the contents within.

Cleaning materials were stored securely in line with the Control of Substances Hazardous to Health Regulations (COSHH) 2002. COSHH is the legislation which requires employers to control substances which are hazardous to health.

**Environment and equipment**

Resuscitation equipment was readily available and we saw it was regularly checked. Staff completed daily checks which were documented to evidence their completion. We did a random check of documentation between June and August 2018 and there were no gaps in daily check records. Staff in each area had easy access to the resuscitation equipment.

Clear signage was visible for ‘controlled areas’ within the department. A controlled area is one designated to assist in controlling and restricting radiation exposures of patients and staff. Each treatment room had details of what activity was performed clearly attached to the doors (local
rules). Magnetic resonance imaging (MRI) equipment and devices were clearly labelled within the MRI environment. This was in accordance with Medicines and Healthcare Products Regulatory Agency (MHRA) (2015) recommendations.

Radiographers in the emergency department x-ray department raised an issue with inspectors about their personal safety at night-time. The orthopantomogram (OPG) machine, which x-rays the lower face, was in a room away from main x-ray and had no personal alarm system. Radiographers told us there were fewer staff on at night and were concerned about the lack of back up to support them or raise an alarm. One told us of a dangerous situation they experienced with a drunk and aggressive patient some months before this inspection. The departmental lead told us they were aware of this and in response, an additional machine was acquired which could be located in or nearer to the emergency department. However, this was not set up; it was included in the three-year departmental business plan which needed to be finalised. We confirmed this was not on the risk register.

The imaging service ensured that ionising radiation areas had arrangements in place to control the area and restrict access. We noted the warning signs were working correctly at the time of the inspection.

Members of the senior leadership team acknowledged that a significant amount of the equipment was aging and prone to breaking down. Minutes from the August 2018 clinical support services integrated report noted that there was an increase in reporting backlog due to equipment breakdown, particularly in computerised tomography.

The diagnostics services site lead was responsible for ordering replacement equipment. They told us this was a very time-consuming process which went through different stages of approval. This caused delays and not all requests got approval due to financial restraints, which caused frustration for staff and poor service delivery to patients. Many radiographers told us the frequent breakdowns caused clinic cancellations and patient delays. The quality of images from some old machines was poor and they were hard to read.

During the inspection, we found that the mobile dose area product (DAP) on the mobile x-ray machine in the accident and emergency x-ray department was not working. DAP is a quantity used in assessing the radiation risk from diagnostic X-ray examinations and interventional procedures. The diagnostics services site lead confirmed it had been broken for some six months. We raised our concerns about this with the site lead who confirmed that the mobile x-ray machine was taken out of service with immediate effect.

The trust subsequently told us the clinical physics team had confirmed the last quality assurance on the machine was in November 2017, when the DAP was still in use. A replacement was ordered following this inspection. In the meantime, the clinical physics team confirmed the machine was compliant with IR(ME)R legislation despite the lack of DAP. It was safe to use as it displayed the exposure factors kV and mAs which allowed the patient dose to be manually calculated. kVp is the component that controls the quality of the x-ray beam produced. Milliamperage (ma) is a major factor in determining the quantity of x-rays produced and therefore is a good indication of the type of examination that can be performed with a machine.

We found radiofrequency coils on the floor behind the magnetic resonance imaging (MRI) machine. These coils are the receivers and occasionally the transmitters of radiofrequency signals in equipment used in MRI. This was of concern for a number of reasons; their position meant that radiographers did not have 360° access to the machine and these coils are both fragile and very expensive. We raised this with the diagnostics services site lead who told us there was a problem with funding agreement for a suitable storage unit and a specialist trolley to transfer these coils.
After the inspection, the trust subsequently sent confirmation that an agreement was reached and the coils were no longer stored on the floor.

There were two MRI safe wheelchairs, one for bariatric and one for non-bariatric patients. Staff showed us the non-bariatric wheelchair which had a broken footplate for several months. They demonstrated how difficult it was for patients with mobility problems. Without a footplate, these patients struggled to get out of the wheelchair safely and move to the MRI machine.

We raised this with the trust who subsequently sent information following the inspection which confirmed that a new the non-bariatric wheelchair had been ordered. They also said that the bariatric wheelchair would be used in the interim. However, staff told us during inspection they did not use this wheelchair as it was too difficult to manoeuvre and they were concerned about personal injuries.

We noted that the static x-ray machine in the GP x-ray department had some tape around the edge of the plate. A radiographer explained that the tape alerted staff to the possibility of a crush injury when the plate was lowered. The tape had been implemented as a direct action in response to an injury sustained by an older person. The way the machine operated meant that the patient had to stand unsupported whilst for example, their knee was x-rayed. On one occasion where a person needed to balance with their walking stick, the plate lowered and trapped their fingers as they rested on the walking stick.

Radiographers told us two out of three of the x-ray machines were static and so not safe for patients with mobility and balance issues. Patients had to move their body so that part of their body could be x-rayed. In ideal circumstances the x-ray machine would be fixed to the ceiling so that a radiographer could easily move the machine around the patient. Staff also told us there was only one table in the department for patients with back problems to lie on.

The temperature in the GP x-ray waiting area and radiography rooms was high with no ability for temperature control and patients had also reported the temperature as being hot. The waiting area was cramped and had limited seating. The toilet doors were not wide enough to allow wheelchair access. We saw three patient and relative complaints about this which received a full and proper response. There was a building notice on the doors which informed the public that improvement works on the facilities were scheduled to begin in November 2018 after which they would be fully accessible. Patients who were checked in waited along a very narrow corridor for x-ray. It was impossible for a patient with a frame or wheelchair to pass by unless the seated patients stood up to all them to pass through. Although the diagnostics services site lead and department lead acknowledged the difficulties with this, it was not possible to alter this arrangement due to the physical environment.

However, the ultrasound waiting area and corridors were welcoming spacious and clean. There were nine ultrasound rooms all of which were furnished with new equipment and well maintained.

Following this inspection, the trust told us that lead screens and syringe shielding in nuclear medicine were inspected and no damage was found, although there was no mechanism to formally record this information.

The service had 24-hour support for their Picture Archiving and Communication System (PACS) which was the system used to store patient images.

**Assessing and responding to patient risk**

The hospital had a medical physics expert and a radiation protection advisor available and contactable for consultation to give advice on radiation protection for medical exposures in radiological procedures. This was in line with IR(ME)R guidance. The service had named
Radiation Protection Supervisors (RPS) to give advice when needed to ensure patient safety and minimise radiation risk. RPS supervisors received the appropriate training and achieved 100% attendance.

Dose reference levels (DRLs) were displayed in all x ray rooms. The Ionising Radiation Medical Exposure Regulations (IRMER) employer’s procedures were up to date and organised into a comprehensive document. We saw local rules were available for all staff to follow in the imaging areas we visited. Local rules required under ionising radiations regulations (IRR)17 were displayed throughout the department. All areas that utilised medical radiation in hospitals were required to have written and displayed local rules which set out a framework of work instructions for staff.

Some radiographers expressed concern about the night duty working conditions. Whilst there were three radiographers on duty at night, there was usually only one CT trained radiographer. There were times when more than one patient was brought down from the wards with one escort. This meant it was difficult to safely monitor all patients; in addition, the radiographer usually positioned the patient in the scanner without assistance as the escort remained with the other patients.

Magnetic resonance imaging (MRI) staff told us they were not always able to immediately receive the patients from the handover area into the MRI area. They told us ward staff often returned to the ward and left the patient unattended. This area was behind double doors and out of the line of sight of MRI staff, which was of concern to them since they were not able to monitor the patient. This was not just a problem with the wards; other staff told us that patients from accident and emergency were frequently left unattended.

During our inspection, we saw two patients left alone in the inpatient waiting area of the ultrasound department. An imaging assistant checked on them intermittently and returned to an office where there was no line of sight. We asked the lead sonographer about this practice and they explained that patients were triaged by the ward to determine whether they required a healthcare escort. We were told the two patients we saw were considered low risk and therefore did not require an escort from the ward.

We spoke with porters who confirmed they saw unattended patients in the computerised tomography (CT) handover area, especially following any procedure. A member of staff in the nuclear medicine department told us that most patients (approximately 80%) came down from the wards without an escort.

We spoke with the service lead about unattended patients who acknowledged there were occasions when unattended hospital in-patients had to wait in what should be a handover area rather than a waiting area, due to patient flow in the department. The lead told us that various safety measures were considered, including the installation of closed circuit television, none of which were actioned.

The service lead also said there had been previously reported incident of a patient who deteriorated whilst in the handover area which we saw was reported and investigated as an incident. Staff said the practice of leaving patients unattended in the waiting area was consistently raised with ward managers. The agreement was that the patient should be sent back to the ward if they could not have an escort. There was no mitigation in place to protect a patient in similar circumstances in the future.

Staff told us what action they would take if a patient became unwell or distressed while waiting for or during an investigation. Staff provided examples which showed they would take appropriate action according to the situation. Patients whose condition deteriorated whilst in the department...
received initial care by the staff in the department and were quickly transferred to the emergency department if required.

All diagnostic imaging areas had access to dedicated paediatric resuscitation equipment. There were dedicated child sized oxygen saturation monitoring probes for sedated children in MRI and CT. In the event of a deteriorating child, staff told us they specified it was a paediatric emergency when they dialled the trust emergency number and the paediatric resuscitation team responded. We were told that before a paediatric inpatient went for x-ray, a risk assessment of the patients care, escort, infection control and transportation needs was made.

**Staffing**

The trust did not provide any planned vs actual staffing data for diagnostic services prior to this inspection. It did not supply data related to vacancy, turnover, sickness or bank/ agency. However, the data below was subsequently submitted and includes all staff within diagnostic services.

Following this inspection, the trust reported staffing numbers for diagnostic services as of August 2018.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>WTE funded</th>
<th>WTE contracted</th>
<th>WTE worked</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses - Band 7</td>
<td>1.00</td>
<td>1.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Nurses - Band 6</td>
<td>2.00</td>
<td>2.00</td>
<td>2.00</td>
</tr>
<tr>
<td>Nurses - Band 5</td>
<td>2.60</td>
<td>1.72</td>
<td>1.72</td>
</tr>
<tr>
<td>Medical Consultant</td>
<td>13.50</td>
<td>11.50</td>
<td>11.50</td>
</tr>
<tr>
<td>Locum Consultant (Fixed Term)</td>
<td>0.00</td>
<td>2.60</td>
<td>2.21</td>
</tr>
<tr>
<td>Specialty Doctor Career Grade</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Radiographer - Band 8b</td>
<td>1.00</td>
<td>1.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Radiographer - Band 7</td>
<td>8.24</td>
<td>7.00</td>
<td>7.00</td>
</tr>
<tr>
<td>Radiographer - Band 6</td>
<td>27.82</td>
<td>28.76</td>
<td>27.31</td>
</tr>
<tr>
<td>Radiographer - Band 5</td>
<td>14.40</td>
<td>12.60</td>
<td>12.60</td>
</tr>
<tr>
<td>Radiographer - Band 3</td>
<td>2.00</td>
<td>2.00</td>
<td>2.00</td>
</tr>
</tbody>
</table>

_(Additional Document Request)_

In August 2018, Whipps Cross Hospital reported a vacancy rate of 15.7% for nursing staff in diagnostic services. This was higher than the trust’s target of 6.3%.

In August 2018, Whipps Cross Hospital reported a vacancy rate of -4.4% for medical staff in diagnostic services. This was lower than the trust’s target of 6.3%, and indicates there is an over-establishment of staff.

In August 2018, Whipps Cross Hospital reported a vacancy rate of 3.9% for radiographer staff in diagnostic services. This was lower than the trust’s target of 6.3%.

_(Additional Document Request)_
Sickness rate data for staff in diagnostics services from August 2017 to July 2018 is shown in the table below.

<table>
<thead>
<tr>
<th>Department</th>
<th>Cumulative sickness absence rate (FTE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiology - Medical Staff</td>
<td>0.23%</td>
</tr>
<tr>
<td>Radiology Nursing Whipps</td>
<td>2.17%</td>
</tr>
<tr>
<td>Ultrasound Whipps X</td>
<td>0.56%</td>
</tr>
<tr>
<td>WXH A&amp;C Staffing</td>
<td>6.95%</td>
</tr>
<tr>
<td>CT Scanning</td>
<td>2.68%</td>
</tr>
<tr>
<td>Imaging Junior Medical Staff</td>
<td>1.46%</td>
</tr>
<tr>
<td>Imaging Management</td>
<td>3.52%</td>
</tr>
<tr>
<td>Imaging Medical Consultants</td>
<td>0.68%</td>
</tr>
<tr>
<td>MRI Scanner</td>
<td>1.79%</td>
</tr>
<tr>
<td>Medical Illustration</td>
<td>2.22%</td>
</tr>
<tr>
<td>Nuclear Medicine</td>
<td>3.76%</td>
</tr>
<tr>
<td>P.A.C.S</td>
<td>0.20%</td>
</tr>
<tr>
<td>PET - CT</td>
<td>5.11%</td>
</tr>
<tr>
<td>R.I.T.S.</td>
<td>3.43%</td>
</tr>
<tr>
<td>WXH Core Services</td>
<td>4.37%</td>
</tr>
</tbody>
</table>

Nine of the 15 teams and departments met the trust’s target of 3%.

(Source: Additional Document Requests)

The turnover rates for diagnostic services as of August 2018 are shown in the table below.

<table>
<thead>
<tr>
<th>Team/department</th>
<th>Sum of FTE leavers</th>
<th>Sum of average FTE</th>
<th>Turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>CT Scanning</td>
<td>1.0</td>
<td>12.0</td>
<td>8.3%</td>
</tr>
<tr>
<td>Imaging Management</td>
<td>0.0</td>
<td>5.2</td>
<td>0.0%</td>
</tr>
<tr>
<td>Imaging Medical Consultants</td>
<td>3.7</td>
<td>38.4</td>
<td>9.6%</td>
</tr>
<tr>
<td>Medical Illustration</td>
<td>0.0</td>
<td>5.0</td>
<td>0.0%</td>
</tr>
<tr>
<td>MRI Scanner</td>
<td>1.0</td>
<td>17.4</td>
<td>5.7%</td>
</tr>
<tr>
<td>Nuclear Medicine</td>
<td>5.0</td>
<td>23.8</td>
<td>21.0%</td>
</tr>
<tr>
<td>P.A.C.S</td>
<td>0.0</td>
<td>7.0</td>
<td>0.0%</td>
</tr>
</tbody>
</table>
Three of the 16 teams and departments did not meet the trust’s target of 13%.

(Additional Document Request)

Following this inspection, the trust reported bank and agency usage for diagnostic services between October 2017 and September 2018.

Whipps Cross Hospital had a total of 4,998 allied health professionals (AHP) staff shifts during this period. A breakdown of bank and agency usage and unfilled shifts is shown below:

<table>
<thead>
<tr>
<th>Bank and agency</th>
<th>Number of shifts (% of total shifts)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank</td>
<td>923 (18%)</td>
</tr>
<tr>
<td>Agency</td>
<td>403 (8%)</td>
</tr>
<tr>
<td>Not filled</td>
<td>20 (&lt;1%)</td>
</tr>
</tbody>
</table>

(Source: Additional Document Requests)

From October 2017 to September 2018 Whipps Cross Hospital had a total of 389 medical staff shifts. A breakdown of locum and agency usage and unfilled shifts is shown below:

<table>
<thead>
<tr>
<th>Locum and agency</th>
<th>Number of shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Locum</td>
<td>0</td>
</tr>
<tr>
<td>Agency</td>
<td>0</td>
</tr>
<tr>
<td>Not filled</td>
<td>0</td>
</tr>
</tbody>
</table>

(Source: Additional Document Requests)

From October 2017 to September 2018 Whipps Cross Hospital had a total of 34 qualified nursing staff shifts. A breakdown of bank and agency usage and unfilled shifts is shown below:

<table>
<thead>
<tr>
<th>Bank and agency</th>
<th>Number of shifts (% of total shifts)</th>
</tr>
</thead>
</table>

514
From October 2017 to September 2018 Whipps Cross Hospital had a total of 220 nursing support staff shifts. A breakdown of bank and agency usage and unfilled shifts is shown below:

<table>
<thead>
<tr>
<th>Bank and agency</th>
<th>Number of shifts (% of total shifts)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank</td>
<td>81 (37%)</td>
</tr>
<tr>
<td>Agency</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Not filled</td>
<td>7 (3%)</td>
</tr>
</tbody>
</table>

(Source: Additional Document Requests)

During inspection, the clinical lead told us that locum staff were not included in the on-call rota.

On-call consultant radiologists reported urgent CT remotely. Out of hours plain film reporting was done at another hospital within the trust. Reporting on urgent studies, (usually CT scans) were outsourced to two private companies between 8:30pm and 09:00am on weekdays and between 7:00pm and 9:00am at weekends.

Many radiography staff told us it was an accepted practice that they did extra shifts in addition to their rostered hours in order to make up for staff shortages. This was voluntary but most said the department would struggle to function if they did not do these ‘bank’ shifts.

Records

The diagnostic imaging department had a central electronic patient records system to record comprehensive details of each patient’s imaging history. The service used a combination of paper requests (mainly from GP’s) and internal electronic requests. Paper requests were scanned onto the radiology information system. All requests were checked on receipt by either the senior radiographers or consultant radiologist.

We reviewed eight patient records and found they contained information for staff if a patient required additional support whilst under investigation. This included highlighting to staff if the patient had mobility issues, or presented an infection risk for example. This information was reviewed at the point of investigation by the radiographer. The system made sure all relevant fields of information were completed and that results were easily accessible to relevant personnel. Reports were available digitally and were part of the electronic patient record. Records also included confirmation that the patient consented to the intervention.

The staff we spoke with in diagnostic imaging had a good understanding of patient confidentiality and data protection and had attended information governance training. We saw the receptionist demonstrate this by double checking patients details when they attended.

The service used two electronic record systems. The computerised radiology information system (CRIS) and picture archiving and communication system (PACS). CRIS was a password protected record of patient’s demographics and was used to book patients into vacant investigation slots. PACS was the system for storing completed images and the associated reports. This system was
also password protected and accessible only to radiology staff for reporting and clinicians who had requested the image. The service maintained comprehensive electronic patient records on PACS, with details of all investigations and their findings.

All computers observed were password protected and locked when not in use. We saw computers were generally not visible in patient areas, but those which were, were turned to prevent patients reading confidential information.

**Medicines**

The trust had a policy for the safe management of medicines and staff had access to it on the intranet. There were processes in place to ensure when medicines were used they were ordered, delivered, stored and disposed of in a safe way.

There were reliable systems for storage of medicines in diagnostic imaging. Medicines were stored in locked cupboards and the person in charge of the relevant areas held the keys. The medicines cupboards we inspected were locked and secure, all stock was within expiry date and there was evidence of stock rotation. Fridge temperatures were within the correct range and we saw that daily checks were logged.

Systems were in place to ensure the right patients received the right medication at the right time by the right route. Care was taken to ensure the right patient received the right medicine. For example, a patient’s identity was checked, confirmed and then checked against their referral request.

**Incidents**

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

From August 2017 to July 2018, the trust reported no incidents that were further classified as never events for diagnostics at Whipps Cross Hospital. (Source: NHS Improvement - STEIS)

In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SI) in diagnostics which met the reporting criteria set by NHS England from August 2017 to July 2018. This was a diagnostic incident including delay which met SI criteria (including failure to act on test results). (Source: NHS Improvement - STEIS)

We read the investigation report for this SI which identified learning to be shared across sites. One of the contributory factors to the delayed diagnosis was a suggestion there were frequent interruptions during the initial examination of the report and a range of modality reports were being reviewed at the same time. This may have affected the accuracy of the reporting.

Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses and to report on the electronic system. There were 520 incidents reported in diagnostic imaging between September 2017 and August 2018.

<table>
<thead>
<tr>
<th>Level of Harm Classification</th>
<th>Number of Incidents</th>
<th>% of Total Incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Harm - Extra observation/Minor treatment required/Minimal harm caused</td>
<td>19</td>
<td>4</td>
</tr>
<tr>
<td>Moderate Harm - Moderate increase in treatment/Significant but not permanent harm caused</td>
<td>4</td>
<td>0.8</td>
</tr>
</tbody>
</table>


The one incident categorised as severe harm related to a delayed diagnosis. The four moderate harm incidents included delay in availability of diagnostic test results; prescribing incorrect prescription and two incidents related to delay in care. We saw that duty of candour regulations were applied in each of these incidents and the patients were written to with an explanation and apology.

The table below indicates the category of incident:

<table>
<thead>
<tr>
<th>Category</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication Issues</td>
<td>121</td>
</tr>
<tr>
<td>Equipment (Non-Medical)</td>
<td>60</td>
</tr>
<tr>
<td>Delays in Care</td>
<td>58</td>
</tr>
<tr>
<td>Medical Devices</td>
<td>46</td>
</tr>
<tr>
<td>Estates/Facilities</td>
<td>41</td>
</tr>
<tr>
<td>Staffing Issues</td>
<td>40</td>
</tr>
<tr>
<td>Radiation</td>
<td>35</td>
</tr>
<tr>
<td>IT related</td>
<td>20</td>
</tr>
<tr>
<td>Treatment</td>
<td>18</td>
</tr>
<tr>
<td>Appointments and Clinics</td>
<td>17</td>
</tr>
<tr>
<td>Patient Falls</td>
<td>12</td>
</tr>
<tr>
<td>Patient Records</td>
<td>9</td>
</tr>
<tr>
<td>Staff injuries/illness at work</td>
<td>7</td>
</tr>
</tbody>
</table>

Staff told us they knew how to report incidents and gave examples of incidents they recorded on the trust electronic incident record. Staff told us the system was easy to use and demonstrated knowledge of how to do this. Staff were also able to tell us of incidents they reported and feedback received.

Radiographers told us they reflected on significant incidents and any learning from them in their team meetings. They also described the process to follow when a patient was over-exposed to radiation. These incidents were reviewed at the radiation protection supervisor’s monthly meeting.

The service shared the learning from incidents effectively. For example, we saw e-mails to staff which informed them of incidents and learning from them. Incidents were also discussed at the daily safety huddle and in the weekly site governance meeting. Minutes recorded discussion and actions; for example, in a (no harm) incident where a patient was given the incorrect fluid, the recommended action was to improve storage. We could confirm during inspection that this action was completed. Incidents were also discussed at the monthly cross-site radiological meeting which helped to share learning across all sites in the trust.

We also reviewed the computerised tomography (CT) weekly team bulletin which highlighted any incidents and learning was shared. Members of staff told us these bulletins were a good way to keep up with any departmental issues and learn from them.

The trust submitted one reportable radiation incident to CQC and Health and Safety Executive between October 2017 and September 2018. This related to unintended exposure to radiation. Remedial action included reinforcing the patient three-point identity check.

We noticed safe practice around a non-medical referrer on the electronic incident reporting system. Non-medical referrers are registered healthcare professionals who are trained according
to local guidelines and competent to provide appropriate clinical data when requesting an x-ray. A radiographer did an incident report where they refused to accept a referral from a nurse in a GP practice on the basis that the person was not an approved referrer.

Minutes from the monthly radiological meeting in May 2018 noted that the site lead reminded those in attendance that where a patient has an unnecessary scan, it should be recorded on the trust electronic incident record and escalated as serious incident.

Is the service effective?

Evidence-based care and treatment

The hospital had a named radiation protection advisor (RPA) whose role was to lead on the development, implementation, monitoring and review of the policy and procedures to comply with Ionising Radiation (Medical Exposure) Regulations IR(ME)R regulations.

Staff had access to evidence based protocols and pathways based on National Institute of Clinical Excellence (NICE) and Royal College guidelines including quick reference guides on the trust intranet. For example, we saw that radiography protocols updated in June 2018. Relevant clinical guidelines and standard operating procedures were readily available for all imaging tests and staff could show us during the inspection.

The trust told us they did not participate in the Imaging Services Accreditation Scheme (ISAS). However, the division hoped to submit a request in the 2019-2020 business planning cycle for a quality manager to lead this work across all the trust Sites.

The trust submitted data following this inspection which confirmed that an adult patient dose audit was carried out in August 2018 by the trust medical physics expert (MPE) as required under the Ionising Radiation (medical exposure) Regulations 2017. This dose audit allowed for the production of up to date locally derived diagnostic reference levels. Diagnostic reference levels are required under IR(ME)R as part of dose optimisation to ensure that patient doses are kept as low as reasonably achievable.

It was noted that doses at Whipps Cross Hospital were generally higher and at times, considerably higher than the other hospitals in the trust. It was commented that this was due to both the age of the equipment and manual setting of exposures on certain equipment, especially mobile x-ray units. It was recommended that clinical practice, training and protocol selection be addressed.

The MPE made exposure optimisation recommendations to the trust which included the setting up of imaging optimisation working groups. Members should include radiologists, radiographers and medical physicists. The purpose of the working group would be to harmonise protocols and optimise exposures. The MPE also recommended that a programme of regular local audits of local doses and surveys of local practice be set up to include direct radiography and computed radiography in all rooms and mobile units.

Staff doses were monitored as required under the Ionising Radiation Regulations 2017. Staff radiation monitors were analysed monthly and returned to the trust radiation protection advisor. Any results that exceeded the investigation level were highlighted to the trust with associated reasons as to why a higher than expected dose was recorded. The investigation level is set at 0.5 millisieverts and recorded doses in April 2018 from two members of staff were 0.56 and 0.58. This was not considered to be of concern but required local investigation.
Staff were expected to submit their dose monitors for analysis; data submitted by the trust following this inspection showed there was 94% return rate in July 2018 and 100% in August and September 2018.

Audits carried out by radiologists and radiographers were presented at the monthly radiology discrepancies meetings and included new ionising radiation regulations, trauma, knee x-ray and CT pulmonary angiography.

The service completed an audit between September and December 2017 which focussed on the implementation of pregnancy protocols for patients receiving medical ionising radiation. This was essential to avoid the unintentional exposure to a developing foetus during pregnancy. The goal was to ensure that all females of childbearing age (12-56) in this patient group were consulted about the possibility of pregnancy and a form completed.

<table>
<thead>
<tr>
<th>25 forms from each x-ray area</th>
<th>Forms scanned</th>
<th>Incorrectly completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>92%</td>
<td>16%</td>
</tr>
<tr>
<td>GP</td>
<td>92%</td>
<td>16%</td>
</tr>
<tr>
<td>Emergency department</td>
<td>92%</td>
<td>12%</td>
</tr>
<tr>
<td>Computerised tomography</td>
<td>92%</td>
<td>28%</td>
</tr>
<tr>
<td>Fluoroscopy</td>
<td>96%</td>
<td>4%</td>
</tr>
</tbody>
</table>

The action plan to address these results included radiographers to check patient’s age and to have the form ready for completion with the patient and scan immediately; scanners to be in all x-ray areas; self and peer audit to improve level of compliance with the IR(ME)R Regulations and to protect the patient against the hazards associated with ionising radiation.

**Nutrition and hydration**

There were water fountains available around the department for patients to access cold water. There were café facilities close by within the hospital which patients and relatives could access. Staff told us they did not provide snacks for patients as they came prepared and waits in the department were usually short.

Patients were advised on whether they could eat or drink prior to their treatment in their appointment letters. One member of staff told us if booked patients needed to fast before their procedure, they were telephoned the day before to remind them of this.

**Pain relief**

Pain relief was not routinely used in diagnostic imaging, except for when patients were attending for invasive procedures. Staff provided patients with pain control specific to the investigation being undertaken. Staff told us some patients were advised when procedures may be uncomfortable, and time was taken to reassure the patients and keep them informed of the length of time remaining for procedures.

Staff ensured patient’s comfort prior to completing simple diagnostics, such as ultrasound scans, and x-rays. We saw patients were assisted to reposition themselves if they reported they were uncomfortable and reassured during procedures of the time required in the position.

**Patient outcomes**

The service held discrepancy meetings in accordance with the Royal College of Radiologists (RCR) guidance. The RCR ‘Learning from Discrepancy meetings’ template was used and kept
centrally within the imaging department. The Imaging Network Board recently agreed to introduce a further element of quality assurance in the form of a more formal peer review system.

Radiologists who reviewed imaging during their routine reporting were expected to record their level of agreement with the reviewed report based on the RCR guidance. Any discrepancies felt to require further investigation as a cause of potential harm; or felt to be the result of an unacceptable standard would be flagged up to a ‘committee’ of radiologists. The same peer review system would be used and an internal assessment initiated as required.

**Competent staff**

From April 2017 to March 2018, 11 members of medical and dental staff were eligible to receive an appraisal and the service achieved 100% completion rate against a trust target of 90%.

The trust has not provided a core service breakdown for non-medical staff therefore we are unable to provide any completion rates.

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

The trust submitted data following inspection which showed that the diagnostics imaging department was 94% compliant with staff appraisals.

There was an established development plan for newly qualified radiographers. Staff completed competencies and worked towards gaining additional skills. We saw competencies were specific to the area worked and staff were encouraged to undertake additional training to support them in their roles.

All staff administering radiation were appropriately trained to do so. Those staff who were not formally trained in radiation administration were adequately supervised in accordance with legislation set out under IR(ME)R. Each area within the imaging department had lead radiographers. This was a senior practitioner to ensure delivery of recommended standards as recognised by the Society of Radiographers (SoR).

Superintendent radiographers were recently given responsibility for staff appraisals in their department which included up to eight members of staff. They completed an appraisal training workshop before they began to appraise staff and we saw that some appraisals were already completed with the rest booked in over the following three months.

The computerised tomography (CT) lead regularly liaised with Medical Physics and did annual radiation protection supervisor refresher training. The lead told us staff completed six weeks training in CT before they were signed off as competent and had regular one to one supervision with the lead to maintain standards.

However, various members of staff in the urgent and emergency x-ray department told us there was no formal additional training or continuous professional development (CPD) available. This was attributed to the fact there was no core modality lead or education officer in place. However, staff told us their line manager arranged lunchtime CPD sessions twice a month which involved case discussion and where possible a speaker which helped to improve their practice.

Non-medical referrers are registered healthcare professionals who are trained according to local guidelines and competent to provide appropriate clinical data when requesting an x-ray. The trust submitted a list of non-medical referrers, which included the authorising radiologist, the supervising consultant and the examinations they were authorised to request. There were four
non-medical referrers in the emergency department; 12 in urology and eight physiotherapists. Radiographers told us they ensured the referrer was a trust approved referrer before they accepted the patient.

**Multidisciplinary working**

We saw doctors, radiographers, radiography assistants, porters and administration staff worked collaboratively to assist with the patients experience in the department.

There was evidence of good working relationships between the imaging department and the radiation protection team.

There were multidisciplinary one-stop clinics, such as in the breast clinic, where patients could access consultations, diagnostics, results and clinical nurse specialists in one appointment. This meant there was collaboration with a range of staff including nursing, medical and radiographers to minimise delays on the day as the patient transitioned through their appointment.

**Seven-day services**

GP plain film patient referrals attended the GP x-ray department between 9.00am to 5.00pm Monday to Friday and no appointment was necessary. Out of hours x-ray services were provided for emergency patients referred from the wards and emergency department twenty-four hours a day seven a week as were computerised tomography and ultrasound. There was magnetic resonance imaging (MRI) on site between 8:00 and 8:00pm Monday to Friday. Where there was a need for out of hours MRI, patients were taken to a nearby hospital in the trust.

**Health promotion**

Staff provided support to patients with health promotion when necessary. For example, staff from different clinics told us where they identified abnormalities or risk factors; these were first discussed with their manager. Staff would then have discussions with the patient and provide any additional supporting information or interventions where needed. Staff told us this was often a challenging process as it could have life changing implications for the patient.

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

The staff we spoke with understood consent and the decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. The process for obtaining consent was accessible to staff on the trust intranet. We saw examples of accurately completed consent forms. Patients we spoke with told us they knew what procedure they were having and that staff always asked for consent before proceeding.

**Is the service caring?**

**Compassionate care**

We observed staff treat patients with respect. Although the departments we visited were busy, staff were seen to be competent, caring and ready to undertake the relevant examinations as requested.

However, the changing facilities in the GP x-ray department were small and compromised patient dignity. Curtains did not provide full privacy and patients in wheelchairs could not access the cubicles. Once changed, patients in their hospital gown had to walk past other patients and wait with fully clothed seated patients for their x-ray examination. We saw this on several occasions
during our inspection. Staff told us they had continuously tried to work out ways in which patient
dignity was protected; however, the environment placed limitations on alternatives.

We spoke with 21 patients and relatives during the inspection. There were no negative aspects of
care highlighted to us. Patients we spoke with told us the staff were very kind and friendly.

A family member stopped inspectors to say how kind and professional a porter was with their
relative and said, “They went out of their way to help my [relative]; they were so willing and
cheerful – nothing was too much bother for them.”

A patient told us, “The staff are brilliant – they remembered who I was from my last visit here.”
Another patient said, “The staff are just fantastic, I don’t know how they keep going; there never
seem to be enough of them.”

The trust did not submit any patient feedback to CQC. Following this
inspection, we were told an
alternative method of gathering feedback was introduced which was a text messaging service.
However, this was not able to accurately reflect feedback specific to diagnostic services. The text
related to the primary contact; for example, if a patient came into the emergency department, any
feedback was attributed to that department, irrespective of whether the patient was also treated in
diagnostics or not. To improve the volume and accuracy of patient feedback, the trust introduced
paper surveys shortly before this inspection and there was no currently available analysis. The
trust planned to introduce patient experience champions in each clinical area and all staff were
encouraged to tell the patient that their feedback was valuable and would be requested via a text
message.

A chaperone is an adult who is present during an intimate examination of a patient. They are
present to protect both the patient and the practitioner from allegations of inappropriate behaviour.
Staff in the ultrasound department told us it was not possible to provide a chaperone for all
patients. This was escalated to management and we were told it was on the risk register. Two
patients told us they were not asked whether they wanted a chaperone and we saw on three
separate occasions that sonographers did not ask patients if they wanted a chaperone. informed
sonographer told us that chaperones were always provided for intimate pelvic ultrasound
examinations.

**Emotional support**

We observed staff give patients reassurance throughout their examinations. Patients told us staff
were professional and supported them well to minimise their distress. The staff in the MRI
scanning unit explained how some patients found the experience claustrophobic and noisy, and
staff had to reassure them constantly.

Staff had good awareness of patients with complex needs and gave examples of how they would
deal with individuals presenting as anxious. The nuclear medicine department gave patients a
pictorial diagram which showed them how they should prepare for a stress test. This was a simple,
but effective information sheet for patients.

Staff told us they occasionally dealt with patients with challenging behaviours, particularly on night
duty. In more extreme circumstances, they called site security for assistance.

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

We saw staff ensure patients understood the investigation they were due to receive. Staff told us
when they had patients who were unable to communicate clearly; they used communication aides
to support patient interaction including pictorial aids and translation services. We heard staff
remind patients when they were likely to receive their results
Some patients told us they were involved with decisions about their care and treatment; staff gave them sufficient information to help them make choices. Staff informed patients how long it would be before they received the results of their investigations and advised patients when it would be appropriate to book a repeat appointment with their GP to review the results.

Is the service responsive?

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

The emergency department (ED) had a designated x-ray facility that offered a 24-hour service specifically for ED patients. The department offered a walk-in service for all plain film (x-ray) examinations requested by the person’s GP, which meant patients did not need to make appointments to attend. Many patients told us they valued this service as it was a ‘local service for local people’.

Children from birth to 16 had in-ward, plain X-ray mobile and departmental procedures as well as MRI, CT and fluoroscopy. Children accessed emergency department, outpatient and GP plain x-ray imaging as a walk-in on demand service.

Receptionists in the GP x-ray department let patients know how long they may be waiting for their examination. At time when the x-ray clinic very busy, patients were offered alternative next day appointments in community based facilities nearer to their home.

This department was in an old part of the hospital and had limited adaptations for people with disabilities; for example, the toilets were not wheelchair accessible and patients in a wheelchair had to return to the main hospital building to use an accessible toilet. The department did not have a defined children’s play area.

Patients received appointment letters, explaining the purpose of their diagnostic test, what they needed to bring and how they needed to prepare. Most patients we spoke with told us they received useful information to help them plan their visit.

**Meeting people’s individual needs**

Staff in all departments told us a double slot was booked for patients with complex needs, including those with learning difficulties or dementia. The extra slot was used to explain the process to the patient and help them get used to the environment. However, there were no easy read patient information leaflets to explain some procedures.

Staff told us they accessed a telephone translation service to support patients for whom English was not their first language. They told us that patients frequently were accompanied by a family member or friend who could translate. However, it is best practice for an independent interpreter to explain treatment and assist with consent, to ensure medical information is translated correctly.

We saw leaflets with information about scans and tests, drug treatments and patients guide to x-ray within the reception area which were all written in English. There was a telephone number on the leaflet which the patient was invited to contact if they required help with translating the contents of the leaflet.

The ultrasound department ran a pilot service to support the ambulatory care service with same day scans. Sonographers told us the reports were positive and showed signs of improving patient flow. Further development of the service depended on funding agreement.

The breast clinic ran as a one-stop clinic which meant that any additional tests required following imaging results were carried out at the same appointment.
The different areas of the department were well signposted. However, some aspects of the environment in certain areas were not patient centred. For example, the GP x-ray department was in an old part of the hospital. The waiting areas were cramped and poorly ventilated. The toilets and the waiting area for fracture referrals were not wheelchair accessible and patients in a wheelchair had to return to the main hospital building to use an accessible toilet. There was no clearly defined children’s play area.

**Access and flow**

Between July 2017 and October 2017, the percentage of patients waiting more than six weeks to see a clinician was higher than the England average. The following eight months the trusts performance was better than the average. The England average is the mean value from NHS Trusts, NHS Foundation Trusts and Independent Sector Providers in England. The chart below shows 6+ weeks percentages over time.

(Source: NHS England – Diagnostic Waits)

Patients have a right to have a diagnostic test within six weeks of the request being sent. Following this inspection, the trust submitted data on diagnostic waiting times for MRI, CT and ultrasound between September 2017 and August 2018. This showed that performance for these modalities was consistently between 99% and 100% during this whole period.

Members of the senior leadership team told us there was a gap between targets and capability in reporting times. In order to manage this, the service outsourced work to a private reporting company. The trust provided data following this inspection for the average proportion of work outsourced by modalities between August 2017 and July 2018. The average amount of outsourced work for computerised tomography was 29%; magnetic resonance imaging 37% and x-ray 32%.

The trust also submitted data in the table below that related to reporting turnaround times for June to August 2018.

<table>
<thead>
<tr>
<th>Modality</th>
<th>Month</th>
<th>0-12hours</th>
<th>1-24 hrs</th>
<th>7 Days</th>
<th>14 Days</th>
<th>14-21 Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>CT</td>
<td>June</td>
<td>98%</td>
<td>0%</td>
<td>1%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>July</td>
<td>99%</td>
<td>1%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Modality</td>
<td>Average wait to appointment (weeks)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------</td>
<td>------------------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fluoroscopy</td>
<td>3.25</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interventional</td>
<td>4.36</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nuclear medicine</td>
<td>3.63</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Reports for CT and ultrasound were consistently turned around within 12 hours and most reports for other modalities were turned around within 14 days.

The trust submitted data following this inspection which showed the current waiting time for appointments:

The GP x-ray clinic operated between 9:00am to 5:00pm. However, staff told us there were occasions each month when the clinic was closed from 3:30pm to ensure that patients already waiting were seen by the end of the clinic 5:00pm. This was based on the volume of patients in the waiting area. We spoke with the lead in this area who told us patients who were deferred were encouraged to go to the emergency department x-ray area or could choose to return to the GP x-ray clinic the following morning. On most occasions, the patient returned to the GP clinic. We asked whether patients were risk assessed before their appointment was deferred and were told that patients in that clinic were not emergency patients. A radiographer had a brief discussion with them about their current level of discomfort and pain before their appointment was rebooked.

There was a daily ‘hot seat’ run by a rota of consultant radiologists who reviewed images referred to them from radiographers. The hot seat was covered on site between 08:30am and 5:00pm, and reported from home from 5:30pm to 11:00pm. Any calls between 5:00pm and 5:30pm went to the on-call radiologist until the reporting radiologist logged back on when at home.
Learning from complaints and concerns

The trust submitted data following this inspection which showed there were 18 complaints between April 2018 and September 2018, two of which remained open. Six complaints related to appointments; four to communication; three to healthcare records; two to delays in care; one to patient falls; one to diagnosis/treatment and one to security.

A patient told us of their experience when they made a complaint. They said they got an in-depth written explanation of why their complaint arose. The patient also received a follow-up telephone call to ask if they were satisfied with the response or whether they wished to pursue it further. The patient told us they felt their complaint was adequately answered.

We saw examples of written response to complaints. The complaints were promptly responded to and included future actions and any learning for staff.

Is the service well-led?

Leadership

The imaging department was part of the clinical support services (CSS) division and was undergoing a restructuring programme at the time of our inspection. A local triumvirate model of management was introduced with two managers already in place; a site lead for imaging and a service manager. The function of the third part of this triumvirate was yet to be decided. Diagnostic imaging was represented at the hospital site management board by the director of Quality Performance in CSS. The clinical lead told us this was a significant improvement since the last CQC inspection in July 2016 where there was no direct imaging link with the trust board.

Most staff told us that local departmental managers were visible, supportive and approachable. The site lead post was new since the time of the last CQC inspection in December 2016. The site lead reported to the head and deputy head of diagnostic imaging, both of whom were based at Bart’s hospital. The site lead had a wide brief which included management of diagnostic modalities excluding ultrasound; governance issues and business planning. The service manager post was introduced in June 2018. The service manager worked on operational matters and improvement issues which included better workflow and better service provision to certain areas, for example to theatres as well as dissemination of data within the department. They told us they expected to be involved in equipment replacement as part of the three-year business strategy.

The site lead had a wide range of responsibilities which included governance matters, business planning, project management of improvements, equipment replacement as well as management of the clinical service provision. They told us there were times when the wide scope of their role meant that they did not have as much oversight of clinical matters as they would like. However, the site-lead hoped that the addition of a site based service manager would redress this situation.

Superintendent radiographers were given junior managerial roles with responsibility for rotas and locally based decisions in their department. However, many superintendents told us there was no protected time allocated to perform these extra managerial duties alongside their clinical responsibilities or to update their learning for this extended role. This role carried many responsibilities in addition to clinical duties which included audit, radiation protection and research lead and staff management responsibilities which included rota management, supervision and mentoring of staff.

Vision and strategy
The service had a three year ‘equipment and space strategy’ which was waiting for final approval before plans could be put in place. The strategy focussed on replacing deteriorating equipment and restructuring spaces to maximise good patient experience and flow.

**Culture**

Staff across the different modalities in the imaging department described strong teamwork within their modality and a sense of getting on with the job, despite some challenging working conditions. During our inspection the staff were friendly and willing to engage with the inspection. They demonstrated strong commitment to providing a good service for their patients. It was evident that quality and patient experience was a priority for the service and was everyone’s responsibility.

The duty of candour (DoC) is a regulatory duty which relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person.

Most staff we spoke with were aware of the DoC regulation and the incidences in which it should be applied. Staff also told us that in situations where the formal application of DoC was not applicable, they were always honest with patients and relatives and informed them when procedures did not go according to plan.

**Governance**

The governance structure included a variety of meetings at site and trust level. Radiation protection supervisors (RPS) met weekly with the site lead. The diagnostic imaging governance group met monthly and attendance included the site lead, modality leads, service manager, picture archiving and communication system (PACS) manager, RPS, radiologists and imaging governance coordinator. The site radiation protection committee included the same attendees.

There was also a monthly radiological site meeting (Cogwheel) which shared information and issues across all the modalities. Attendance included the head of Imaging, site lead, modality leads, service manager, RPS, radiologists, PACS manager, and administration and clerical manager. Matters of interest from this meeting went to the imaging network board which was a cross site meeting and from there to the CSS board. The CSS board met monthly and produced a clinical support services integrated report which reported on operating performance, risk registers, action log, quality and safety, staffing and finance.

At the time of this inspection, the trust had not fully implemented the Ionising Radiation (Medical Exposure) Regulations 2017 which replaced the 2000 regulations (including amendments made in 2006 and 2011). Following the inspection, we were told that changes to the regulations were disseminated through a series of update talks at continuous professional sessions and audit day talks.

**Management of risk, issues and performance**

The service had an on-site radiation protection committee which reported to the divisional governance structure. There was a cross-site and cross-modality multi-disciplinary imaging optimisation committee, the remit of which was to drive and monitor imaging optimisation across the trust. However, some senior staff told us they were not always able to attend cross-site governance meetings held at another hospital in the trust due to pressures of their work. Senior staff told us this was of concern as they wanted all aspects of Whipps Cross hospital to be well-represented and understood across the trust.

The risk register was reviewed monthly and all identified high risks were discussed at the cross-site imaging network board and up to the CSS board. There were 16 risks on the register in
August 2018. The highest of these risks included deteriorating equipment, poor working environments, insufficient clinic capacity, staffing levels and lack of availability of male and female chaperones in the ultrasound department. However, senior leaders did not seem fully aware of some the concerns staff raised with us, for example personal safety and the extent to which patients were left unescorted in some departments.

Radiation incidents were discussed in a cross-site discrepancy meeting which included physicists and the person involved. For example, we saw minutes of the monthly radiological site meeting which reported that because of the body coil not working, an inappropriate coil was used in some MRI scans which may need to be repeated.

There was good awareness of the procedures to follow in the event of a major incident and staff could show us where the major incident plan was located on the trust intranet. Staff ensured their personal contact information was up to date with switchboard and their line manager should they be called into the hospital in the event of a major incident.

Information management

During inspection we found some specialty doctors were using personal laptops and desktop computers without official trust antivirus software installed when they reported from home. There was no schedule in place for quality assurance testing of the home computers or assurance that antivirus software was up to date. Furthermore, there was no assurance of Digital Imaging and Communications (DICOM) grey scale display function compliance.

If the laptops do not meet current Royal College of Radiologists (RCR) recommendations for primary reporting monitors, they cannot be used for primary reporting. They may impact patient safety during diagnostic reporting with pathology potentially missed due to inadequate equipment calibration or inadequate equipment. We raised this in a meeting with the trust divisional director for imaging when on site. Following this inspection, the trust sent us a record of actions taken to address each matter.

Two radiologists had non-compliant devices; one was a laptop that did not meet the minimum guideline for screen size and resolution. The other non-compliant device did not meet the screen size and luminance contrast ratio. Mitigations were put in place to ensure those radiologists remained on site between 5:00pm and 9:00 pm to do their on-call reporting on trust compliant screens; after this time the on-call was outsourced to a third-party provider.

Home access at Barts Health NHS Trust was provided through a secure virtual private network (VPN) which used a digital token with two-factor authentication. This cannot be infected by viruses or malware as no data can be passed between the host personal computer and the virtual computing software. In this same way, no patient data can be transferred to the personal computer.

The trust acknowledged there was no schedule in place for quality assuring (QA) workstations used for home reporting. A monitor self-assessment quality check has since been deployed to the picture archiving and communication system (PACS); radiologists were expected to complete the quality check of their home reporting screens by 11 October 2018. The trust had plans to implement acceptance tested compliant self-calibrating monitors for home reporting by 28 October 2018.

The trust updated CQC following this inspection. We were told all radiologists completed a quality check of their home reporting screen and no issues were identified.

All imaging reviewed at home was via the full PACS client exactly as used when on site which provided full DICOM images and functionality. The trust acknowledged that it could not provide
assurance of grey scale compliance for all home monitors. However, the trust planned to address this through the provision of acceptance tested compliant self-calibrating monitors for home reporting by 28 October 2018.

The trust updated CQC following inspection and confirmed diagnostic monitors were ordered and due for delivery 29 October 2018; acceptance testing and installation was planned to follow immediately.

Each diagnostic department displayed details of performance over time in staffing levels, response times and safety checks.

The hospital introduced enhanced security in the IT system following a cyber-attack in 2017. This protected patient and staff data from unauthorised access and ensured staff had local access to records in the event of a server failure.

Engagement

Many radiographers told us they did not often make their multidisciplinary team meeting due to pressures of work.

Each modality had an audit meeting once a month. This was an opportunity to share learning as well as presentation of any recent audit findings.

Most staff we spoke with were aware of the three year ‘equipment and space strategy’ and said they were optimistic that this would improve service delivery and patient experience.

Learning, continuous improvement and innovation

At the time of our inspection, the service had a three-year business plan which had not been fully signed off. However, managers told us this included restructuring of the environment as well as equipment replacement both of which were risks on the departmental risk register.
This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.
Urgent and emergency care

Facts and data about this service

The ED is a designated Major Trauma Centre, providing a 24/7 specialist service to the north east and east London areas alongside patients received via its role within the London Trauma Network. The department saw 164,710 patients in 2017/18 of which approximately a quarter were children. The department has approximately 300 WTE staff with a well developed research facility and extended training opportunities for clinical staff.

Patients present by walking into the adult or children’s reception areas or if arriving by ambulance via a separate entrance. If a patient arrives on foot, they are booked in by reception before being seen by an initial assessment nurse, who then streams them to an appropriate area. If the patient arrives by ambulance, they are assessed by an emergency medical consultant or senior registrar / Advanced Clinical Practitioners in the emergency assessment area before then being taken to the most appropriate area. If the patient arrives via the designated red phone patch alert system (via air or road ambulance), they are taken straight into the department’s eight bay resuscitation area.

The department also has a consultant-led psychiatric liaison team.

Children under 16 years of age are booked in at a separate children’s ED reception and triaged by a qualified children’s emergency department nurse where they are then streamed to an appropriate area. It has its own high dependency area and new four-bedded clinical decisions unit.

(20180517 RPIR Acute - NUH Documents – Context)

Activity and patient throughput

Total number of urgent and emergency care attendances at Barts Health NHS Trust compared to all acute trusts in England, July 2017 to June 2018
From July 2017 to June 2018 there were 440,983 attendances at the trust’s urgent and emergency care services as indicated in the chart above.

(Source: NHS England)

Urgent and emergency care attendances resulting in an admission

The percentage of A&E attendances at this trust that resulted in an admission increased in most recent year compared to previous year. In both years, the proportions were lower than the England averages.

(Source: NHS England)

Urgent and emergency care attendances by disposal method, from April 2017 to March 2018

* Admitted to hospital includes: no follow-up needed and follow-up treatment by GP
^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional
# Left department includes: left before treatment or having refused treatment

(Source: Hospital Episode Statistics)
## Is the service safe?

### Mandatory training

Royal London Hospital set a target of 85% for completion of mandatory training.

A breakdown of compliance for mandatory courses as of 30 August 2018 for nursing staff/medical and dental staff in urgent and emergency care is shown below:

Nursing staff

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Target met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia Awareness</td>
<td>111</td>
<td>111</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>111</td>
<td>111</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Investigation of Incidents</td>
<td>22</td>
<td>22</td>
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<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk Assessment for Managers</td>
<td>22</td>
<td>22</td>
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<td>85%</td>
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</tr>
<tr>
<td>Working at Barts Health</td>
<td>111</td>
<td>111</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>109</td>
<td>111</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Emergency Planning</td>
<td>108</td>
<td>111</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fraud Awareness</td>
<td>108</td>
<td>111</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety</td>
<td>108</td>
<td>111</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>108</td>
<td>111</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Security</td>
<td>108</td>
<td>111</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Harms - Catheter Acquired Infections</td>
<td>107</td>
<td>111</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Harms - Pressure Ulcer Prevention</td>
<td>107</td>
<td>111</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Harms - Slips, Trips and Falls (Patients)</td>
<td>107</td>
<td>111</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Harms – VTE</td>
<td>107</td>
<td>111</td>
<td>96%</td>
<td>85%</td>
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</tr>
<tr>
<td>Complaints</td>
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<td>85%</td>
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</tr>
<tr>
<td>Nutritional Care</td>
<td>107</td>
<td>111</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation - Basic Life Support</td>
<td>106</td>
<td>110</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Early Warning Systems</td>
<td>106</td>
<td>111</td>
<td>95%</td>
<td>85%</td>
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</tr>
</tbody>
</table>
Nursing and midwifery staff exceeded the 85% completion target for all of the 27 mandatory training modules.

Medical and dental staff

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Target met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Planning</td>
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<td>34</td>
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<td>85%</td>
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</tr>
<tr>
<td>Consent</td>
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</tr>
<tr>
<td>Security</td>
<td>32</td>
<td>34</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness</td>
<td>62</td>
<td>68</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling - Patient Handling Low Risk</td>
<td>62</td>
<td>68</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>61</td>
<td>68</td>
<td>90%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Early Warning Systems</td>
<td>60</td>
<td>68</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>60</td>
<td>68</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety</td>
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<td>68</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>48</td>
<td>55</td>
<td>87%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Harms – VTE</td>
<td>59</td>
<td>68</td>
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<td>85%</td>
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</tr>
<tr>
<td>Clinical Documentation</td>
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<td>68</td>
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<td>85%</td>
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<tr>
<td>4 Harms - Catheter Acquired Infections</td>
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<td>68</td>
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<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Harms - Slips, Trips and Falls (Patients)</td>
<td>58</td>
<td>68</td>
<td>85%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Working at Barts Health</td>
<td>58</td>
<td>68</td>
<td>85%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Harms - Pressure Ulcer Prevention</td>
<td>57</td>
<td>68</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>----</td>
<td>----</td>
<td>-----</td>
<td>-----</td>
<td>----</td>
</tr>
<tr>
<td>Fraud Awareness</td>
<td>57</td>
<td>68</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Nutritional Care</td>
<td>57</td>
<td>68</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Privacy and Dignity</td>
<td>57</td>
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<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
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<tr>
<td>Information Governance</td>
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<td>85%</td>
<td>No</td>
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<tr>
<td>Infection Prevention and Control – Clinical</td>
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<td>85%</td>
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<tr>
<td>Resuscitation - Basic Life Support</td>
<td>42</td>
<td>68</td>
<td>62%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Medical Gas Safety</td>
<td>9</td>
<td>16</td>
<td>56%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical and dental staff exceeded the 85% completion target for 15 of the 24 mandatory training modules.

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

ED clinical staff received mandatory training on how to recognise and provide a first response to patients with mental health needs, learning disabilities, autism or dementia. ED staff said that their induction training covered meeting the diverse needs of patients and included training on mental health, learning disabilities and dementia. Induction also included an introduction to the mental health liaison team and how to make a referral.

**Safeguarding**

Staff had access to the trusts safeguarding policy and knew how to access the safeguarding team for advice and guidance when required. Staff told us the team were supportive in giving advice and guidance where required.

Safeguarding information, including contact details of the trust lead were kept available and staff were aware of how to access this.

Staff we spoke with were aware of their responsibilities in relation to safeguarding vulnerable adults and children and were able to define triggers that would prompt them to obtain a safeguarding assessment for patients.

Staff we spoke with in the Paediatric Emergency Department (PED) were aware of their responsibilities to protect vulnerable children. They were knowledgeable about safeguarding procedures. The PED had a safeguarding flag system in place. Patients were checked against the Child Protection Register. Any safeguarding concerns were escalated to the safeguarding team who visited the department daily to collect the referral forms. There was a psychosocial meeting to review referrals and outcomes to share learning.
The electronic ED triage and assessment tools supported practitioners to consider safeguarding risk and record multi agency involvement. Staff were familiar with the recording and questioning process and understood the reasons for the line of questioning and the importance of recording agencies involved in the records. The majority of records were completed correctly and the safeguarding cases reviewed evidenced direct contact had been made with the named social worker and details recorded.

There was a positive approach to multiagency working. The department held a weekly psycho social meeting with a wide range of internal and external practitioners attending. We saw the database of the CYP reviewed at the meeting and the actions to be taken recorded. The meeting coordinates care of vulnerable children and young people who had attended ED and supported joint working.

Children and young people who were receiving statutory support due to their vulnerability were flagged appropriately by the online system. This supported early identification and alerting of partner agencies.

The safeguarding team was now using information from the police to record on the system when a child was known to be at risk of child sexual exploitation.

The person accompanying the child was consistently recorded in the records. However, the recording of the children’s and young people’s voice was variable, the assessments were not clear on whether the child or young person had offered their perspective of why they are there or what had happened. Seeking the child’s view adds meaning and context to the assessment. The recording of the child’s father was still not always documented in records. Although it was possible to record this as free text it was not being undertaken. This meant the child was not always seen within the context of the family as a whole.

The person accompanying the child was consistently recorded in the ED records.

Royal London Hospital set a target of 85% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses as of the 30 August 2018 for nursing staff/ medical and dental staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Target met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Level 1</td>
<td>111</td>
<td>111</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>109</td>
<td>111</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>108</td>
<td>111</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>103</td>
<td>106</td>
<td>97%</td>
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<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 3</td>
<td>21</td>
<td>26</td>
<td>81%</td>
<td>85%</td>
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</tr>
</tbody>
</table>

Nursing and midwifery staff exceeded the 85% completion target for four of the five safeguarding training modules.
## Medical and dental staff

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Target met</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Level 1</td>
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<td>68</td>
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<td>85%</td>
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<td></td>
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<tr>
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<td>85%</td>
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<td>Safeguarding Children Level 2</td>
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<td>84%</td>
<td>85%</td>
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<tr>
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<td>79%</td>
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<td>2</td>
<td>50%</td>
<td>85%</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

Medical and dental staff exceeded the 85% completion target for two of the five safeguarding training modules.

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

There were robust systems in place for recording and reporting suspected cases of female genital mutilation (FGM) within the department. If FGM was identified or suspected the nurse would inform the senior nurse or consultant in charge. This was followed up with referral to the safeguarding team.

When staff within the ED suspected sexual exploitation, this was discussed with trust safeguarding lead and the consultant and nurse on-call. This was then documented in patient notes, an incident report completed also communication with social services, police and school as required.

### Cleanliness, infection control and hygiene

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

All the infection prevention and control standard operating procedures we reviewed were up to date and accessible by staff on the hospital intranet.

There were housekeeping staff for cleaning all areas of the emergency department including the urgent care centre, paediatric emergency department (PED), majors, resuscitation, clinical decision unit (CDU) and the waiting areas. We saw cleaning staff frequently over the course of the inspection.

Throughout our visit we found all areas of the emergency department to be maintained to a high standard of cleanliness. Areas were clean, tidy and free from dust.

We reviewed patient areas across the wards as well as dirty utility areas and treatment rooms. All areas were visibly clean. Patients and relatives were satisfied with the level of cleanliness on the wards.
There was easy access to personal protective equipment (PPE) such as aprons and gloves in all areas we inspected and saw all staff used PPE as required. There was also sufficient access to handwashing and drying facilities. Services displayed signage prompting people to wash their hands and gave guidance on good hand washing practice.

Staff were ‘bare below the elbow’ and adhered to infection control precautions throughout our inspection, such as hand washing and using hand sanitisers when entering and exiting the unit and bed spaces, and wearing PPE when caring for patients.

At the last inspection we found some hand sanitisers were empty. During this inspection we found no empty hand sanitisers.

Where patients had a known or suspected infection, they were nursed in single rooms. There were signs displaying presence of infection, which meant staff, and visitors were aware of the precautions to take prior to entering the patient area. We observed staff adhering to these protocols and doors remained closed.

Throughout the inspection we observed staff practicing good hand hygiene including washing hands between betweens and using hand sanitisers.

Hand hygiene audits were completed monthly. We reviewed hand hygiene audit data and found performance varied. Between September 2017 and August 2018, compliance in the adult ED varied between 77% and 98%. In the paediatric department compliance varied between 45% and 92%. The department had put in an action plan to improve performance which included discussions about poor performance in handovers, teaching sessions around technique and challenging staff following future audits.

Waste management, including those for contaminated and hazardous waste was in line with national standards.

At the last inspection the decontamination room contained two showers and was being used for storage. There was also no evidence that the showers had been run which increases risk of infection, such as legionnaires disease. During this inspection, we saw the showers had been run and staff told us the water outlets were flushed daily.

**Environment and equipment**

In the emergency department (ED) there was a waiting area for patients waiting to see the triage nurse. This area was visible from the ED reception desk so patients in the ED could be observed as they waited. The adult triage cubicles were within the waiting area so staff were able to view patients every time they came to the door to get the next patient.

The adult ED had two triage rooms where patients were seen before being streamed to either the Urgent Care Centre (UCC) or ‘majors’. The UCC had ten patient bays and one treatment room.

The ED had one main ‘majors’ area for treating patients. In total there were 16 ‘majors’ cubicles, and one treatment room. The ‘majors’ area was where patients were accommodated within the ED who required a bed whilst having monitoring, assessments or investigations. There were nine cubicles located in the ‘minors’ area.

The ED had a designated psychiatric assessment room which was now fully compliant with guidance. At our last inspection in July 2016 we found that the psychiatric assessment room was not safe because both doors opened inwards, which meant that a patient had the potential to barricade themselves into the room. The provider had rectified this and now one door opened outwards, so that staff could always access the room. Doors had viewing panels for observation. The room had appropriate alarms and, furniture and patients could be observed safely. There
were no ligature anchor points. The room had been risk assessed and staff were aware of one small area that was a 'blind spot' to CCTV and had plans to mitigate this. The assessment room and ensuite were visibly clean. The walls of the psychiatric assessment room had been recently decorated with messages of hope to make it a more calming environment from input from service users.

The ED also had an assessment room with subdued lighting which could be used by patient with autism or a learning disability if they wished.

There were eight bays in the resuscitation area, two of which were designated paediatric bays. Each bay had a resuscitation trolley and was checked on a daily basis.

The minors injury area of the department had a dedicated room for maxillofacial injuries, a plaster room and an eye examination room was available. The paediatric emergency department also had a maxillofacial injuries room and plaster room available.

The equipment and facilities in resuscitation were still of a high standard as found at the last inspection. There were two CT scanners available immediately off the resuscitation area which meant there was quick and easy access for patients. There were also access to O-negative blood via a blood bank, staff led blood testing and x-rays.

A five-bedded clinical decision unit (CDU) was adjacent to the major’s department and staffed by the ED. This provided a short stay ward facility for patients awaiting test results or requiring overnight observation.

There was a still a separate reception for paediatric patients. Once patients were booked in they were admitted to the paediatric waiting room. Access was secured. The department had benefit of a well-equipped and child friendly PED. The waiting environment of the department was decorated appropriately. There were sufficient activities for children and young people and this supported a positive experience for the child while waiting to be seen.

The Child Looked after Safeguarding Review (CLAS) had highlighted the glass screen in PED was not child friendly. The department had not changed this but had changed the booking in system so this area was not currently being used.

The paediatric waiting room was visible to nursing staff when they went into the department to collect the next patients. However, similar to the last inspection, the paediatric waiting room was not visible to nursing staff and was reliant on nurses doing 15 minute spot checks. We checked the records for these spot checks and saw the documentation was varied. Checks were not always completed every 15 minutes.

The paediatric area had an eight cubicle emergency room used for treating and monitoring unwell children. This had equipment within it to provide a step-down facility from the resuscitation room in order to keep the facility available for emergencies. Each bay was clean and contained all relevant equipment. There was also a five bedded paediatric CDU.

Staff told us they were able to access equipment required to care for patients and access to computer terminals to allow access to pathology and imaging results for example as well as policies and guidelines.

We checked various pieces of equipment throughout our inspection including electrocardiogram (ECG) and weighing scales and saw they had all been safety checked. Scales had stickers on to say when they had last been calibrated.

We observed spare consumables and other equipment were appropriately stored and labelled. We checked various consumables, such as fluids, and found all of them were in date.
Resuscitation trolleys were available in the emergency department. Trolleys were secured with plastic snap locks so it was clear if someone had accessed the resuscitation equipment. Trolleys were usually checked daily with staff signing to confirm the checks had been made. We reviewed resuscitation trolleys and saw good completion. There were occasions when days had been missed, however this was only a couple times over a three month period.

There were resuscitation grab bags available adults and paediatric emergency departments. We checked bags in the adult paediatric area and found these had been checked. However, the paediatric bag had no evidence that checks were completed. When we asked staff about this we were told this was part of the daily checklist. We reviewed this checklist and did not see a section for paediatric grab bags on there.

At the last inspection we found a number of patients waiting for over four hours on trolley beds who were at risk of developing pressure ulcers. We checked some patients to see if pressure ulcer assessments had been completed and found this was done. We did not see any action plans as a result of the last inspection findings.

We checked 13 sharp bins and found 12 of them were correctly assembled and labelled. However, we found one sharps bin was open which could be a risk if patients or staff put their hand into the bin.

**Assessing and responding to patient risk**

Patients presented to the department either by walking into the reception area or by ambulance via a dedicated ambulance-only entrance. Patients transporting themselves to the department were seen by a triage nurse (triage is the process of determining the priority of patients’ treatments based on the severity of their condition).

In line with NHS Improvement good practice guide on improving patient flow (2017) the department was streaming patients attending at the front door by a trained member of staff to the most appropriate area. Streaming involved taking a brief history and performing basic observations including calculation of early warning scores. At the last inspection, reception staff were streaming patients to either an illness stream or an injury stream. This was no longer the case.

We observed triage of a number of patients and saw a patient triaged within 15 minutes of arriving at the emergency department. Patients were streamed to the appropriate areas of the department and observations were taken. Within triage there was a doctor who was there to assist and support triage nurses if required. For example, to assess patients with more risk, offer guidance and support and prescribe any medications if required.

Children were booked in at reception and had an initial assessment by a registered sick children’s nurse. This was meant to happen within 15 minutes of arriving in the department.

Audit data provided by the trust showed between September 2017 and August 2018 only between 38% and 47% of patients were triaged within the 15 minute standard.

Ambulance patients were taken into a separate entrance called emergency assessment area which had access to resuscitation if required. The ambulance service telephoned the department to alert them of the arrival of a patient needing immediate treatment so a team was waiting for them on arrival.

This area had 24 hours a day, seven-day week medical cover. This meant patients were seen by either a consultant or ST4 (a speciality doctor in training) on arrival in the department which ensure appropriate assessment.
The trust scored about the same as other trusts for all five Emergency Department Survey questions relevant to safety.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
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</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?</td>
<td>7.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>5.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?</td>
<td>6.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q33. In your opinion, how clean was the emergency department?</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)
The median time from arrival to initial assessment was better than the overall England median over the 12 month period from July 2017 to June 2018. In the latest month June 2018 the median time to initial assessment was 11 minutes compared to the England average of 7 minutes.

Ambulance – Time to initial assessment from July 2017 to June 2018 at Barts Health NHS Trust

(Source: NHS Digital - A&E quality indicators)
From June 2018 to June 2018 there was a stable trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Royal London Hospital. We did not see an action plan to address this.

Ambulance: Number of journeys with turnaround times over 30 minutes
A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. From April 2017 to March 2018 Royal London Hospital reported three “black breaches”.

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

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

A tiered adult trauma team response was introduced in March 2015 to ensure appropriate attendance at trauma calls and reduce unnecessary disruption to other clinical activity. The levels ensure patients received multidisciplinary care appropriate to severity of injury.

For stroke patients arriving by London Ambulance Service (LAS) they were screened using the Face Arm Speech Test (FAST) screening tool. If patients screened positive for FAST the EDs resuscitation department was informed via a call and the patient transported to the department. Upon arrival in the department all stroke patients bypassed streaming and were transferred to resus for further assessment.

Where stroke patients self-presented at the department they had a Rule Out Stroke in the Emergency Room (ROSIER) completed by ED staff and moved to resus.

The hospital had a sepsis steering group which met monthly to discuss sepsis and serious infection. There was also a sepsis lead nurse within the department who liaised with the sepsis lead in the trust. The lead nurse was running a sepsis awareness day during our inspection to educate staff.
The department used the National Early Warning Scoring System, and the modified versions for children, neonates.

The ED conducted audits between February 2018 and May 2018 looking at compliance with NEWS assessments during the day and night. Compliance was poor for daytime in February 2018 (73%) and March 2018 (75%) this improved to 100% in May 2018. For night, compliance was similarly poor in February (77%) and March 2018 (70%), but improved to 90% in April and 84% in May.

We reviewed 35 records during the inspection and saw early warning scores had been completed for all patients. The children’s department used an age appropriate paediatric early warning score to assess deterioration and all 23 records we viewed had this completed.

Staff highlighted that violence and aggression against staff by patients was a risk within the department. There were gangs within the local community. If a gang related incident occurred the department had the option of locking down the resuscitation area. The department worked closely with the firearms unit in the local police. All the coordinators in the resuscitation area had training around police, crime and violence and the process required in the event of a penetrating injury.

Clinical staff had round the clock access to the East London NHS Foundation Trust Tower Hamlets mental health liaison service. The mental health liaison service provided assessments of patients aged 16 or over presenting to the Royal London ED with mental health needs and drugs and alcohol needs. The Tower Hamlets mental health liaison service also provided advice, assessment and brief psychological interventions for adults, including older people, on acute inpatient wards at Royal London, Mile End and St Bartholomew’s hospitals.

The mental health service had ED staff arranged psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. ED staff told us they contacted the mental health liaison team when there were concerns that a patient may be at risk of self-harm or suicide.

We read five sets of patient records for patients referred to the mental health liaison team. Three of these patients were at risk of self-harm. These records included a psychosocial assessment of the patient, which explained their current mental health needs and social circumstances. Records included a risk assessment and a management plan to ensure the safety of the patient.

ED staff told us they worked with the mental health liaison team and contracted security staff to ensure the safety of staff and patients. An additional nursing staff member could be arranged to observe a patient when necessary. Staff said they followed a set procedure if a patient went missing from the ED which included a search of the immediate area by security staff.

The mental health liaison team advised ED clinical staff in relation to the safe use of medicines including rapid tranquilisation by injection. Records confirmed that staff followed NICE guidance in relation to the observation of patients after rapid tranquilisation.

The mental health team had a current operational policy, due for review in June 2019. This set out the target times for the team to respond to referrals. For Royal London ED, the target response time was one hour, for assessment units, it was four hours and for the wards, it was 24 hours.

ED staff told us that the mental health liaison team responded to referrals very promptly and care records we looked at confirmed that patients had been seen within the one-hour target time.

The Tower Hamlets mental health liaison service received approximately 300 referrals each month from the Royal London ED.

There were established arrangements for obtaining mental health assessments for patients under the age of 16.
Appropriate arrangements were in place to ensure that children and young people who harm themselves were seen and assessed by Child and Adolescent Mental Health Services (CAMHS) professionals. Children and young people were seen in the department for their presenting medical condition were assessed by a CAMHS clinician.

A pilot was starting in department in November to increase access to a CAMHS worker. This would mean a practitioner is on site Monday to Friday from 10am to 10pm and for six hours on Saturday. This would help ensure children and young people receive specialist care in a timely way.

The trust provided data showing staff compliance with life support training. In the paediatric department 90% of nursing staff had completed paediatric immediate life support (PILS) training. Advanced paediatric life support (APLS) training had been completed by 56% of nursing staff. We asked the trust for data for medical staff but this was not provided.

In the adult department 50% of nursing staff had completed intermediate life support (ILS) training and 25% of adult nurses had completed PILS training. Advanced life support (ALS) had been completed by 50% of nursing staff. We asked the trust for data for medical staff but this was not provided.

**Nurse staffing**

The Royal London Hospital reported the following nurse staffing numbers for urgent care and emergency services in March and April 2018. The hospitals fill rate remained below 90% in March and April 2018.

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<tbody>
<tr>
<td>Urgent Care and Emergency Services</td>
<td>119.1</td>
<td>137.5</td>
<td>87%</td>
<td>123.9</td>
<td>147.5</td>
<td>84%</td>
</tr>
</tbody>
</table>

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

From May 2017 to April 2018 Royal London Hospital reported a vacancy rate of 14.1% for nursing staff in urgent and emergency care services, this was higher than the trust target of 6.3%.

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

From May 2017 to April 2018 Royal London Hospital reported a turnover rate of 30.8% for nursing staff in urgent and emergency care services, this was higher than the trusts target of 13%. Senior leaders told us recruitment and retention was high on their list of priorities.

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

From May 2017 to April 2018 Royal London Hospital reported a sickness rate of 1.7% for nursing and midwifery staff in urgent and emergency care services, this was lower than the trusts target of 3%.
From May 2017 to April 2018 the Royal London Hospital had a total of 7,746 nursing staff shifts in urgent and emergency care. A breakdown of bank and agency usage and unfilled shifts is shown below:

<table>
<thead>
<tr>
<th>Bank and agency</th>
<th>Number of shifts (% of total shifts)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank</td>
<td>2,776 (35.8%)</td>
</tr>
<tr>
<td>Agency</td>
<td>1,395 (18.0%)</td>
</tr>
<tr>
<td>Not filled</td>
<td>1,209 (15.6%)</td>
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Following the inspection, we requested more up to date information regarding nursing vacancy figures. Data showed for band 5 nurses there were 66.69 WTE and 64.62 of posts were filled. For band 6 nurses the department was overestablished and had 18.9 WTE. Band 7 nurses had 13.82 WTE posts and of these 13.54 were in post.

For the paediatric department there were 14.6 WTE band 5 posts and of these 13.9 WTE were in post. For band 6 nurses there were 7.25 WTE posts and of these 5.61 were in post. Band 7 nurses were over established.

During the inspection we found there were appropriate numbers of nursing staff in the department, based on number of staff and skill mix and the types of patients seen in the department. Staff told us the department felt safe.

A nursing handover took part at the start of every shift. This included allocation so that each nurse was aware of the area they were working in. Other key information was shared during the handover including any flow issues, breaches and incidents.

Since the last inspection the department had increased nursing staffing from 14 nurses each shift to 21 nurses per shift. This increase was a result of an increase in demand. Within resuscitation there were one nurse for every two patients and one nurse floating. Within cubicles there were one nurse per four patients, one nurse in the fit to sit area and one nurse coordinator.

The 12-hour nursing shift was split into two blocks of six hours. This meant that nurses did not have to work a full 12-hour shift in resuscitation which could be challenging due to the number of traumas.

During the inspection we asked about nursing vacancies. For the adult emergency department there were 13.2 whole time equivalent (WTE) band seven nurses with two vacancies. For band six nurses the department was over established and had 17.9 WTE. There were 66.69 named nurses with four vacancies.

In paediatric emergency department there were 2.3 WTE band seven nurses with 2.21 in post. For band six there were 7.25 WTE with 5.61 in post and band 5 there were 14.6 WTE with 13.9 in post. In the six months preceding our inspection all shifts in the paediatric department had a paediatric trained nurse on shift and a nurse trained in paediatric life support.

**Medical staffing**
The Royal London Hospital reported the following medical staffing numbers for urgent care and emergency services in March and April 2018. The hospital's fill rate decreased by 8% in April 2018.

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</thead>
<tbody>
<tr>
<td>Urgent Care and Emergency Services</td>
<td>93.7</td>
<td>101.0</td>
<td>93%</td>
<td>88.2</td>
<td>104.7</td>
<td>84%</td>
</tr>
</tbody>
</table>

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

From May 2017 to April 2018, the Royal London Hospital reported a vacancy rate of 7.4% for medical and dental staff in urgent and emergency care services, this was higher than the trust target of 6.3%.

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

From May 2017 to April 2018, the Royal London Hospital reported a turnover rate of 4.6% for medical and dental staff in urgent and emergency care services, this was lower than the trust's target of 13%.

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

From May 2017 to April 2018, the Royal London Hospital reported a sickness rate of 0.2% for medical and dental staff in urgent and emergency care services, this was lower than the trust's target of 3%.

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

From May 2017 to April 2018, the Royal London Hospital had a total of 5,624 medical staff shifts in urgent and emergency care. A breakdown of bank and agency usage and unfilled shifts is shown below:

<table>
<thead>
<tr>
<th>Locum and agency</th>
<th>Number of shifts (% of total shifts)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Locum</td>
<td>3,358 (59.7%)</td>
</tr>
<tr>
<td>Agency</td>
<td>1,253 (22.3%)</td>
</tr>
<tr>
<td>Not filled</td>
<td>295 (5.2%)</td>
</tr>
</tbody>
</table>

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

From March 2018 to March 2018, the proportion of consultant staff reported to be working at the trust was the same as the England average and the proportion of junior (foundation year 1-2) staff was lower.
Staffing skill mix for the 176 whole time equivalent staff working in urgent and emergency care at Barts Health NHS Trust.

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>0%</td>
<td>15%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>48%</td>
<td>33%</td>
</tr>
<tr>
<td>Junior*</td>
<td>22%</td>
<td>23%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

There was consultant cover in the department between 24 hours a day, seven days a week. This met the recommended 16 hours per day cover recommend for A&E departments by the College of Emergency Medicine (CEM).

The department has 27 consultants which equated to 20 WTE. doing the rota. At the last inspection the department had 7.4 WTE consultants in post. The department met the 10-consultant minimum per department as recommended by CEM at the time of our inspection. Out of the 27 consultants three of the consultants were locum.

There were two tiers of middlegrade doctors. Senior middlegrade doctors were ST3 and above and junior middlegrade doctors were staff grade posts. There were 20 WTE middlegrade doctors at ST4 and above. There were also three WTE advanced care practitioners (ACPs).

There were 19 WTE junior doctor posts in the department which were filled by the deanery or covered by locums.

The PED had nine WTE junior doctors, 7 WTE middlesgrades and two type of paediatric consultants. Three WTE paediatric trained who only worked in paediatrics and four WTE who were both paediatric and adult trained. Consultantsw were in the department Monday to Friday 9am till 10pm. After 10pm there was an on-call consultant available.

Between August 2017 and August 2018, the locum fill rate varied between 15% and 40%.

Medical handovers took place at the start and end of each shift where all key information was handed over efficiently and effectively.

Records
Since the last inspection the department had continued to implement its ‘paper-lite’ system, which meant that most parts of the patient records were stored on the computer. This now included electrocardiograms (ECGs) and there were plans for medicines administration to be added in the future.

The department computer system fed into the main hospital system which meant staff on medical assessment units could view the patient notes. We were told with permission community services could also access the patient records.

The department were using SSKIN assessments for patients attending the majors department. SSKIN is a five step model for pressure ulcer prevention. We reviewed two patients records who were at risk of developing pressure ulcers and saw these were appropriately assessed.

We reviewed 35 patient records in the adult emergency department and found completion was good. Recording of pain scores and early warning scores were completed and recorded in all patient notes. We reviewed 23 paediatric patient records and all were completed to a good standard.

We saw risk assessments were appropriately completed in patient records, such as risk of falls and Glasgow Coma Scale (GCS) scores for patients with head injuries or confusion.

Patients discharged directly from the department had a letter sent electronically to local GPs.

**Medicines**

Medicines including those requiring secure storage (controlled drugs) were stored securely and within locked cabinets. We saw controlled drugs (CDs) had daily checks and were dispenced by two nurses as per trust guidance.

However, in cubicles we found one medicines cupboard containing benzodiazepines, codeine, hypnotics and antipsychotics had a faulty key lock and was unlocked. We notified a nurse who locked the cupboard with difficulty and it was unclear whether the lock was reported. A fridge in the resus area was also unlocked due to a faulty lock. All medicines should be secured in order to ensure that there is no unauthorised access of medicines which may cause harm.

Medicines stored in designated fridges and rooms were subject to daily temperature monitoring, recorded appropriately and were within the specified ranges, ensuring that medicines were kept in their optimum conditions for safe use.

We found three instances in the emergency department where duplication of ordering had occurred. We also found there were medicines/items not requiring secure storage stored in the CD cabinets. For example, we found paracetamol for intravenous use and a trial medicine stored in the CD cabinet; in resus, a doppler monitor and ketone meter were stored in the outer CD cabinet. Non CD medicines/items should not be stored in the CD cabinet.

Oxygen cylinders were stored securely and safely. All cylinders were in date and suitably full.

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

**Incidents**

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

From August 2017 to July 2018, the trust reported no incidents classified as never events for urgent and emergency care at the Royal London Hospital.

In accordance with the Serious Incident Framework 2015, the trust reported three serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from August 2017 to July 2018.

The types of incidents reported were:

- Sub-optimal care of the deteriorating patient meeting SI criteria: two incidents
- Apparent/actual/suspected self-inflicted harm meeting SI criteria: one incident

Between September 2017 and August 2016, the department reported 1948 incidents. Of these, 1842 were no harm, 103 low harm, two moderate harm and one was severe harm.

We saw learning points from incidents were available to staff and displayed within the department. This included actions the department needed to take based on the root causes identified from the investigation.

Every serious incident had a completed root causes analysis which included identifying the root causes for the incident, what the department could have done better and any good practice identified. These were shared within the departments training hub room.

Incidents were discussed at weekly departmental clinical governance meetings that were open to all staff. Staff were aware when these meetings were taking place and told us learning from departmental incidents as well as incidents from other departments were mentioned. Staff also received emails to inform them about incidents and changes to practice.

Staff told us they always got feedback following incident reporting which motivated them to report incidents. Staff had a good understanding of the types of incidents they should be reporting including near miss incidents.

Mortality and morbidity (M&M) meetings occurred within the department on a weekly. Cases were appropriately discussed and minutes were disseminated electronically to staff.

The duty of candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. Staff we spoke with had a good knowledge of duty of candour and, senior staff were very clear about their responsibilities in relation to DoC.

**Safety thermometer**

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

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

Data from the Patient Safety Thermometer showed that the trust reported five new pressure ulcers, 32 falls with harm and two new urinary tract infections in patients with a catheter from June 2017 to June 2018 within urgent and emergency care.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Barts Health NHS Trust**

1. **Total pressure ulcers**
   - (5)

2. **Total falls**
   - (32)

3. **Total CUTIs**

Insert commentary on any trends.
1. Pressure ulcers levels 2, 3 and 4
2. Falls with harm levels 3 to 6
3. Catheter acquired urinary tract infection level 3 only

*(Source: NHS Digital - Safety Thermometer)*

There was information displayed in the department advising staff about falls assessments and what steps could be taken to reduce falls.

**Is the service effective?**

**Evidence-based care and treatment**
We looked at various clinical policies and guidelines during the inspection within the emergency department (ED) and on the trust’s internet. We saw policies were based on National Institute of for Health and Care Excellance (NICE) and best practice guidelines.

At the last inspection we found a number of paediatric guidelines were out of date. During this inspection we reviewed 15 sets of clinical guidelines and found that eight out of 15 had not been recently reviewed or were out of date.

Staff showed us how they would access the local guidelines on the trust intranet. Staff told us that clinical guidelines were easily accessible. The department informed staff of updates to guidelines via clinical governance meetings. During the inspection, staff were being given information regarding updates to the sepsis pathway via the sepsis lead nurse.

Staff used a variety of information technology within the department to enhance speed and access to patient care and treatment. This included internal electronic systems and systems used for digital imaging.

The department undertook regular audits. These included national audits requested by the Royal College of Emergency Medicine (RCEM); others were based on NICE guidance such as pain management and hand hygiene.

We saw examples of care pathways completed for patients who had presented with specific conditions such as head injuries and falls. These pathways followed evidence based guidance for management of treatment and conditions. We tracked two cardiac arrests, three trauma and two strokes and saw pathways and guidelines were followed.

Patients who were receiving intravenous fluid (IV) were cared for by healthcare professionals competent in assessing patient fluid and electrolyte needs in line with NICE guidance. IV therapy delivers liquid substances into the vein and can be used for injections or infusions.

Patients were assessed for venous thromboembolism (VTE) and those at risk of VTE were offered appropriate prophylaxis in accordance with NICE guidance. VTE is a condition where a blood clot forms in the vein.

Skin vulnerability assessments were completed on arrival for frail and elderly patients. We looked at patient records and saw that this was completed in line with RCEM guidance.

The Clinical Decision Unit (CDU) was using frailty scoring systems to help identify levels of acuity within the area to ensure safe staffing.

**Nutrition and hydration**

In the CQC Emergency Department Survey, the trust scored 5.5 for the question “Were you able to get suitable food or drinks when you were in the emergency department?” This was worse than other trusts.

Water was available in all areas of the department and we observed patients with drinks at their bedside.

Patients were offered food and drink where appropriate and staff met patient’s nutritional needs.

Since the last inspection the department was not able to offer hot food for patients who spent longer times in the department.

There were vending machines available in the department for snacks and drinks.

**Pain relief**
In the CQC Emergency Department Survey, the trust scored 5.6 for the question “How many minutes after you requested pain relief medication did it take before you got it?” This was the same as other trusts.

The trust scored 7.4 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was the same as other trusts.

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

The department used a range of pain scoring tools including scales (where patients rated their pain on a scale of 1-10), the use of faces and pictorial pain guides and the use of the Face, Legs, Activity, Cry and Consolability (FLACC) pain scale. The paediatric emergency department still used the Wong-Baker smiley face pain rating tool, an age appropriate tool, to record children’s pain levels.

Patients we spoke with told us they had been asked about pain and offered pain relief if required. We observed staff asking patients if they were in any pain.

At the last inspection we found pain scores were not always recorded. We reviewed 58 patient records and found good completion of pain scores.

The department had introduced penthogx pain relief into the department which helped give patients in severe pain access to pain relief in a timely way.

Patient outcomes

In the 2016/17 Royal College of Emergency Medicine (RCEM) Moderate and acute severe asthma audit, Royal London Hospital emergency department failed to meet three of the national standards.

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

- Standard 3 (fundamental): High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the emergency department. This department: 44%; UK: 25%.
- Standard 9 (fundamental): Discharged patients should have oral prednisolone prescribed as follows: Adults 16 years and over: 40-50mg prednisolone for five days, Children six to 15 years: 30-40mg prednisolone for three days and Children two to five years: 20mg prednisolone for three days.

This department was 80% and the UK was 52%.

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

- Standard 4 (fundamental): Add nebulised Ipratropium Bromide if there is a poor response to nebulised β2 agonist bronchodilator therapy. This department: 24.2%; UK: 77%.
- Standard 5a (fundamental): within 60 minutes of arrival (acute severe). This department: 0%; UK: 19%.
- Standard 5b (fundamental): within 4 hours (moderate). This department: 0%; UK: 28%.

The department’s results for the remaining two standards were between the upper and lower UK
quartiles.

- Standard 1a (fundamental): O2 should be given on arrival to maintain sats 94-98%. This department: 19%; UK: 19%.
- Standard 2a (fundamental): As per RCEM standards, vital signs should be measured and recorded on arrival at the emergency department. This department: 30%; UK: 26%.

In the 2016/17 Consultant sign-off audit, Royal London Hospital emergency department failed to meet three of the national standards.

The department’s results for one standard which was in the upper UK quartiles

- Standard 2 (developmental): Consultant reviewed: fever in children under 1 year of age. This department: 33.3%; UK: 8%.

The department’s results for two standards which were in the lower UK quartiles.

- Standard 1 (developmental): Consultant reviewed: atraumatic chest pain in patients aged 30 years and over. This department: 4%; England: 11%.
- Standard 4 (developmental): Consultant reviewed: abdominal pain in patients aged 70 years and over. This department: 0%; UK: 10%.

The department’s results for one standard which was between the upper and lower UK quartiles.

- Standard 3 (fundamental): Consultant reviewed: patients making an unscheduled return to the emergency department with the same condition within 72 hours of discharge. This department: 12.5%; UK: 12%.

In the 2016/17 Severe sepsis and septic shock audit, The Royal London Hospital emergency department failed to meet one of the national standards.

The department’s results for all eight standards were all between the upper and lower UK quartiles.

List of standards in this audit that are agreed for inclusion in inspection reports:

- Standard 1: Respiratory rate, oxygen saturations (SaO2), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival. This department: 67%; UK: 69.1%.
- Standard 2: Review by a senior (ST4+ or equivalent) emergency department medic or involvement of critical care medic (including the outreach team or equivalent) before leaving the emergency department. This department: 74.3%; UK: 64.6%.
• Standard 3: O2 was initiated to maintain SaO2>94% (unless there is a documented reason not to) within one hour of arrival. This department: 25.3%; UK: 30.4%.

• Standard 4: Serum lactate measured within one hour of arrival. This department: 65.1%; UK: 60%

• Standard 5: Blood cultures obtained within one hour of arrival. This department: 51.9%; UK: 44.9%.

• Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given within one hour of arrival. This department: 52.3%; UK: 43.2%.

• Standard 7: Antibiotics administered: Within one hour of arrival. This department: 55.6%; UK: 44.4%.

• Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival. This department: 20%; UK: 18.4%.

From July 2017 to June 2018 the trust’s unplanned re-attendance rate to A&E within seven days was worse than the national standard of 5% and worse than the England average. In the latest month June 2018, trust performance was 9.3% compared to an England average of 7.9%.

**Unplanned re-attendance rate within seven days - Barts Health NHS Trust**

![Graph showing unplanned re-attendance rate]

(Source: National Episode Statistics)

The trust provided site specific data for unplanned re-attendance. This showed between September 2017 and August 2018 the unplanned re-attendance for the trust varied between 1.58% and 2.15%.

The trust was part of the Trauma Audit and Research Network (TARN). The trust reported that there was an awareness that data submission to TARN was incomplete leading to lower predicted mortalities for a cohort of seriously injured patients. The trust had undertaken a clinical review which determined there were a number of issues with the quality of TARN data. This led to the development of a workstream around the data quality of the trauma patient data. The clinical
trauma team had worked in collaboration with TARN to understand and correct the issue, including a review and re-calculation of the existing patient cohort. The amended risk adjustment showed an improved overall performance level for the team in the TARN audit. The TARN lead informed us that the target was to not be a negative outlier by the end of the financial year.

The team discussed audit performance during clinical governance days. Within the education hub was information for staff on what changes needed to be made in order to improve performance on national audits.

**Competent staff**

The department had a practice development nurse (PDN) who supported education within the emergency department. PDNs also supported new nurses within the department. We saw a competency pack for new nurses that they were required to complete to be signed off to work in specific areas of the department, such as the resuscitation room.

All new doctors were provided with an induction handbook prior to started working in the department. The handbook provided them with a range of information including rotas and information about working in the department.

All trauma team member leaders were trained in trauma team leader training and had a local induction.

The induction process for new nurses in the department consisted of a supernumerary period whilst competencies were signed off. Staff told us they were able to ask senior colleagues for advice and support.

There was an induction process in place for agency nurses who were new to the department. On arrival they were given a tour of the department and completed an local induction document before starting the shift.

From April 2017 to March 2018, 189 members of medical and dental staff were eligible to receive an appraisal, they achieved a 93% completion rate against a trust target of 90% (175 members of staff received an appraisal). We requested a breakdown of appraisals rates for medical staff. Information provided by the trust showed non-consultant appraisal rates were 89% and consultant appraisal rates were 71%.

The Royal London Hospital has not provided a core service breakdown for non-medical staff therefore we are unable to provide any completion rates.

The department education hub was still being used as a dedicated teaching and handover room. The room displayed recent initiatives and results from audits for staff to view. The room was also used for daily handovers so every staff member had the opportunity to review the information before starting their shifts.

All staff we spoke with said there was excellent access to teaching and education within the department.

Doctors told us of the excellent learning culture and training that was available on a weekly basis. Training included simulation training.

**Multidisciplinary working**

A psychiatric liaison team consisting of a team manager psychiatric liaison nurses and medical staff attended the department when requested if patients needed a mental health assessment or support. Paediatric mental health support was provided by the child and adolescent mental health services (CAMHS) team from the local mental health trust.
Barts Health Trust staff worked with East London Foundation NHS trust and with other agencies on the recent Tower Hamlets frequent attenders project. This aimed to first, liaise across disciplines and agencies to better address the unmet psychosocial needs of vulnerable individuals who were frequently attending the Royal London ED, with very frequent attenders prioritised. Secondly, the project aimed to reduce unnecessary attendances as part of an effort to reduce strain on ED, thereby improving patient care and safety. Results of the project were reported as 64 people receiving a full multidisciplinary team intervention and for these people, overall, attendances reduced by approximately 64% (compared with the NHSE target of 20%). There was a significant reduction in ED attendances and bed days. Number of admissions did not increase as ED attendances reduced.

Similar to the last inspection, we saw good examples of internal multidisciplinary team work, including specialists such as neurology visiting the emergency department.

There was still a drug and alcohol referral team available within the department for referrals Monday to Friday and an out of hours bleep system.

Youth workers were available within the department as part of a youth violence intervention programme.

The department still had an information sharing protocol with the metropolitan police in order to provide information about locations where violent crime occurred. This information meant the police could review their patrols in order to reduce violent crime.

The trauma centre provided trauma care for North East London and Essex. The department provided care for patients from London Air Ambulance.

The department still worked with the London Air Ambulance Service to support pre-hospital care. The department had doctors within it that undertook shifts on the London Helicopter Emergency Service (HEMS) that was based at the hospital. Additionally, doctors from the department could undertake observation shifts with the Physician Support Unit (PRU) that provided advanced medical support outside the hospital within Tower Hamlets and the City.

A specialist team were bleeped when a stroke patient within the time frame for treatment was expected to arrive at the department. The stroke team consisted of a range of professionals including medical staffing, nursing, radiographers and a site manager. The team met and assessed the patient within the resuscitation room on their arrival.

The HEMS service ran bi-weekly clinical governance meetings to discuss cases. PRU meetings were held on a bi-weekly basis and included discussion frequent attenders and cases within the community.

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

**Seven-day services**

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

There was an ST4 doctor available 24 hour a day, seven days a week. Consultants were physically available 24 hours a day, seven days a week.

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

There was access dedicated access to two computerised tomography (CT) scanners and X-ray facilities 24 hours a day. Radiology worked out of this space during evenings and weekends.
Blood products were available within the resuscitation room which meant there was direct access to 24 hours a day patient who required intervention.

Health promotion
There were a range of information available leaflets available for patients in the department. For example, the paediatric emergency department had information about a number of conditions including wheeze management and chickenpox. There was also information displayed in the waiting room regarding sepsis and what signs to look out for.

There was information available about stress and how to reduce stress. Also, information on the importance of physical activity.

There was information available advising patients what to do if they had any issues related to alcohol and how to cut down.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards
Most staff demonstrated a good knowledge of the principles of informed and implied consent as well as the Mental Capacity Act (2005) in relation to patients with dementia.

Staff could explain about deprivation of liberty safeguards (DoLS) of patients. They did say that DoLS was usually completed on the ward and was not common practice in the ED.

Staff recorded capacity assessments and best interest’s decisions in patient’s clinical records. A Mental Capacity checklist was available to support staff in conducting this. However, we were unable to review examples of capacity assessments during our inspection and staff had difficulties identifying patients who had a capacity assessment.

We saw the trust policy and consent form included reference to “Gillick competence”. This is when it is appropriate for consent to be obtained from a child under the age of 16 without the knowledge or authority of the parent.

ED staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.

The ED staff we spoke with understood their responsibilities in relation to patients who lacked the mental capacity to make decisions about their care and treatment and the key principles of the Mental Capacity Act 2005. They understood their duty to act in the patient’s best interests. The five care and treatment records we reviewed included mental capacity assessments of the patient in relation to decisions about care and treatment.

Is the service caring?

Compassionate care
All the patients we spoke with were extremely positive about the care and treatment they received in the emergency department from the staff. Patients said things like: “They have been good”, “The care here is good”, “They listen to me and explain things”.

We observed staff chatting with patients and asking them questions about their interests. Patients told us staff made them feel comfortable.

ED staff we spoke with showed understanding and a non-judgmental attitude when talking about patients with mental health needs, learning disabilities, autism or dementia.
We observed staff maintaining patients’ privacy and dignity at all times by keeping them covered and drawing curtains during examinations and procedures. We observed all nurses asking for permission to enter patient bed areas when the curtains were closed.

Staff supported patients who became distressed in an open environment, and helped them maintain their privacy and dignity. ED staff and the mental health liaison team had worked with patients to improve the environment for patients with special needs. For example, as a response to patient feedback signage was being improved. There had also been improvements to patient assessment rooms in the ED to make them more patient friendly.

We observed several interactions between patients and staff and saw staff speaking to patients in a kind and reassuring manner. Staff spent time to listen to what patients had to say.

All staff we observed treated patients in a compassionate and courteous manner.

We observed medical staff interacting appropriately with patients. Staff took extra time to explain care and treatment options and answered any questions the patients had.

In the paediatric emergency department, we observed staff taking extra time to engage with children and young people during procedures. Staff used methods to distract patients during painful procedures such as cannula removals. There was also a play specialist available who used distraction techniques with children during painful procedures.

The trust’s urgent and emergency care Friends and Family Test performance (% recommended) was generally better than the England average for the first four months of the reporting period, however from December 2017 to July 2018 trust performance was worse than the England average.

*There is no data available for November 2017.

A&E Friends and Family Test performance - Barts Health NHS Trust

(Source: NHS England Friends and Family Test)

Emotional support
Following challenging trauma calls and major incidents in London the trust had offered staff the opportunity to attend debriefing sessions. Staff were also offered counselling to support them.

There was a bereavement service information leaflet available for when a patient passed away. The information leaflet provided information on what to do following a death. This included information on how to access the bereavement team and how to register the death. The leaflet also provided information on a range of support services for people to access if needed.

There was also a bereavement cupboard which had a variety of information leaflets available for different situations. There were also bereavement boxes for relatives.

There was a multi-faith chaplaincy service available in the hospital which provided a multi-faith service for patients and their families.

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

We observed doctors and nurses offering patients and relatives the opportunity to ask questions and to clarify anything they were unsure of.

Patients and relatives told us staff would always explain things in a language they could understand.

Patients told us they were always kept informed of the treatment plans and staff explained any test they were due to have. Patients said staff have offered to chaperone them to have scans and x-rays.

The trust scored about the same as other trusts for 22 out of the 24 Emergency Department Survey questions relevant to the caring domain. The trust scored worse than other trusts for the remaining two questions.

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you told how long you would have to wait to be examined?</td>
<td>3.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>7.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses examine and treating you?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q17. Did doctors or nurses talk to each other about you as if you weren't there?</td>
<td>8.4</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>7.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the emergency department?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>7.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</td>
<td>7.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?</td>
<td>6.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q26. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q27. Before you left the emergency department, did you get the results of your tests?</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q28. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?</td>
<td>9.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q39. Did a member of staff tell you about medication side effects to watch out for?</td>
<td>5.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you when you could resume your usual</td>
<td>5.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>activities, such as when to go back to work or drive a car?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q41. Did hospital staff take your family or home situation into account</td>
<td>4.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>when you were leaving the emergency department?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q42. Did a member of staff tell you about what danger signals regarding</td>
<td>5.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>your illness or treatment to watch for after you went home?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q43. Did hospital staff tell you who to contact if you were worried</td>
<td>6.0</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>about your condition or treatment after you left the emergency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>department?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q45. Overall... (please circle a number)</td>
<td>7.7</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

**Is the service responsive?**

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

The department still provided 24 hour a day accident and emergency services for children and adults in the local boroughs of Tower Hamlets, Waltham Forest and Newham. Additionally, they provided services for patients who suffered stroke or major trauma across neighbouring London boroughs and counties outside London.

The emergency department services a local population of homeless people. We spoke with nursing staff about provisions in place when homeless people attended the department. The department had information leaflets available for homeless people which gave information about local support services including shelter.

The service held meetings to discuss frequent attenders which enabled them to put a care management plan in place. This meant when a frequent attender visited the emergency department staff could access a care plan on the patients records and ensure they were treated appropriately. The Physician Response Unit (PRU) also worked with frequent attenders and could visit them out in the community to prevent attendances at the department.
There was a display screen within the assessment area of the department which displayed up to date waiting time information. There were plans for these screens to be added to other areas in the department including the waiting room.

We found there was adequate space and seating in the departments waiting areas.

There were violence and aggression link nurses within the department who helped lead on the reducing violence and aggression initiative. Due to the local gang culture the department worked corroborative with the police and other services around gangs and violence and aggression.

**Meeting people’s individual needs**

The trust was about the same as other trusts for all three Emergency Department Survey questions relevant to the responsive domain.

<table>
<thead>
<tr>
<th>Question – Responsive</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency department last?</td>
<td>6.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

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

The service had arrangements, known to all staff on duty, to meet patients’ urgent or emergency mental health care needs at all times, including outside office hours and in an emergency. The service ensured ED staff were made aware of the mental health service operational policy at induction and how to refer patients.

Staff and the care systems they followed helped to provide good care to patients in need of additional support. ED staff made early referrals to the mental health liaison team or the learning disability lead nurse for advice and support. From care records, it was clear that staff also spoke with the patient’s family to clarify their needs. Care and treatment plans showed that staff had considered the psychosocial needs of the patient.

Appropriate discharge arrangements were used for people with complex health and social care needs. Where patients were returning home their follow up needs were addressed. Staff communicated with the patient, their family, the GP and other agencies as necessary. Patients received written information about this in a leaflet. In the case of patients transferring to another health setting such as an inpatient mental health ward staff ensured that the receiving ward received appropriate information.

The hospital had a Paediatric Liaison Team (PLT) who were from a local Mental Health Trust. They were an in-house mental health team who provided all psychiatric and psychological support and liaison to the children and young people admitted and seen in children's outpatients. The PLT did not see any children or young people who presented with self-harm. For patients who presented with self-harm there was access to community CAMHS colleagues who would attend
the paediatric ED and the ward areas to assess all children and young people who present with self-harm. The PLT were a 9am to 5pm service and the community CAMHS duty worker for the self-harm patients covered 9am till 4pm in hours for assessments. There was also 24 seven CAMHS cover both a specialist registrar (SpR) and Consultant.

Children and young people who presented to paediatric ED out of hours were assessed by RAID (adult mental health team). RAID discussed the patient with the on call duty Psychiatric SpR through switchboard based at Great Ormond Street hospital. These patients were generally admitted to a paediatric ward as per NICE guidelines to be formally assessed by CAMHS the following morning.

The hospital has a site based dementia and delirium (DaD) teams with at least one dementia clinical nurse specialist (CNS). The DaD teams see patients on a referral basis and are contacted by all disciplines or relatives for specialist nursing advice, treatment plans and complex care needs. Referrals are responded to within 24 hours.

All patients who attend the department and have learning disabilities are flagged on the electronic system. There was access to a learning disability nurse within the hospital. Hospital passports were also in use which patients kept with them through their journeys and involved input from carers.

There was an enhanced care area within adult emergency department. This area was used for patients with dementia or learning disabilities. It provided a calm space with soft lighting and sensory lights.

There were pictorial guides available in the department for use with patients with communication issues or learning disabilities. This allowed staff to be able to ask questions about pain, food and drink. There were also pictorial guides where patients could point to different parts of the body to identify any concerns.

The department still had access to an alcohol liaison nurse 9am to 5pm Monday to Friday. Outside these hours staff could request for an appointment via a bleep service.

When patients were severely blind or deaf then the department made reasonable adjustments to individual care and treatment plans to accommodate the specific needs of each patient. For example, the use of communication aids such as pictorial guides. Staff could access specialist teams such as the Bilingual Health Advocacy and Interpreting Service (BHAIS) for users of sign language.

The department still had access to interpreting and translation services for those who did not speak English. This included face-to-face, British Sign Language (BSL), telephone interpreting and translation services. There were language books within the department so patients could point to which language was theirs and staff had access to common quotes.

There was a play specialist available within the department. They could help with a variety of things such as distraction techniques for children undergoing painful procedures. There were also virtual reality headsets which could be used as a means of distraction.

There were a range of toys, games, books and DVDS for children and young people available in the paediatric emergency department.

The department still used a ‘Code Red’ system. This was an indication to staff to expect a patient with excessive blood loss. There was also a ‘Code Black’ system which indicated a head trauma was on the way. The department had in place a ‘Code Red’ system to indicate to staff that a patient with excessive blood loss was to be expected. A similar ‘Code Black’ system had
previously been developed by the department and introduced to indicate that a patient with head trauma was to be expected.

As we found at our last inspection, the signs in the department were all in English and no other languages. We did not see the department had put in anything to address this.

**Access and flow**

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust did not meet the standard for five months over the 12-month period from July 2017 to June 2018.

From July 2017 to June 2018 the trust's performance generally followed the national trend although in December 2017 the median time to treatment was 55 minutes compared to the England average of 62 minutes.

**Median time from arrival to treatment from July 2017 to June 2018 at Barts Health NHS Trust**

![Graph showing median time from arrival to treatment from July 2017 to June 2018 at Barts Health NHS Trust](Image)

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

The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department. From August 2017 to July 2018 the trust failed to meet the standard and performed worse than the England average.

**Four-hour target performance - Barts Health NHS Trust**

![Graph showing four-hour target performance at Barts Health NHS Trust](Image)
We requested this data at a site-specific level for the Royal London emergency department. Between September 2017 and September 2018, performance against the four hour wait target varied between 80% and 87%.

From August 2017 to July 2018 the trust’s monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was generally worse than the England average.

Percentage of patients waiting more than four hours from the decision to admit until being admitted - Barts Health NHS Trust

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

At a site-specific level between September 2018 and August 2018, patients waiting between four and 12 hours varied between 13% and 20%.

Over the 12 months from August 2017 to July 2018, one patients waited more than 12 hours from
the decision to admit until being admitted. The highest numbers of patients waiting over 12 hours were in March 2018 (1,759), January 2018 (1,721) and October 2017 (1,645).

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients waiting more than four hours to admission</th>
<th>Number of patients waiting more than 12 hours to admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aug-17</td>
<td>1,056</td>
<td>0</td>
</tr>
<tr>
<td>Sep-17</td>
<td>1,191</td>
<td>0</td>
</tr>
<tr>
<td>Oct-17</td>
<td>1,645</td>
<td>0</td>
</tr>
<tr>
<td>Nov-17</td>
<td>1,484</td>
<td>0</td>
</tr>
<tr>
<td>Dec-17</td>
<td>1,570</td>
<td>0</td>
</tr>
<tr>
<td>Jan-18</td>
<td>1,721</td>
<td>0</td>
</tr>
<tr>
<td>Feb-18</td>
<td>1,351</td>
<td>1</td>
</tr>
<tr>
<td>Mar-18</td>
<td>1,759</td>
<td>0</td>
</tr>
<tr>
<td>Apr-18</td>
<td>1,227</td>
<td>0</td>
</tr>
<tr>
<td>May-18</td>
<td>1,217</td>
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<tr>
<td>Jun-18</td>
<td>828</td>
<td>0</td>
</tr>
<tr>
<td>Jul-18</td>
<td>499</td>
<td>0</td>
</tr>
</tbody>
</table>

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

At a site-specific level there were no patients who waited for longer than 12 hours between September 2017 and August 2018.

From July 2017 to June 2018 the monthly percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment was similar to the England average. In the latest month June 2018, the percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment was 2.5%, compared to the England average which was 2.4%.

**Percentage of patient that left the trust’s urgent and emergency care services without being seen - Barts Health NHS Trust**

(Source: NHS Digital - A&E quality indicator)
At a site-specific level, the number of patients who left the department before being seen between September 2018 and August 2018 varied between 0% and 3.53%.

From August 2017 to July 2018, the trust’s monthly median total time in A&E for all patients was higher than the England average. In the latest month June 2018, the trust’s monthly median total time in A&E for all patients was 187 minutes compared to the England average of 148 minutes.

**Median total time in A&E per patient - Barts Health NHS Trust**

![Graph showing median total time in A&E per patient]

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

Senior leaders told us flow and demand was one of the departments biggest risks. There were three bed meetings every day to discuss flow within the hospital. There had also been a meeting to discuss different ways the hospital could improve flow through the emergency department.

The department had navigators whose role was to redivert patients from the emergency department to GPs, dentists and other healthcare providers. The purpose of this was to decrease attendances in the department and improve flow.

The department had recently opened an ambulatory care area to improve flow within the department. This allowed patients who needed further testing or results to sit and wait in a separate area rather than within the emergency department. Patients could also leave the department and return to have further appointments to get results. This helped the department avoid breaching on patients who were required to be there for longer than four hours. Some staff raised concerns that patients were sent to ambulatory care too early to avoid a four hour breach.

There was also an area still being used for patients who were able to sit in a chair and were able to walk but required enhanced assessment. This was open between midday to midnight seven days a week and reduced the number of patients needing a cubicle.

There was an escalation procedure with local health and social care agencies in relation to resolving delayed discharges. Patients who had mental health needs but were medically fit often had considerable waits of several hours in ED before discharge. The mental health liaison team
had analysed the reasons for these delays which included delays in the completion of Mental Health Act, delays in accessing an in-patient mental health bed, particularly if the patient was from another area and delays in transporting the patient to a mental health ward.

**Learning from complaints and concerns**

From April 2017 to March 2018 there were 56 complaints about urgent and emergency services at the Royal London Hospital. The trust took an average of 51 days to investigate and close complaints, this is in line with their complaints policy, which states complaints should be completed between 10-60 days.

The top three wards with the most complaints were:

- A&E minors: 31 complaints
- Emergency assessment: seven complaints
- Initial assessment: five complaints

33 complaints related to diagnosis/treatment which involved poor care and communication from staff.

From April 2017 to March 2018 there were 39 compliments given to Barts Health NHS Trust. Specific site or core service breakdown was not available.

Complaints could be made in a number of ways including through the Patient Advice and Liaison Service (PALS), via a formal written process through the Chief Executive (CEO) and directly to staff. When complaints were made directly to staff the team tried to resolve these issues directly so a formal complaint was not required.

We saw PALS leaflets throughout the department informing patients how to make a complaint if required.

**Is the service well-led?**

**Leadership**

The department still had a site based management team. However, since the last inspection the department now had a matron in post who along with the clinical lead and general manager, led the department.

Similar to the last inspection, consultants and other senior staff members had a visible presence within the department. The trust had a strong focus on improvement of management processes and a leadership approach that was highly visible and inclusive.

During our inspection we noticed senior staff were visible on the wards and knew ward staff by name across the service. Staff across the emergency department spoke positively about the senior leaders, praising their supportive attitudes and open approach to management. We were told they were readily available and approachable.

The nursing and medical clinical leadership teams worked collaboratively to plan and deliver a safe and responsive service. We saw good evidence of communication and a good relationship between the teams was evident.
The majority of staff reported feeling valued and felt the management team cared for their well-being. A couple of staff said the department could feel tense during busier periods or when agency staff were used.

**Vision and strategy**

The trust vision statement was ‘to be a high performing group of NHS hospitals, renowned for excellence and innovation and providing safe and compassionate care to our patients in east London and beyond’.

The trust had a clear vision and strategy and delivery of this was underpinned by the six values which were; Welcome, Engaging, Collaborative, Accountable, Respectful, Equitable: We Care.

Senior leaders told us staff were expected to work towards these values every day. Staff were aware of the trust values and understood their roles in ensuring these values underpinned their work on a daily basis.

Due to the new local railway service the department anticipated an increase in demand and pressures in the near future. As a result senior leaders told us they wanted to grow the number of consultants present in the department. The overall target was to have 10 new Whole Time Equivalent (WTE) in post. There was also work going on with key stakeholders to prepare for this.

Senior leaders told us there were plans to continue to redesign the front door to the emergency department. Plans were to increase the capacity and increase streaming areas. However, these were currently plans and we were not assured about delivery times. There were plans to have a primary care/urgent treatment centre built within the hospital which would have an impact on the departments capacity. However, the urgent treatment centre plans were still under discussion.

There were plans to improve streaming within the paediatric department. For the short term there has been a redesign since the last inspection of the paediatric entrance and access.

The department had recently opened an ambulatory care area which was jointly run between the emergency department and other specialities within the hospital. The model was still in the process of being developed. Senior leaders said the plans were for this area to improve flow within the department and offer an area for patients who required longer than four hours within the department to be seated and treated. It also allowed patients who might need a review from another speciality to go home and come back for an appointment rather than wait in the department.

**Culture**

Staff described a ‘no blame’ culture and told us they were encouraged to report clinical incidents. There was a proactive culture in learning from incidents and sharing information and staff were able to identify changes as a result of incidents.

Staff reported a positive culture and were enthusiastic about the care and services they provided for patients.

Staff we spoke with were aware of the trust whistleblowing policy and said they would raise any concerns.

**Governance**

The emergency department was part of the Emergency Care and Trauma Division within the trust. We reviewed minutes from the performance review meeting in May 2018. The divisional review meeting had a standardised agenda which included quality, finance, operational performance workforce and any other departmental issues. These meetings were held on a monthly basis.
There were daily meetings to discuss incidents which fed into a weekly meeting. The weekly clinical governance meeting took place to discuss serious incidents and other departmental issues. At this meeting the team looked for any trends from incidents in the department. There was a band 7 nurse on management days everyday who attended this meeting. This allowed them the opportunity to learn about governance. For example, serious incidents processes and the risk register.

The clinical governance meeting fed into the weekly divisional meeting. There was also a monthly clinical governance meeting where items such as national audits, evidenced based guidelines and complaints were discussed. During this meeting the education hub was split into stations, with each station covering a different topic. Staff would work their way around the room and discuss each area. During the inspection, we saw things such as pain management, national audit performance and serious incidents had been discussed.

Any issues were escalated to the site wide quality, safety and improvement meeting which was held on a monthly basis. This then fed into the trust board meeting if required.

Since the last inspection the departments clinical governance arrangements had been fully embedded.

The trust had a Service Level Agreement with East London Foundation NHS Trust for mental health liaison and Mental Health Act management.

There were monthly meetings involving ED managers and the mental health liaison team to look at security issues, clinical governance issues and the clinical pathways for patients.

Management of risk, issues and performance

Every day an admin consultant and admin nurse had a meeting to review and discuss clinical incidents. This included opening investigations if required and closing incidents down.

The weekly meetings gave the team the opportunity to identify any trends occurring within the department. For example, the department picked up on an increase in medicines related incidents. As a result of this they did some work with the pharmacist to review incidents and educate staff.

The department held clinical governance mortality and morbidity (M&M) meetings for the trauma service. The team discussed any performance improvement areas and identified ways to improve and refine trauma care. For example, the M&M process had led to change in the ED check out process for patients leaving resus, and blunt thoracotomy management and practice had been updated and amended.

The risk register was reviewed during clinical governance and divisional meetings and mitigations put in place. The department risk register reflected the risks we found. Senior leaders identified the top risk in the department to be demand. To improve this, the department had opened an ambulatory care area and held regular bed management meetings to discuss flow within the hospital. The department also forecast an increased footprint due to the opening of the new train line in the local area. This would potentially put additional pressures on the department. The trust were working with key stakeholders to think of ways to prepare for this and maintain flow and safety within the hospital.

Another top risk was violence and aggression towards staff within the emergency department. The trust had increased the number of security staff to improve staff safety. The department had also implemented a violence reduction initiative. There were monthly meetings to discuss and review all incidents of violence and aggression within the department. The department had invited external visitors to discuss ways of reducing violence and aggression. For example, a guest from
Transport for London (TFL) had discussed their work around the impact of providing updates on a regular basis on violence and aggression. As a result, the department was improving its information sharing for patients in the waiting rooms. Such as introducing screens which displayed news updates and waiting time updates.

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

The departments had received a letter from the Trauma Audit and Research Network (TARN) because they were a negative outlier for mortality performance. As a result the department conducted an in-depth review of their TARN data with the help of TARN. The department looked back at cases from 2015 and set up a committee with the trusts mortality lead to meet on a monthly basis to review TARN data. Some issues were identified with the data collection and submission process. When these were rectified the probability of survival score improved. The TARN lead for the department told us that staffing was also an issue. For the number of trauma cases the department received they did not have enough staff working on TARN submissions and a lack of senior clinical oversight before the data was submitted. The department had put a business case forward to improve staffing levels. The department had also changed the scoring system for mortality reviews to bring it in line with the NCEPOD scoring system. The departments’ aim was to stop being an outlier for mortality over the next three quarters of the year.

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

Sepsis awareness was being promoted throughout the department. During the inspection there was a sepsis awareness day run by one of the sisters who was the sepsis lead for the emergency department. This day included updating staff on changes to the sepsis pathway and competency training for taking blood cultures. There was a sepsis board game for staff to discuss cases of sepsis. The department had also had a guest from the ‘Listening Project’ to discuss their experience of sepsis.

**Information management**

The department was able to monitor performance of accident and emergency and performance against the four-hour target on a daily basis. This information was shared during bed management meetings each day. Any breaches were escalated by the nurse in charge to the site manager. The emergency department was part of the divisional meeting which fed into the trusts board. Key quality indicators such as four-hour waits were discussed here and any concerns in the department were escalated to the trust.

Prior to our inspection, the trust IT system had been victim of a cyberware attack. Since then the computers are all now remote which means they were more secure.

Some staff highlighted issues with the number of computers available within the department. We were told at times doctors left the department without documenting treatment plans due to long waits for computers.

In each area of the emergency department there were journey through emergency department boards. This provided patients with information about the patient journey.

**Engagement**

There was a ‘you said, we did’ board in the main emergency department which gave feedback on what the department was doing about complaints. However, this only displayed one issue which
was waiting times. The paediatric ‘you said, we did’ board had no information displayed regarding changes as a result of feedback.

We did not see any information about audits such as hand hygiene and infection control displayed in patient waiting areas.

The department encouraged excellence reporting and used an online form to complete this. The purpose of excellence reporting was to encourage staff to report good practice from the department and boost morale.

There were no monthly newsletters for staff, however the matron told us they sent regular updates and had ‘Matron Mondays’ every week. Staff were also invited to weekly clinical governance meetings to get updates about the department. In the education hub there were also updates about learning from incidents, audits and other departmental issues.

The department had service users from the ‘listening project’ provide information to staff about their experience in the department so they could learn from it. The department also encouraged patients and relatives to complete the friends and family test.

The department had also utilised a staff well-being survey to identify areas for improvement. One example, was feedback regarding violence and aggression within the department. As a result changes had been made to improve staff safety including increased security presence.

There were recognition awards for staff including the hero’s award which staff could win for good work. The ‘Hero of the Month’ award winner was posted on social media.

**Learning, continuous improvement and innovation**

The department had introduced pentorex for pain management. This initiative meant that patients in severe pain could access a strong pain relief straight away whilst waiting for prescriptions of morphine.

The department had introduced virtual reality headsets in the paediatric emergency department which could be used to distract children during painful procedures.

The department had recruited educational fellows and a consultant who focused on medical education. The department wanted to bring education to the shop floor rather than the classroom. Within the main emergency department an ‘education station’ had been added. This meant education could run alongside real life clinical cases as it was happening.

The department had undergone a health and wellbeing review following some difficult trauma cases and major incidents. Senior leaders told us as a result of this they were planning to create a quiet space for staff to access. There was also a ‘Silent Sunday’ session with meditation for staff.

The physician support unit (PRU) had developed further since the last inspection. PRU consultants reviewed frequent attender cases. PRU staff would visit frequent attenders in the community to prevent them from attending the emergency department.

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Medical care (including older people’s care)

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Facts and data about this service
Medical care services at the Royal London Hospital include acute, specialist and general medical services within two divisions. Specialist Medicine Division services are delivered across mixed and dedicated inpatient wards. There are five wards, including a 26-bed renal ward, a 26-bed cardiac and respiratory ward, a 22-bed HIV, infectious diseases and respiratory ward, a 26-bed ward specialising in diabetes, endocrine and metabolic diseases and a 26-bed ward for gastroenterology and hepatology. Within the division is the endoscopy unit as well as HIV and sexual health services, dermatology and rheumatology services, provided on an outpatient basis.

The division of emergency care and trauma’s medical services are provided across the four medical specialties of acute medicine (a 52-bed acute medical admissions ward), Stroke Medicine (26-bed ward, with 12 of these beds designated as hyper-acute stroke unit (HASU) monitored & funded beds), Older peoples medicine (two 26-bed wards) and neurology medicine (this includes a large outpatient neurophysiology unit / sleep centre study centre and an outpatient specialist infusions unit).

(20180517 RPIR Acute - NUH Documents – Context)

For the medicine core service, the trust had 87,427 medical admissions from April 2017 to March 2018. Emergency admissions accounted for 42,691 (48.8%), 5,040 (5.7%) were elective, and the remaining 39,696 (45.4%) were day case.

Admissions for the top three medical specialties were:

- General medicine: 24,413
- Gastroenterology: 22,946
- Cardiology: 11,059

(Source: Hospital Episode Statistics)

Is the service safe?

Mandatory training

Mandatory training was completed via a mixture of online ‘e-learning’ packages and face to face training. Nursing staff were meeting the trust’s 85% completion rate for all of the 28 mandatory training modules. Medical staff were meeting the trust’s completion rate for most mandatory training with the exception of six of the 24 required modules.

The trust set a target of 85% for completion of mandatory training. Data provided by the trust was split between medical care and the other medical specialties and services.

A breakdown of compliance for mandatory courses as of the 4 June 2018 for nursing and midwifery staff in medicine (dermatology, rheumatology, gastroenterology, cardiology, respiratory medicine, renal and diabetes services) is shown below:
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes / No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving and Handling - Patient Handling Low Risk</td>
<td>20</td>
<td>20</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness</td>
<td>388</td>
<td>392</td>
<td>99%</td>
<td>85%</td>
<td>Yes</td>
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<tr>
<td>Working at Barts Health</td>
<td>388</td>
<td>392</td>
<td>99%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>386</td>
<td>392</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Investigation of Incidents</td>
<td>70</td>
<td>72</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Harms - Pressure Ulcer Prevention</td>
<td>379</td>
<td>392</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Harms - VTE</td>
<td>379</td>
<td>392</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Harms - Slips, Trips and Falls (Patients)</td>
<td>378</td>
<td>392</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fraud Awareness</td>
<td>378</td>
<td>392</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Privacy and Dignity</td>
<td>378</td>
<td>392</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Security</td>
<td>378</td>
<td>392</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Harms - Catheter Acquired Infections</td>
<td>377</td>
<td>392</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Nutritional Care</td>
<td>376</td>
<td>392</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
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<tr>
<td>Risk Assessment for Managers</td>
<td>69</td>
<td>72</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety</td>
<td>375</td>
<td>392</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Clinical Documentation</td>
<td>374</td>
<td>392</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>374</td>
<td>392</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
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<tr>
<td>Early Warning Systems</td>
<td>374</td>
<td>392</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
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<tr>
<td>Emergency Planning</td>
<td>373</td>
<td>392</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention and Control - Clinical</td>
<td>373</td>
<td>392</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>338</td>
<td>358</td>
<td>94%</td>
<td>85%</td>
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<tr>
<td>Complaints</td>
<td>368</td>
<td>392</td>
<td>94%</td>
<td>85%</td>
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<tr>
<td>Information Governance</td>
<td>367</td>
<td>392</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
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<tr>
<td>Moving and Handling - Patient Handling Practical</td>
<td>344</td>
<td>372</td>
<td>92%</td>
<td>85%</td>
<td>Yes</td>
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<tr>
<td>Medicines Management</td>
<td>346</td>
<td>384</td>
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<tr>
<td>Medical Gas Safety</td>
<td>342</td>
<td>380</td>
<td>90%</td>
<td>85%</td>
<td>Yes</td>
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<tr>
<td>Fire Safety</td>
<td>343</td>
<td>392</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation - Basic Life Support</td>
<td>336</td>
<td>391</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

A breakdown of compliance for mandatory courses as of the 4 June 2018 for medical and dental staff in medicine (dermatology, rheumatology, gastroenterology, cardiology, respiratory medicine, renal and diabetes services) is shown below:
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict Resolution</td>
<td>129</td>
<td>143</td>
<td>90%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety</td>
<td>129</td>
<td>143</td>
<td>90%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling - Patient Handling Low Risk</td>
<td>129</td>
<td>143</td>
<td>90%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>128</td>
<td>143</td>
<td>90%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Consent</td>
<td>126</td>
<td>143</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fraud Awareness</td>
<td>126</td>
<td>143</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Harms - Slips, Trips and Falls (Patients)</td>
<td>125</td>
<td>143</td>
<td>87%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Security</td>
<td>125</td>
<td>143</td>
<td>87%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Harms - Catheter Acquired Infections</td>
<td>124</td>
<td>143</td>
<td>87%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Harms - Pressure Ulcer Prevention</td>
<td>124</td>
<td>143</td>
<td>87%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Nutritional Care</td>
<td>124</td>
<td>143</td>
<td>87%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Harms - VTE</td>
<td>123</td>
<td>143</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Clinical Documentation</td>
<td>123</td>
<td>143</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Emergency Planning</td>
<td>123</td>
<td>143</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness</td>
<td>122</td>
<td>143</td>
<td>85%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Working at Barts Health</td>
<td>122</td>
<td>143</td>
<td>85%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Early Warning Systems</td>
<td>121</td>
<td>143</td>
<td>85%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Privacy and Dignity</td>
<td>121</td>
<td>143</td>
<td>85%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention and Control - Clinical</td>
<td>109</td>
<td>143</td>
<td>76%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>107</td>
<td>142</td>
<td>75%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>102</td>
<td>143</td>
<td>71%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>99</td>
<td>143</td>
<td>69%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation - Basic Life Support</td>
<td>85</td>
<td>143</td>
<td>59%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Medical Gas Safety</td>
<td>23</td>
<td>44</td>
<td>52%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

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

The trust had introduced an ‘app’ that staff could use to complete mandatory training on their mobile phones. Staff could also complete mandatory training on trust computers. However, some managers reported the trust’s mandatory training booking system was a source of frustration, as staff had to book themselves onto training. Managers said it would be easier if managers could directly book staff on training, as managers could avoid spending time sending staff training reminder emails.

Staff told us that the professional development nurse (PDN) emailed them when their mandatory training was due for renewal. However, some managers expressed frustration with staff being responsible for booking their own training courses on the trust’s electronic booking system. A manager told us they would find it easier to monitor staff training and manage shifts if they could book staff directly onto training on the system.
Following our inspection, we requested data from the trust on mandatory training rates in September 2018. The trust returned an overall figure for nursing staff mandatory training completion which was 95% across medical care services.

Agency staff completed mandatory training through their agencies. A senior nurse told us the trust’s bank team checked that agency staff had up to date mandatory training. The nurse said the ward did not see evidence of agency staff mandatory training completion. However, the hospital would offer specialist training to agency staff where required.

**Safeguarding**

The safeguarding team had been reconfigured in 2018. There was a new trustwide lead for safeguarding adults, who had taken up their post on 2 July 2018. The safeguarding lead told us work was in progress on recruiting a safeguarding adults’ coordinator for RLH. The safeguarding adults’ coordinator would be responsible for the local RLH safeguarding adults remit, reporting to the trustwide lead for safeguarding adults. The plan was for local safeguarding adults’ coordinators to have a trustwide remit for specific areas of safeguarding practice. The safeguarding adults coordinator at RLH would have the RLH site based safeguarding adults remit and also have a trustwide remit for the Mental Capacity Act 2005 (MCA), the Deprivation of Liberty Safeguards (DoLS), and ‘PREVENT’, (this is training in regards to the risks of radicalisation and the roles involved in supporting those at risk).

Staff we spoke with understood and could identify the different types of abuse, such as neglect, psychological and emotional abuse, financial abuse, and physical and sexual abuse. There were safeguarding link staff across wards and departments who were responsible for liaising with the safeguarding team and raising staff awareness of safeguarding issues.

There was a policy in place to safeguard women or children with, or at risk of, Female Genital Mutilation (FGM).

Staff in sexual health services had access to specialists in sexual exploitation and people trafficking, working closely with local authority social workers to protect patient wellbeing.

We saw step by step guidance for staff on actions to take in the event of a safeguarding concern, and how to report concerns displayed in staff rooms. The guidance included the contact details of the trust’s safeguarding team.

The trust set a target of 85% for completion of mandatory training. Data provided by the trust was split between medical care and the other medical specialties and services.

A breakdown of compliance for safeguarding courses as of the 4 June 2018 for nursing and midwifery staff in medicine (dermatology, rheumatology, gastroenterology, cardiology, respiratory medicine, renal and diabetes services) is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Level 1</td>
<td>387</td>
<td>392</td>
<td>99%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>381</td>
<td>392</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>251</td>
<td>266</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>368</td>
<td>392</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Nursing and midwifery staff exceeded the trust’s 85% completion rate target for all four safeguarding training modules.

A breakdown of compliance for safeguarding courses as of the 4 June 2018 for medical and dental staff in medicine (dermatology, rheumatology, gastroenterology, cardiology, respiratory medicine, renal and diabetes services) is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>131</td>
<td>143</td>
<td>92%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 1</td>
<td>131</td>
<td>143</td>
<td>92%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>115</td>
<td>143</td>
<td>80%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>41</td>
<td>53</td>
<td>77%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical and dental staff exceeded the trust’s 85% completion rate target for two of the four safeguarding training modules.

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

The hospital required all staff to undertake safeguarding adults’ level 1 and safeguarding children level 1 training, with more advanced levels for clinical staff depending on their role. There was an 85% minimum target for up to date safeguarding training amongst staff teams. The safeguarding adults lead told us ‘PREVENT’ training was mandatory for all staff.

The lead told us the safeguarding team were in the process of reviewing all safeguarding training to ensure it met the requirements of the respective intercollegiate documents for safeguarding in both adults and children’s services.

Following our inspection, we requested data from the trust on safeguarding training rates in September 2018. The trust returned a breakdown figure for specific services safeguard training completion. We found older peoples services, the AAU and stroke unit had over 90% compliance with safeguarding training level 1 to level 3. Specialist medicine had a compliance rate of over 90% for level 1 to level 2. However, the rate for level 3 training in specialist medicine was 82%, this was slightly below the trust’s standard of 85% of eligible staff trained in level 3 safeguarding.

**Cleanliness, infection control and hygiene**

RLH had an infection prevention and control team (IPC). The IPC team were linked with the associate director of nursing (ADON) for each division. The IPC lead told us this had improved engagement with the IPC team across the wards and departments.

IPC audits were complete using an ‘app’ system. This was an electronic system which enabled audit and monitoring of audits at a local ward based, hospital and trustwide level. Wards completed monthly infection prevention and control audits using the ‘app’. The IPC team had scheduled six monthly audits for all acute inpatient areas via the ‘app’.

The IPC team completed ‘five and five’ audits. These involved five patients’ records being audited across five areas. The IPC team had developed a red, amber, green (RAG) rated dashboard to enable wards to monitor their own monthly hand hygiene and ‘saving lives’ audits. The dashboard formed part of an exception report that was reviewed by the RLH IPC committee monthly and the
trust’s IPC committee quarterly. We viewed the dashboard dated 1 May to 1 September 2018. This recorded 98.2% compliance with the hospital’s hand hygiene standards in the period.

The IPC lead told us data at RLH would suggest that infections had reduced when comparing 2017 data with 2018 data. However, we did not see the data from 2017 and were unable to confirm this. There had been no episodes of hospital acquired Clostridium difficile (C. diff), a bacterium that can infect the bowel and cause diarrhoea, Escherichia coli (E. coli), this is bacteria which can cause food poisoning; or Meticillin-resistant Staphylococcus aureus, this is a bacterium that is resistant to several widely used antibiotics. There were three patients with community acquired MRSA being cared for on the wards at the time of inspection. We found that staff used appropriate Aseptic Non-Touch Technique (ANTT) when caring for these patients. We also saw alerts on the clinical record system (CRS) to alert staff to infectious patients.

Sanitising hand gel dispensers were available at the entrance to every ward and clinical area. During our previous visit we found some of these were empty. However, during this inspection we found hand gel dispensers contained hand gel on all the wards and departments we visited.

Overall, we found staff adhered to IPC and hand hygiene practice. Although we saw a nurse on ward 13E who did not take a sharps bin to a patient’s bedside. The same nurse used personal protective equipment (PPE) in the form of gloves, but, did not gel or wash their hands before providing care to the next patient. We also saw an administrator on ward 13E who did not adhere to the trusts ‘bare below the elbows’ policy on the ward and wore a watch and ring that contained precious stones.

Each ward had an infection control link nurse responsible for conducting monthly hand hygiene audits in every ward and clinical area as part of the ‘saving lives’ programme. Hand hygiene audit results were displayed on the wards and departments. For example, staff used “I am clean” stickers to indicate when an item of equipment had been cleaned and disinfected. During our previous visit we reported that the stickers were used inconsistently. However, during this inspection we found improvements in the use of ‘I am clean’ stickers and most equipment had been labelled appropriately.

The endoscopy unit was compliant with Department of Health (DoH) Technical Memorandum 01-06 relating to the management and decontamination of flexible endoscopes, including in monitoring and auditing. The endoscopy unit had a decontamination team. The team had a daily safety briefing to ensure scopes and equipment were ready for use. Decontamination of equipment was monitored by regular audits. Instructions for decontamination processes including guidance from the Medicines and Healthcare Products Regulatory Agency were on display in the unit. Endoscopy treatment rooms had direct access to the decontamination area. This meant used scopes and equipment could be transported directly to be decontaminated without the risk of cross-infection in other areas.

Wards and the endoscopy unit had side rooms available, which could be used to care for patients with infectious conditions. Patients with suspected or confirmed tuberculosis were cared for in negative pressure rooms. This prevented the condition spreading to other patients.

We viewed IPC audits for medicine and older people services dated from April 2017 and found there was between 98% and 100% compliance in all months for all wards. These met the trust’s 98% cleaning standards, with the exception of wards 9E and 9F which scored 97% in March 2018; this was below the trust’s 98% minimum standard of cleanliness.

Cleaning services were provided by a private contracted cleaning company. The IPC lead did monthly walk arounds with the cleaning company manager. Staff told us the private contracted cleaning company had a help desk staff could telephone to raise issues.
The trust had an IPC social media account where information on IPC could be disseminated to staff. IPC information was also shared on the running news feed ‘We Share’ page of the trust’s intranet.

**Environment and equipment**

We found equipment was not always stored securely. We visited ward 13E on the evening of 11 September 2018. We found the door to a store room containing a large quantity of patients paper based notes was open. We also found the door to the medical room which stored medicines was open. The nurse in charge closed both doors immediately.

During our previous inspection we found there were significant gaps in understanding and practice in relation to the control of substances hazardous to health (COSHH). During this inspection, we found on the 12 September 2018 in the endoscopy unit a door to a cupboard used to store cleaning chemicals open. The cupboard contained substances which were corrosive, including, peracetic acid. The senior charge nurse closed the door immediately when we drew this to their attention and informed the decontamination nurse. Furthermore, we found the COSHH assessment form in use on ward 9E was out of date; the form had an issue date of 12 November 2009 and was due for revision in March 2012. The dirty utility room on 9E was unlocked and had unlocked cabinets containing chlorine tablets and scissors. We also found sepsis trollies on ward 9E and 13E that were not locked. This meant there was a risk that unauthorised people could gain access to equipment, patients’ personal information, medicines, and hazardous substances.

The infection control team adhered to the principles of the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (2013) in relation to the reporting and investigation of needle stick injuries. However, we found sharps bins stored in the dirty utility room on ward 9E partially open and sharps bins that were partially open on ward 11C, this was not in accordance with the trust’s policy for the safe handling of sharps.

Each clinical area had resuscitation trollies with emergency drugs and oxygen. Staff also had access to an echocardiogram machine. Daily checks of resus trollies were recorded in every area we visited. The resuscitation team completed monthly audits of resuscitation equipment.

Staff on ward 10E told us they were concerned about the risk to patients posed by the ward environment, for example, cords on call bells. Staff said they did not know whether the ward had a ligature risk assessment in place. Following our inspection, the hospital informed us that a site wide risk assessment was performed and acted upon in 2015 by the estates department. The hospital did not consider that the ward based teams needed to perform a further assessment of the area, or that an additional divisional risk was necessary. The hospital did not submit evidence of whether the 2015 risk assessment had been reviewed in accordance with the trust’s policy.

The neurology planned investigations unit on Ward 11D had a risk added to the divisional risk register on 7 September 2018 due to a risk to patients with a need for infusions for neurological conditions. This was due to the service expanding and being unable to accommodate referrals for patients in need of intravenous immunoglobulin (IVIg), this is a therapy for patients with immune deficiencies. This meant there was a risk that new diagnoses or those with treatment resistant conditions could not receive treatment to prevent acute deterioration. Patients requiring IVIg infusions were placed on the inpatient waiting list. Following our inspection, the hospital informed us that a risk assessment had been undertaken dated 29 August 2018. The risk assessment proposed an action plan. This included: a business case to improve staffing levels and expand the physical space on ward 11D, discussion of potential alternative locations that IVIg could be administered, and robust governance processes around decision to start/stop IVIg. We did not receive any confirmation from the hospital whether the action plan had been implemented.
However, the risk register recorded on 21 November 2018 that there was no “credible” plan to address this risk.

The equipment library held all medical device inventories. The equipment library was responsible for ensuring prompt servicing of equipment. Equipment was numbered and held by the library on a database which prompted equipment library staff when equipment was due to be serviced. Ward staff told us the equipment library were responsive when equipment broke down and repairs were prompt. Wards had equipment logs to record when the clinical engineering department had removed equipment for servicing or repair; the log also recorded when the equipment had been returned to the wards.

**Assessing and responding to patient risk**

Resuscitation and basic life support training formed part of the trust’s mandatory training programme and had a 85% minimum completion rate. We found on 4 June 2018 nursing staff had better than the trust’s 85% standard for resuscitation. Following our inspection, the hospital submitted data on the 15 October 2018 to demonstrate that on this date medical staff training in resuscitation was 88% of consultants and 80% of non-consultant medical staff had up to date training.

We asked the hospital for data on the percentage of nursing staff with advanced life support training (ALS). The hospital informed us that it was not a requirement for ward based nurses to undertake ALS. All registered nurses and health care assistants (HCA) undertook BLS as part of their mandatory training. Some individual nurses undertook ALS as a personal development opportunity but this was not recorded as a percentage in the hospital's training records.

The hospital also told us all junior doctors were required to undertake ALS as part of their training. Some clinical fellows and consultants had undertaken ALS training as a personal development opportunity, but this was not recorded as a percentage in the training records.

To identify patients who were at risk of deteriorating, RLH used the patient at risk score (PARS). This is designed to enable health care professionals to recognize “at risk” patients and to trigger early referral to medical staff. RLH also used the national early warning score (NEWS). An early warning score is based on vital signs and used to quickly determine the degree of illness of a patient.

Where patients were identified as being at risk, staff reviewed their needs at handovers, board meetings and ward rounds. In our previous report, published 15 December 2016, we reported that staff did not consistently record observations relating to an elevated NEWS score. During this inspection we reviewed 18 patient records across the medicine and older people’s wards. found that staff were still inconsistent in their recording of NEWS scores. For example, one patient on ward 14E had a NEWS score that had been scored incorrectly on the 8 September 2018. We also found that the same patient did not have one of their hourly observation recorded on the 10 September 2018.

Staff asked were familiar with ‘sepsis six’ - a bundle of medical therapies designed to reduce mortality in patients with sepsis - and could explain the use of the hospitals sepsis bundle, including the giving of antibiotics, fluids and oxygen. Staff were aware of tests that should be completed for a patient with suspected sepsis, including taking cultures and samples and monitoring patients urine output.

Endoscopy staff completed World Health Organisation (WHO) safety checklists; this is a core set of safety checks, identified for improving performance at safety critical time points within the
patients care pathway, in the treatment room prior to procedures. We viewed safety checklists for three patients and found these were complete.

We viewed the quality and safety dashboard dated 1 May 2018 to 1 September 2018, this recorded there had been three grade 3 pressure ulcers in the period and no grade 4 pressure ulcers. The hospital had pressure ulcer reduction plans in place. For example, we viewed the hospital’s ‘Enhanced Measures Action Plan’ for pressure ulcers within renal and diabetes services. This outlined measures the hospital were taking to reduce the risk to patients with pressure ulcers, this included a review of patients at handovers and safety briefings and newly identified pressure ulcers being recorded on the electronic incident report system.

The quality and safety dashboard dated 1 May 2018 to 1 September 2018, recorded there had been 88 falls in the period, with 71 of these resulting in ‘no harm’ to patients, 16 resulting in ‘low harm’ and one resulting in ‘severe harm’ to a patient. Renal wards had an action plan for falls prevention. This included training for staff and the re-introduction of sensor pads in clinical areas for patients at risk of falls.

The critical care outreach team provided support to ward-based staff where a patient had been identified as at risk of deteriorating. The team was available from 7.30am to 8.30pm seven days a week. Outside of these hours a hospital at night team provided support. Clinical areas were supported during the night in the management of the deteriorating patient by the on call resuscitation team.

Staff on ward 10E were concerned about the risks to staff from patients, a member of the 10E staff told us, “Sometimes we call security multiple times a day.” Staff on ward 10E told us security were supportive when called, but, said they had been asked to call them less frequently.

Where respiratory patients required highly specialised care a transfer pathway was in place for high acuity respiratory patients to be transferred to St Bartholomew’s Hospital. Respiratory nurses were trained in the safe transfer of patients using the pathway.

**Nurse staffing**

Royal London Hospital (RLH) reported the following nurse staffing numbers for medical care in March and April 2018.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Care</td>
<td>693.9</td>
<td>769.7</td>
<td>90.1%</td>
<td>684.2</td>
<td>769.1</td>
<td>88.9%</td>
</tr>
</tbody>
</table>

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

During our previous visit, we found RLH did not ensure nurse to patient ratios were managed in relation to the individual needs of patients, including whether they are bed bound and/or cared for in a side room. The hospital used the Shelford Group Safer Nursing Care tool to establish the minimum staffing requirements in inpatient areas based on patient acuity. This was monitored on a monthly basis against established criteria for the nurse to patient ratios.

Following our inspection, the hospital informed us staffing ratios were monitored daily through the site safety huddle and twice daily through safe care live. In addition, senior nurses on evening and weekend duties supported the assessment of safer staffing.
Where ratios are above establishment these are as a result of enhanced care assessments an enhanced care policy and assessment tool was used. There was a separate budget on site to support the ad hoc use of staff to support the release of staff for enhanced care.

We viewed data for general staffing levels for general medicine for May 2018. This recorded that actual staffing levels for general medicine had improved, with the rate during the day at 99% for registered nurses (RGN) compared to the established staffing level, and 103% for health care assistants (HCA). At night the staffing levels in general medicine were 103% of established staffing levels for RGN and 114% of established staffing for HCA. RLH regularly over established staffing levels based upon anticipated patient acuity. However, a few staff told us lean working had meant some wards and teams staffing establishments were insufficient to meet the demands on the service, and this had led to staffing levels being above the established levels as teams had to supplement shifts with bank staff.

Ward managers told us overall the trend in nurse staffing at RLH was improving. For example, a renal ward manager told us, “Staffing is much improved. In 2016, we had around 40% actual staff rate in renal. We now have a 90% rate.” Staff told us this was due to changes RLH had made. The renal ward had introduced a band 5 nurse renal programme accredited by Southbank University. This included nurses rotating and gaining the opportunity to train in haemodialysis. However, a few wards told us staffing was still a challenge. During an evening visit to ward 11E we found the ward was one nurse short of the established number of five nurses for the night shift. Staff told us staff shortages on 11E had improved for a while, but, had recently become more of a regular occurrence. Staff on 10E also told us the ward was one nurse under establishment. Staff on 10E said staff were leaving due to stress and not for promotion or better opportunities with another employer.

Staff in the AAU told us there had been a staffing uplift in the previous six months as a result of a safe staffing review. This was an increase in one RGN during the day and a band 2 HCA at night. Staff told us the staffing uplift was in response to the increasing frailty of patients admitted to the AAU.

From May 2017 to April 2018, the Royal London Hospital reported a vacancy rate of 10% for nursing staff in medical care, this was higher than the trust target of 6.3%.

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

From May 2017 to April 2018, the Royal London Hospital reported a turnover rate of 16% for nursing staff in medical care, this was higher than the trust’s target of 13%.

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

From May 2017 to April 2018, the Royal London Hospital reported a sickness rate of 3.6% for nursing and midwifery staff in medical care, this met the trust’s target of 3%.

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

From May 2017 to April 2018, the Royal London Hospital had a total of 34,696 nursing staff shifts in medicines and older people’s services. A breakdown of bank and agency usage and unfilled shifts is shown below:

<table>
<thead>
<tr>
<th>Bank and agency</th>
<th>Number of shifts (% of total shifts)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank</td>
<td>23,946 (69.0%)</td>
</tr>
</tbody>
</table>
Renal ward staff told us there had been a reduction in the use of agency staff. RLH had a policy of offering shifts to their own staff and the trust’s bank staff before advertising shifts to agencies. A ward manager told us, “We don’t use many agency anymore, most of the time we use bank staff.” When wards had unfilled shifts the ward manager would call the trust’s bank staff team the day prior to the unfilled shift, if the shift was not covered by midday the bank staff team would approach agency staff to fill the shift.

We saw four shifts that needed staffing cover in November and December 2018, being advertised to staff on the staff noticeboard on ward 13E. The lead nurse told us they would advertise shifts to their own staff before requesting cover from the trust’s bank staff. The lead nurse told us they could usually cover shifts with their own staff.

Wards had daily handover meetings at 8.00am and 8.00pm. Handover meetings reviewed patients on the ward and highlighted any issues in regard to patients’ care, discharge, or assessments. All incoming staff were required to attend handover.

**Medical staffing**

The hospital had a unique rota system. The ratio of medical doctors’ specialisms were 40% specialist and 60% acute. A consultant told us the idea of the model was to promote the recruitment of new doctors. Medical staff could join as an acute doctor, but received support from the hospital to train as a specialist.

RLH had a rota for all medical specialities. All other medical staff in medical care were acute admissions unit (AAU) medics. The AAU daytime consultant on-call was based in the accident and emergency department, supported by two junior doctors. At night the AAU had the consultant on-call, a registrar and two junior doctors. The AAU had an early consultant and post-take consultant. The early consultant had the role of consultant of the week and reviewed any patients who had remained acutely unwell on the AAU from the previous day and any patients admitted overnight. The post take consultant reviewed any patients who had been admitted during the previous day.

The trust had consultant rotas to ensure that urgent or un-planned medical admissions were seen and assessed by a relevant consultant within 12 hours of admission, or within 14 hours of the time of arrival at the hospital in accordance with the London Quality Standards, and ensure patients were assessed by a suitably qualified medical practitioner within 30 minutes. The (AAU) had a lead consultant and a senior nurse who were responsible for all aspects of delivery of care according to national and local standards on the unit. On the acute admissions unit there was a consultant present from 8am to 9pm, seven days a week, with non-resident on-call overnight. The rota was staffed by consultants qualified in general internal medicine, and when non-resident they were able to reach the hospital within 30 minutes if necessary. The consultant did not have other commitments and was dedicated to the AAU for the entirety of their shift.

On the specialty medicine wards, there was an established seven day consultant ward round in renal, the consultant of the week, respiratory and gastroenterology/hepatology. A seven day cardiology ward round in cardiology was scheduled to commence in October 2018. Metabolic medicine had a consultant of the week Monday to Friday from 9am to 5pm, and cover at weekends with daily ward rounds. Outside these hours there was a specialty consultant on call.
In hours, the AAU was staffed with at least one registrar 24 hours a day, seven days a week with an additional registrar working between 5pm and 9pm. There were no staff grade doctors employed in acute medicine at RLH.

Speciality wards were staffed by at least one appropriate trained registrar at level ST3 and above at all times Monday to Friday from 9am to 5pm. At weekends and out of hours, there was a minimum of one resident appropriately trained ST3 or above doctor covering speciality wards, they were supported by a junior medical team. Additionally, there were non-resident out of hour’s registrar rotas for renal, gastroenterology/hepatology, HIV, respiratory and cardiology. A rota of competent decision makers were assigned to all inpatient areas 24 hours a day, seven days a week. Junior medical staff had a rota that included floating days.

At 8.30 am, daily specialist wards completed a ward round. At 9am daily there was a board meeting to discuss where patients in the AAU would be triaged. Consultants from the patients’ specialism attended the meeting. Medical staff told us the process had sped up the decision-making process for patients.

At night there were four F2 doctors, two covered the accident emergency department and two covering medical wards. There was also a consultant on-call. Staff told us out of hours doctors were generally responsive. Staff said night staff prioritised acutely unwell patients, but would always attend a call.

Both nursing and medical staff across the wards we visited were positive about RLH medical cover. For example, a nurse on ward 10E told us, “We have good medical cover. We have seven day consultant presence; we have seven day board rounds. It provides patients with continuity of care.” A consultant told us, “Junior staff love the rota.

The Royal London Hospital reported the following medical staffing numbers for medical care in March and April 2018. The hospitals fill rate was over 90% in both March and April 2018.

<table>
<thead>
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<tbody>
<tr>
<td>Medical Care</td>
<td>291.8</td>
<td>302</td>
<td>96.6%</td>
<td>291.3</td>
<td>310.2</td>
<td>93.9%</td>
</tr>
</tbody>
</table>

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

From May 2017 to April 2018, the Royal London Hospital reported a vacancy rate of 1.7% for medical and dental staff in medical care, this was lower than the trust target of 6.3%.

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

Medical staff told us there was an issue for the trust in recruiting geriatricians. In response a clinical lead had moved into specialist geriatric care from acute care. The hospital were also reviewing older people in the accident and emergency department to provide early assessment for this patient group to review whether the patient needed admission or could be supported in the community.

From May 2017 to April 2018, the Royal London Hospital reported a turnover rate of 7.2% for medical and dental staff in medical care, this was lower than the trust’s target of 13%.
From May 2017 to April 2018, the Royal London Hospital reported a sickness rate of 0.6% for medical and dental staff in medical care, this was lower than the trust’s target of 3%.

From May 2017 to April 2018, the Royal London Hospital had a total of 4,390 medical staff shifts. A breakdown of locum and agency usage and unfilled shifts is shown below:

<table>
<thead>
<tr>
<th>Locum and agency</th>
<th>Number of shifts (% of total shifts)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Locum</td>
<td>1,338 (30.5%)</td>
</tr>
<tr>
<td>Agency</td>
<td>251 (5.7%)</td>
</tr>
<tr>
<td>Not filled</td>
<td>411 (9.4%)</td>
</tr>
</tbody>
</table>

In March 2018, the proportion of consultant staff and the proportion of junior (foundation year 1-2) staff reported to be working at the trust were both lower than the England average.

### Staffing skill mix for the 713 whole time equivalent staff working in medicine at Bart’s Health NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
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<tbody>
<tr>
<td>Consultant</td>
<td>41%</td>
<td>43%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>4%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>36%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>19%</td>
<td>22%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty  
~ Registrar Group = Specialist Registrar (StR) 1-6  
* Junior = Foundation Year 1-2

Source: NHS Digital - Workforce Statistics - Medical (March 2018)

Therapy leads raised concerns in regard to the staffing establishment for therapies. Staff told us the staffing levels at the trust for therapies did not meet National benchmarking standards. Staff told us they did not think this compromised patient care. Staff told us all therapy leads were working more than their established hours, but, the trust were aware that there were issues with the therapies staffing establishment being underestimated due to therapies filling most of their band 5 and band 6 vacancies. Staff told us the recruitment of new band 5 and band 6 therapists
had placed extra strain on band 7 and band 8 staff due to increased supervisory responsibility and training remits. Therapies had produced a feasibility proposal which was awaiting presentation to the trust’s investment and steering committee. As a result, work was in progress on a business case to address the staffing establishment in therapies.

**Records**

Medicines and older people’s services used a ‘paper-lite’ system which meant that most of the patient’s record were stored on a clinical record system (CRS). There were a few exceptions for this with paper records being held for GP referral letters, some pathways and medication administration. Staff on ward 14E told us the trust’s CRS was not fully operational at the time of inspection. However, staff added that if notes were missing from the CRS, staff knew to check the patients’ paper based notes. The electronic records system also meant that patient records could be viewed across the trust’s other hospitals.

During our previous Inspection in July 2016, we reported that agency nurses did not have access to the patient electronic record system. However, during this inspection we found that locum and agency staff were issued with a temporary access card in order to access the CRS system. This ensured temporary staff working on the wards and departments had access to patient records and could update these as required.

During our previous inspection we reported that we had found inconsistent recording of patient information in several areas. During this inspection we found the hospital had taken action in the form of regular audits to address shortfalls in record keeping. However, recording was still inconsistent. For example, on ward 13E, cardiac and respiratory medicine, we found a patient who was receiving oxygen who did not have whether they were receiving oxygen recorded on their observations. We found five patient records on ward 9E, renal and urology, where observations had not been fully documented. For example, a patient did not have their age recorded on a Waterlow document, another patient had been on the ward for more than six hours and did not have a completed falls risk assessment, mouth health assessment, and skin assessment. Another patient had a malnutrition universal scoring tool (MUST) that was incomplete and a Waterlow assessment that was incomplete. Another patient did not have any records of comfort rounds since 9 September 2018, even though staff and the patient confirmed these had occurred. We found a patient on 14E, elderly care, where the fluid balance charts for a patient had not been fully completed and MUST scores were incorrect as the patient’s weight would indicate the patient was at risk, but the total score was recorded as “0”. We found a patient on ward 9F where a wound assessment had not been recorded since 8 September 2018. However, the patient had another document that recorded the patient’s wound progress had been reviewed on the 10 September 2018, but this had not been recorded on the patient’s wound assessment. The same patient also had their blood pressure recorded in multiple styles, which indicated that staff were not recording blood pressure in accordance with the RLH policy.

As of 4 June 2018, 86% of medical staff and 95% of nursing staff had up to date training in clinical recording. However, staff working on ward 10E told us that they would prioritise patient care rather than completing clinical records. Staff told us they did not always have time to complete patients’ clinical records. However, this practice meant there was a risk that patients’ records would not reflect the care that had been provided and there was a risk that staff could appear to have neglected a patient due to the non-recording of care provision.

We viewed MUST record audit results from June to August 2018 for ward 9E. We found in June the ward had 87% compliance, in July the compliance rate was 58% and in August it was 87%. This indicated that patients may be at risk due to MUST assessments not providing clear and
consistent information on patients’ nutritional status. This meant the trust could not be assured that staff were using the MUST tool appropriately.

We viewed clinical records audits dated from June to August 2018 for the following wards: 9F, 10E, 13F. All the wards scored 100% in the audits for the period. However, from our random sampling of records across the wards we found records that were not fully completed. This indicated that RLH record audits may not be robust in identifying issues with recording.

During our previous inspection we found records were not always stored in a way that ensured patient confidentiality. We found that patient records were still not always stored securely. For example, we found a store room on ward 11E where a door was open and being used for the storage of patient paper based notes. A band 6 nurse closed the door immediately when we drew this to their attention.

**Medicines**

Improvements were required in the management of medicines. The medicines room and all cabinets in which medicines were stored were secure and locked. However, there was some disorganisation within the cupboards on ward 13E. We found medicines which were not placed in their correct locations and not returned to pharmacy as appropriate on ward 14E. We found some examples of patient own drugs (POD), these are medicines bought in by patients from home, stored in the medicines trolley on ward 14E. PODs must not be administered to other patients, however upon finding these medicines within the main trolley we could not ascertain whether this had occurred or not. Medicines requiring secure storage – controlled drugs (CDs) were stored securely within a designated CD cabinet and there was evidence of daily stock checks as per trust policy. However, we found that the CD cabinets were overstocked and some duplication in ordering had occurred. Fridge temperatures were recorded on a daily basis but were not recorded accurately.

Medicines and equipment used for emergencies were accessible, appropriately checked daily and tamper proof. Equipment and fluids needed for the treatment of sepsis, although available were not always checked on a daily basis and we found the trolley was unlocked on ward 13E.

A clinical pharmacy service was available daily, whereby a pharmacist would attend ward rounds, conduct medicines reconciliation, advise medical and nursing staff on medicines related issues and provide counselling to patients where necessary. Medicines reconciliation is the process of ensuring that the list of medicines prescribed by the doctor for a patient is correct.

We reviewed a sample of paper prescription charts and found that all were fully completed with no gaps in administration. All prescriptions were legible and signed for by the prescriber. Antibiotics were prescribed appropriately, with clear documentation of indication and duration of therapy. Allergy statuses were complete for all prescription charts inspected, however we saw one example of a patient with a documented allergy to a penicillin containing antibiotic on the chart and who had been prescribed and administered another penicillin containing antibiotic for 4 days. This was highlighted to the pharmacist and nursing staff for clarification although it was unlikely the patient had a true allergy as the patient had not suffered from a reaction. The allergy status of a patient must be checked with the prescription chart and as good practice with the patient before a medicine is administered.

We reviewed a sample of electronic patient notes and noted that all had a venous thromboembolism (VTE) assessment completed, with appropriate prescription of a low molecular weight heparin if indicated as recommended by NICE. An electronic prescribing system was not in use at RLH, although work was ongoing centrally in the trust to develop one.
Incidents

The trust used an electronic incident reporting record. The electronic records system ensured services followed the guidance of the duty of candour as the system prompted staff to record if the incident was a duty of candour incident. The duty of candour is a set of legal requirements that providers of services must follow when things go wrong with a patient’s care or treatment.

We viewed the medicines and older people’s services incident reporting spreadsheet dated from September 2017 to August 2018. There had been 3661 incidents reported in the period. The main types of incidents reported in this period were: pressure ulcers (24%); patient falls (18%); medicine/drugs security (12%); communication issues (6%); continence management (6%); and staffing issues (5%). The speciality with the most incident reports in the period was acute medicine with 1061 incidents reported in the period, this was followed by renal with 438 incidents reported and older people’s services with 429 reported incidents.

A named member of staff in each ward or department was responsible for the initial investigation of incidents. Staff we spoke with were aware of the process and procedure for reporting incidents. Staff told us the sharing of learning from incidents had improved. For example, staff on ward 13E told us about a duty of candour incident which had been investigated as a serious incident (SI) and a root cause analysis investigation (RCA) completed. Staff told us learning from the RCA was shared with staff at handover and was again shared at a multidisciplinary meeting when therapy staff were present. A consultant told us, “There has been a proper focus on sharing learning from incidents and never events and everyone buys into it.” Staff on ward 3E told us learning from incidents was disseminated by email and at handovers. Staff on 3E said investigation reports were printed and signed by staff to indicate they had read and were aware of the reports. Staff on ward 11C said managers reviewed incidents on the ward at monthly team meetings, where they also disseminated any learning from incidents.

There was evidence of improvements in practice following serious incident investigations. For example, we viewed three root cause analysis investigation (RCA) reports. One RCA involved an investigation into the late treatment of pulmonary emboli (PE); this is a blockage of an artery in the lungs by a substance that has moved from elsewhere in the body through the bloodstream (embolism). The RCA had a clear chronology of events and review of factors that may have contributed to the incident. The RCA also identified lessons learnt as a result of the incident, recommendations from the investigator and a record of how learning from the event would be shared across the trust. For example, reporting the incident to National Reporting and Learning Service (NRLS) to promote shared learning nationally, reporting the incident and its actions to the quality and safety committee and to the trust executive board, completion of actions were monitored by the quality and safety committee.

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

From August 2017 to July 2018, the trust reported no incidents classified as never events for medical care at Royal London Hospital.

(Source: NHS Improvement - OBIEE NRLS STEIS)

In accordance with the Serious Incident Framework 2015, the trust reported 11 serious incidents (SIs) in medical care which met the reporting criteria set by NHS England from August 2017 to July 2018.
The types of incident reported were:

- Diagnostic incident including delay meeting SI criteria (including failure to act on test results): three incidents
- Sub-optimal care of the deteriorating patient meeting SI criteria: three incidents
- Abuse/alleged abuse of adult patient by third party: one incident
- Pressure ulcer meeting SI criteria: one incident
- Slips/trips/falls meeting SI criteria: one incident
- Substance misuse whilst inpatient meeting SI criteria: one incident
- Surgical/invasive procedure incident meeting SI criteria: one incident

(Source: NHS Improvement - OBIEE NRLS STEIS)

Minutes from morbidity and mortality meetings in renal services and dermatology demonstrated they were attended by a range of appropriate staff and individual cases were discussed with the purpose of improving direct patient care, multidisciplinary working, and communication between services.

**Safety thermometer**

We found NHS Safety Thermometer information was available on all of the medical wards we inspected in the form of ‘safety crosses’. These were easy-to-understand visual displays that enabled staff and visitors to quickly identify areas of good and poor performance in the previous month. The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

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

Data from the Patient Safety Thermometer showed that the trust reported 70 new pressure ulcers, 37 falls with harm and 30 new urinary tract infections in patients with a catheter from June 2017 to June 2018 for medical services. The trend was improving for all forms of harm assessed using the Safety Thermometer.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Bart’s Health NHS Trust
1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

Source: NHS Digital - Safety Thermometer

Is the service effective?

Evidence-based care and treatment

The endoscopy service had received renewal of their level 1 full tariff Joint Advisory Group (JAG) accreditation on 3 July 2018; this is a quality improvement and service accreditation programme for gastrointestinal endoscopy. This meant the endoscopy unit and its staff was assessed and monitored for quality performance and clinical safety against established international benchmarks, including in the quality and training of its workforce and its focus on comfort and dignity for patients.

We viewed the endoscopy JAG accreditation report on the ‘assessment of GI bleeding (haemostasis, endoscopy within 24 hours, assessment of NICE guideline measures, 30 day mortality and 8 day readmission’ dated March 2018. This found the service was achieving the following compliance with the NICE guideline measures: Blatchford score documents (20.5%); Endoscopy within 24 hours (84.6%); Aspirin documented to continue when treated if already on (100%).

Clinical pathways, policies and procedures followed national guidance such as those from National Institute of Clinical Excellence (NICE) and Royal College of Emergency Medicine (RCEM) guidelines. These included management of sepsis, fractured neck of femur, acute coronary syndrome, allergic reaction, and first seizure. Guidelines, policies and procedures were available to staff on the trust’s intranet. Policies we reviewed included a review date and were within date.

Wards and departments also had a range of guidance available to staff on the ward. For example, Ward 13E had guidance for staff on the use of the Shelford ‘safer nursing tool’, this is an evidence based tool that enables nurses to assess patient acuity and dependency to ensure that nursing
staffing reflects patient needs in acuity/dependency terms. However, we found a few wards had not fully considered where to position staff guidance. For example, on ward 13E guidance for staff on learning from incidents was behind a door and not visible when the door was open. We also found a few wards where some of the printed guidance was out of date. For example, ward 9E had a sepsis flow chart dated February 2015 which was due for review in February 2017.

The endoscopy unit used the World Health Organisation (WHO) surgical safety checklist. This is a checklist that identifies three distinct phases of an operation, each corresponding to a specific period in the normal flow of work. In each phase a ‘checklist coordinator’ must confirm that the surgical team has completed the listed tasks before it proceeds with the procedure. We viewed four checklists and found these were complete.

Endoscopy treatment rooms displayed the name of the radiation protection advisor (RPA) and radiation protection supervisor in treatment rooms in accordance with the Ionising Radiations Regulations 2017 (IRR17). The role of the RPA is to provide advice to the hospital on the protection of its employees and the public from harmful effects of ionising radiation.

Nutrition and hydration

The wards operated a ‘protected mealtimes’ policy. This meant visitors were asked not to visit the wards at meal times to allow patients to eat their meals uninterrupted. Staff were also asked to observe the policy and to not arrange treatment or assessments at patients’ mealtimes.

96% of nursing staff and 87% of medical staff had up to date training in nutritional care. This was better than the trust standard of 85%.

The hospital had a programme for nutrition link nurse training days. For example, we saw monthly dates advertised on ward 13E for training on the use of blood glucose monitors. We also saw a ‘speech and language’ tips poster, which gave staff guidance from the speech and language therapy (SALT) team on oral care to reduce bacteria in patients mouths and guidance on using thickeners in liquids in accordance with SALT instructions.

Staff on ward 10E told us they used the malnutrition universal screening tool (MUST). However, staff told us the wards audits of staff use of MUST had been disappointing. In response the ward had an action plan to improve staff use of MUST; this included an additional band 5 nurse at weekends to work on improvements in recording of MUST scoring and other records.

Ward 9E had introduced a nutrition folder which was kept at the nursing station. The folder provided staff with guidance on safe management of patients’ nutrition and respect for religious diets. However, we found some of the information was dated. For example, the folder contained a guide on ‘low potassium diets’, this had been produced by the Barts Health dietitian team in February 2011 and did not have a review date. We also found guidance on ‘protecting patients’ meal times’ which had a review date of September 2014.

RLH had introduced a ‘red tray’ system to indicate patients who were at risk of choking; this was a visual reminder for staff to be vigilant when providing food for these patients.

RLH had specialist renal dietitians who provided patients with dietary advice and information on renal diets. The renal dietitians also operated a phosphate analysis programme to assess risk factors for patients at risk of a decline in renal functioning.

Pain relief

The hospital had implemented the Faculty of Pain Medicine’s Core Standards for Pain Management (2015). Staff recorded pain scores routinely and consistently and these were up to date in 21 patient records we looked at.
We asked seven patients about pain relief. In each case they said their pain was managed well and staff asked them frequently about their pain levels.

The trust had an ‘Acute Pain Management’ policy which was dated 16 November 2016, and due for review in July 2019. The policy had appendices which staff could use for assessing patients pain. For example, the ‘PAINAID’ scoring tool for assessing pain in patients with advanced dementia.

The service used the ‘Abbey Pain Scale’ for patients with learning disability or dementia, this is a tool designed to assist in the assessment of pain in patients who are unable to clearly articulate their needs.

The hospital’s acute and chronic pain management team were available 24 hours a day, seven days a week. We saw the pain team visiting wards and advising staff on patients’ pain management. The pain management team also supported staff learning and development in regards to pain management.

**Patient outcomes**

We viewed data from the trust’s sepsis audit for specialty medicine wards, 9E (renal), 9F (renal), 10E (gastroenterology and hepatology), 11C (metabolic and general medicine), 13E (cardiology and respiratory), and 13F (respiratory and HIV), dated from February 2017 to March 2018. We found there were variable results. For example, the numbers of patients audited varied from 10 patients in February 2017 to 40 patients in July 2017. There was also variation in the number of patients screened for sepsis. For example, 30% in August 2017 compared with 67% in September 2017. Although, the trend in patients screening improved from August 2017 to May 2018, there was a decreasing trend in the percentage of patients screened in May 2018 (50%), June 2018 (39%), and July 2018 (22%). There were also variations in the percentage of patients receiving antibiotics within 60 minutes of diagnosis. For example, the rate was 50% in September and November 2017 and 50% in January, February, May, June and July 2018. The rate in March 2018 was 100%. However, the rate in April 2018 was 25%.

RLH informed us that in May 2017 a snapshot audit of inpatient falls was scheduled to take place. However, the audit date had coincided with the NHS cyber-attack. This had resulted in the trust not having functional IT systems for a period of two weeks. The cyber-attack also meant staff were directed to frontline patient care due to the extra work involved in recording and managing patients care and treatment without IT systems. As a result, the Royal London Hospital (RLH) site did not contribute to the 2017 ‘National Audit of Inpatient Falls’. However, the hospital informed us that incidents of inpatient falls were monitored through the division’s governance meetings, site level quality and safety committee reviews and divisional performance reviews. Incidents of falls with a moderate level of harm, severe level of harm or death were reported through the site level serious incident review weekly meeting. Reduction of falls with harm was a trust quality objective and the hospital reported on a monthly basis that falls were below the national threshold of 4.8 pre 1000 bed days to the hospital’s quality and safety committee.

From March 2017 to February 2018, patients at the trust had a higher than expected risk of readmission for elective admissions and a higher than expected risk of readmission for non-elective admissions when compared to the England average.

Across the trust, patients in gastroenterology, cardiology and nephrology had a higher than expected risk of readmission for elective admissions:
Across the trust, patients in general medicine, geriatric medicine and nephrology had a higher than expected risk of readmission for non-elective admissions:

From March 2017 to February 2018, patients at the Royal London Hospital had a higher than expected risk of readmission for elective admissions and a higher than expected risk of readmission for non-elective admissions when compared to the England average.

At the Royal London Hospital, patients in gastroenterology, nephrology and pain management had a higher than expected risk of readmission for elective admissions:

At the Royal London Hospital, patients in general medicine, stroke medicine and nephrology had a higher than expected risk of readmission for non-elective admissions:
Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.

(Source: Hospital Episode Statistics - HES - Readmissions (March 2017 – February 2018))

We asked a consultant about the hospital’s higher than the England average risk of readmission. We were told that the hospital had a demographic which was different from the England average, with higher rates of poverty, homelessness, mental health, substance misuse, and social exclusion, and this was a factor in patients’ risks of being readmitted.

The Royal London Hospital takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the hospital achieved grade B in latest audit, August to November 2017.

(Source: Royal College of Physicians London, SSNAP audit)

The hospital regularly reviewed SSNAP data at governance meetings, for example, we viewed minutes from the stroke governance meeting dated 26 April 2018 where SSNAP audit results were reviewed. Key performance indicators (KPI) from the SSNAP dataset were reported to commissioners on a weekly basis.

The trust participated in the 2017 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 78.2%, which did not meet the audit aspirational standard of 90%. The 2016 figure was 72.3%.

In the 2017 audit, the proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 23.4%. This is good practice. The 2016 figure was significantly better than the national level.

In the 2017 audit, the proportion of fit patients with advanced (NSCLC) receiving Systemic Anti-Cancer Treatment was 81.3%. This is good practice. The 2016 figure was not significantly different from the national level.

In the 2017 audit, the proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 74.9%. This is within the expected range. The 2016 figure was not significantly different to the national level.

The one-year relative survival rate for the trust in 2017 is 40%. This is within expected range. The 2016 figure was not significantly different to the national level.

(Source: National Lung Cancer Audit)

In the National diabetes inpatient audit (NaDIA) 2017, RLH was among the top 15% of hospitals in England for the proportion of patients achieving the glucose control target HbA1c<58mmol/mol. By measuring glycated haemoglobin (HbA1c), clinicians are able to get an overall picture of what a
The patient's average blood sugar levels have been over a period of weeks/months. For people with diabetes, this is important as the higher the HbA1c, the greater the risk of developing diabetes-related complications.

The hospital had developed an action plan in response to an audit in 2016 of NICE Quality Standard QS16: Hip fracture in adults. This included the development of a hip fracture pathway in collaboration with community services. The trust had re-audited hip fracture incidence 12 months after the pathway’s introduction. The re-audit found that following the pathways implementation referrals within the 5 days had seen an improvement from 35% of people being seen within the recommended time frame to 68% in 2017. Data provided by the trust demonstrated that the number of hip fracture patients had increased. For example, from May 2016 to May 2017, the number of hip fracture patients was 102, compared to 128 from May 2017 to May 2018. However, the average length of stay for patients had decreased from 25 days in the year to May 2017, to 20 days in the year to May 2018. There had also been improvements in the numbers of hip fracture patients seen by a geriatrician within 72 hours, time to surgery, pre- and post-operative cognitive assessments, hospital mortality and patients returning to their own home.

Acute Kidney Injury (AKI) is a common complication in hospitalised patients which is strongly associated with adverse outcomes. Patients with AKI often require intensive care unit (ICU) admission. AKI alerting is an important component of the recognition of the deteriorating patient. The trust had piloted a program of managing AKI at Whipps Cross Hospital. A Commissioning for Quality and Innovation (CQUIN) initiative was being introduced at RLH. These are initiatives to make a proportion of the healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of patient care. The CQUIN was designed to support lasting change in the management of AKI patients by implementation of a harmonised London AKI pathway.

The hospital informed us that the cardiology service at Barts Health was networked to St Bartholomew’s Hospital who was responsible for monitoring RLH data. However, the services had input to audit work in response to NICE Quality Standards. For example, the service was supporting Tower Hamlets clinical commissioning group (CCG) in developing a diagnostic pathway. The heart failure standards were updated in September 2018 in response to new NICE guidelines and the service was planning to benchmark against these in the future.

**Competent staff**

Staff received a first appraisal six months after commencing employment, then yearly following that. The appraisal completion rates in September 2018 for non-medical staff were 83%. Appraisal rates for medical staff were 97% in September 2018. Staff spoke positively of the appraisal process and said they received structured, meaningful support from their line manager to progress.

New staff we spoke with told us they had received an induction, including a corporate induction to the trust. The new staff induction also included completion of mandatory training modules and an introduction to the department and wards they would be working on.

Ward managers told us new agency staff received an orientation and induction to the ward. This was recorded on the trust’s e-rostering tool when completed. Ward managers told us the trust’s bank staff team were responsible for background and competency checks on agency staff. However, ward managers said they did not see copies of agency staff competency assessments.

The trust had a team of practice development nurses (PDN) who were responsible for rolling out trustwide education.
The hospital offered a range of training and continuous professional development (CPD) opportunities to staff and students. For example, we saw dates for monthly clinical nurse specialist (CNS) seminars and forums displayed on ward 13E. We also saw dates for monthly ‘Reflections in practice’ sessions displayed on the ward.

The pain team offered study days for hospital staff. The team also offered bespoke training for staff on pain management techniques and equipment. As well as support for staff in prescribing and non-prescription method of pain management.

CNS had a specialist nurse teaching programme. The pain team provided a pain management module as part of the generic modules on specialist programmes. Medical students were invited onto the pain management consultant’s daily ward round. The pain team also provided health care assistants with training on using the trust’s pain assessment tools and how to assess and escalate patients’ pain issues.

Learning disability awareness training was part of staff training programmes. For example, the second-year doctors training programme and monthly new health care assistant (HCA) training programmes.

The safeguarding lead told us some staff had completed de-escalation training and the safeguarding team were working on the introduction of simulation training for conflict resolution. The safeguarding lead said this was due to RLH having a complex cohort of patients and staff increasingly needing skills in moderating patient and carers’ behaviour.

Staff we spoke with told us there had been an increased emphasis on staff ‘skills and drills’ training since our previous inspection in March 2016. Staff on ward 11C told us the ward regularly set aside 30 minutes on a Wednesday and Friday for ‘skills and drills’ training.

Staff told us they were supported by RLH education team with the renewal of their professional registrations. For example, we saw monthly dates for the Nursing and Midwifery Council (NMC) mentor update sessions displayed on ward 13E. Staff on ward 13E also told us about recent simulation training they had attended on tracheostomy care. A tracheostomy is an opening created at the front of the neck so a tube can be inserted into the windpipe (trachea) to help patients breathe.

Therapies had a new recruitment model, which included a two-day workshop and interview for prospective candidates. Therapies had filled all band 5 posts using the model and found increased retention of newly recruited staff. Therapies offered a trustwide education programme including models of evidence based practice, implementing quality, and the NHS outcomes framework. However, therapy leads told us there was a supervision programme for therapists, but said that senior staff were “spreading themselves thinly” in order to support staff development and supervision.

There was a preceptorship programme for newly qualified nurses. The hospital regularly offered placements to student nurses, their training included quarterly multi-professional student forums. The contact details for university link lecturers were displayed on ward 13E. Student nurses we spoke with told us they were well supported. A student nurse on ward 9E had nominated their mentor for the monthly ‘Barts health hero’ awards in June 2018.

The wards had a range of link nurses. Link nurses were part of a system that shared information and provided formal, two-way communication between specialist teams and nurses in the clinical areas to promote and enhance clinical effectiveness and disseminate research findings. For example, wards had link nurses for infection prevention and control and safeguarding. Most staff across the wards were aware of the link nurses for their wards. Although, we found five members
of staff on ward 9E that were unaware of the ward link nurse for safeguarding. A doctor on 9E was not aware of the name of the ward dementia champion.

During our previous inspection in June 2016, staff told us the trust did not support staff wishing to complete qualifications relevant to their role. However, during this inspection staff told us there was money available for staff to complete further study. For example, staff at the Graham Hayton unit told us there were a range of opportunities for training in excess of the service’s mandatory training. Staff said they were encouraged in their yearly appraisal to consider their professional development needs and what training might support this. A band 6 nurse at the Graham Hayton unit told us they were being supported to attend a course in sexual health at Brighton University.

Medical staff had training competencies for trainees maintained and assured via the London Deanery Annual Review of Competence Progress (ARCP) outcomes process. Sufficient competent clinical decision makers, senior decision makers, and consultants with appropriate competences were available so that timescales for assessment and treatment could usually be achieved for the expected number of patients. Consultant and registrar rotas were organised to give reasonable continuity of care for patients.

**Multidisciplinary working**

We found effective multidisciplinary working across the wards and departments. For example, ward 9E had introduced twice daily multidisciplinary team (MDT) meetings. The early MDT meeting had been moved to earlier in the day to facilitate patients’ earlier discharges.

The acute admissions unit (AAU) worked closely with staff from RLH accident and emergency department. The AAU also had a social worker assigned to the team. Staff said this had led to improvements in access and flow as patients discharge planning could commence on admission as the social worker was part of the patients care planning and pathway from admission.

The complex discharge team had developed a single point of access (SAP) where nurses spoke with one member of the complex discharge team from the point of referral to the patient being discharged.

Therapies, including speech and language therapy (SALT), physiotherapy, occupational therapy (OT), and dietitians, worked with staff on the wards and the complex discharge team. Staff in the therapy team told us they worked across medicines wards and found that different services had a different picture of what therapeutic care should look like.

Sexual health services were multidisciplinary. For example, the Graham Hayton unit had a social worker employed directly by the trust and integrated into the team.

The trust provided an international nurse programme for staff recruited outside of the UK, including an English language support programme. Following completion of this programme, international nurses were enrolled on a preceptorship course to enable them in learning about nursing in the NHS in England.

**Seven-day services**

Seven-day services were audited in 2017-2018 as part of a pan-London review against NHS standards. The results of these audits were not available at this time of compilation of this report.

The acute admissions unit (AAU) admitted patients from the accident and emergency department 24 hours a day, seven days a week. Staff told us the AAU could be just as busy at night as during the day. Staff said the staffing uplift at night in the AAU reflected this.
All specialisms provided 24-hour consultant cover, seven days a week. All patients in medicine were reviewed by a consultant daily, via daily ward based board rounds. Consultant bedside reviews occur daily on wards 9E, 9F (renal), 10E (gastroenterology and hepatology), 13E (cardiology and respiratory) and 13F (respiratory). Patients on ward 11C (diabetes and general medicine) have daily bedside review Monday to Friday and Saturday and Sunday on six weeks out of eight weeks. On the remaining two weeks the patients had a registrar led bedside review on Saturday and Sunday, with a consultant available on call to attend if necessary.

Pharmacy services were available 24 hours a day, seven days a week. This included a dispensary lead, staff with full access to stores, and a pharmacy lead.

Clinical and medical engineering services were available 24-hours, seven days a week. There was a medical engineer on-call at night and at weekends to provide equipment repair or replacement.

Routine diagnostics, including: pathology, X-ray, CT and MRI, were available 24 hours a day, seven days a week in the Royal London Hospital. Therapies are provided at weekends (OT, physio and SALT) and emergency physiotherapy is available overnight if necessary.

Occupational therapy and physiotherapy services were provided seven days a week from 8am to 6pm. Dietetics services were available from 9am to 5pm Monday to Friday. Speech and language therapy (SLT) was available seven days a week. The SLT team had a policy to assess patients within 48 hours of referral. Therapy staff on the stroke unit, ward 3E, told us therapy availability had improved since our previous inspection in June 2016.

The critical care outreach team were available from 7.30am to 8.30pm seven days a week. Outside of these hours a hospital at night team supported patients identified as at risk of deterioration.

All pathology results were reported directly on the electronic patient record (EPR). This was available to all staff that had been suitably trained at all times via any trust computer. Access was controlled via an NHS smartcard. Additionally, the biochemistry, haematology and microbiology laboratories could be telephone 24 hours a day, seven days a week to access urgent results.

**Health promotion**

The amount of health promotion information available across the wards was variable from ward to ward.

We asked staff on the evening shift on ward 11E about health promotion information. Staff were unable to tell us where the information was located on the ward. We saw a smoking cessation poster on the ward. However, this was behind a nursing station and patients would have needed to go behind the nursing station to read the posters content.

Ward 9E had a large visible poster on the ward that informed patients of actions they should take to avoid ‘pyjama paralysis’. The posters gave patients advice on mobilising and getting dressed to improve their general health and recovery. Ward 9E were also engaging in a ‘Falls Reduction Rapid Accelerator Programme,’ which was due to commence on the 18 September 2018 and run for 18 weeks. The objectives of the programme were to support ward based teams with falls prevention.

The Graham Hayton unit provided an outreach service in the form of a bus that attended festivals to provide sexual health screening and advice on safe sex in the community. The service also worked with a national charity in providing courses for newly diagnosed human immunodeficiency virus (HIV) patients to assist them in understanding their diagnosis and to provide support.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**
Staff training, knowledge and practice of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS) was good and appropriate to their individual role and level of seniority. The percentage for both medical and nursing staff that had completed mandatory consent training was better than the trust’s 85% standard. The Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) was covered in the trust’s level 2 safeguarding adults training. Data provided by the trust 4 June 2018, found 94% of nursing staff had completed the level 2 training; this was better than the trust’s 85% standard. However, medical and dental staff had a completion rate of 80%, this was worse than the trust’s 85% standard.

Staff had guidance on the RLH care pathway and assessment protocol under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). For example, ward 13E had guidance for staff on ‘What we are allowed to do’ under the DoLS displayed in the staff room. There was also guidance for staff, ‘Where are the tools’, this gave staff information on where they could access the single trust form that covered patients’ capacity, best interest assessments, applying for DoLS authorisations, authorising hand restraint, and how to access an independent mental capacity advocate (IMCA). There was step by step guidance for staff displayed across wards and departments on how they could access the form using a link on the trust’s intranet.

We found that not all patients’ DoLS information was stored securely. For example, we viewed a patient’s DoLS assessment being kept in the patient’s folder on the side of a patient’s bay on ward 9E. The patient’s folder was easily accessible as the folder was close to the bays entrance. This meant there was a risk that unauthorised people could have removed the patient’s DoLS assessment or could have had access to the patient’s confidential DoLS assessment information.

Staff in sexual health and HIV service were aware of ‘Gillick competence’ this is a term used in medical law to decide whether a child (under 16 years of age) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. Staff were also aware of ‘Fraser Guidelines’, these specifically relate only to contraception and sexual health and address the specific issue of giving contraceptive advice and treatment to those under 16 without parental consent.

Sexual health services used the ‘preview’ records system. The system ensured patients sexual health information was not shared with other organisations without the patient’s consent, for example, relatives working in the hospital or the patients GP.

We viewed the RLH performance graph for duty of candour. This was used by the hospital to monitor the hospital’s performance. The graph recorded that the hospital had 135 incidents that met the duty of candour requirement. The hospital was compliant with 112 of these or 83% from September 2017 to August 2018. Older people’s service was 100% compliant in the same period and the medicines division were 95% compliant. The quality and safety dashboard dated May 1 to September 1 2018, recorded 100% compliance with duty of candour requirements in the same period.

We viewed a letter which was sent to a patient following an incident dated 11 July 2018, which clearly set out the expectations on the hospital’s in terms of the duty of candour, the letter also offered the patient an apology and explanation of the actions the trust were taking in response to the incident.

Is the service caring?

Compassionate care
The interactions we observed between permanent staff and patients were positive and compassionate. For example, we saw staff providing personal care to a patient on ward 14E. Staff explained what actions they would take prior to providing any care; this meant the patient knew what care staff would be providing before staff provided assistance. We also saw a health care assistant (HCA) providing compassionate care to three patients in a bay on ward 14F. The staff member checked whether each patient needed any support. The staff member assisted one of the patients when transferring from their bed to a chair, whilst offering the patient reassurance. When the patient was seated the staff member ensured the patient had a drink within reach. The staff member engaged the patients in the bay in conversation on an individual basis, asking how they were feeling and showed interest when patients discussed their families or their lives.

Ward 9E had a sign which read “Welcome” in the nine most commonly used languages served by the hospital. This afforded most patients entering the ward a message of hospitality from the ward.

The Graham Hayton unit and Ambrose King centre provided sexual health services. The Graham Hayton unit had a specific area for the support and treatment of patients with a diagnosis of human immunodeficiency virus (HIV), this ensured patients privacy and dignity was respected.

Most patients we spoke with were positive about staff being compassionate and kind. For example, one patient told us, “They’ve been very kind. I have no complaints.” However, Friends and Family test data found that RLH was rated worse than the England average from July 2017 to June 2018 in terms of the percentage of patients who would recommend its services to their friends or family.

The Friends and Family Test (FFT) response rate for medicine at The Royal London Hospital was 11% which was worse than the England average of 25% from July 2017 to June 2018.

Below is a graph that sets out the FFT response rate between July 2017 to June 2018 by site:

(Source: NHS England Friends and Family Test)

The quality and safety dashboard dated 1 May to 1 September 2018 recorded that 90% of patients in the period would recommend the trust to their friends or family.

**Emotional support**
Patients we spoke with told us staff were supportive. Some staff told us they had received training in supporting patients that became emotional as part of the trust’s conflict resolution training. Over 90% of all staff groups had received this training. This was better than the trust standard of 85%.

All of the staff we spoke with were aware of the on-call arrangements for the RLH chaplaincy service. The chaplaincy service offered a 24 hour confidential support and listening presence for all patients, relatives and friends of patients irrespective of belief systems. The chaplaincy also provided regular religious services including Muslim Jummah prayers, Roman Catholic mass, and Church of England eucharist.

Emotional support services were available for patients in sexual health and HIV services. This included on-site support for patients with a HIV positive diagnosis and targeted support for patients who used recreational drugs. Reception staff in the Graham Hayton unit and Ambrose King centre received emotional support training to assist patients in distress. The service also offered volunteer peer mentors who provided emotional support to patients newly diagnosed with HIV as part of the service’s work to promote wellbeing and positive coping strategies.

During our previous inspection we found some temporary staff, including agency nurses and volunteers lacked the appropriate personal skills to adequately care for patients with understanding and kindness. During this inspection we found interactions between agency nursing staff appropriate, the hospital had also reduced its reliance on agency staff. Volunteers in sexual health services were provided with training in supporting people with their diagnosis.

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

Patients we spoke with across wards and departments told us staff always introduced themselves and explained what they were doing before providing care. For example, patients at the Ambrose King unit told us they felt involved in their care and said they had been offered printed information about their condition and treatment.

There was an inconsistent amount of printed information available across wards and departments. We found some wards had a wide range of information available to patients. For example, ward 13E had a range of information patients or families and carers could take away, including guidance on falls prevention and what actions people should take in the event of a fall at home. Ward 14E had a range of information available to patients and their carers including information on NHS ‘Continuing Healthcare’. This is funding available from the NHS to patients who meet the criteria for a health care package in the community. The AAU had comprehensive information for patients and carers including booklets on falls prevention and charges for patients who may not be eligible to receive free treatment under the NHS.

We viewed the information packs sent to patients awaiting endoscopy prior to endoscopic procedures. The pack explained in accessible language what patients should do prior to their appointment, including how patients should prepare their bowels. Patients were also signposted to online resources to assist them in preparing for their appointment. However, we found there was limited printed information for patients in regard to their health and welfare in the endoscopy waiting area.

All wards had performance boards displayed on the ward. The wards included sections, ‘You said, we did.’ Although, we found not all wards updated the information on the boards monthly. For example, ward 9E had comments from patients and carers dating from May 2018. The comments were positive and included, “Nurses were efficient, every time I rang my bell they came straight away,” another comment was, “Caring, kind and professional staff from the consultants to the nurses and health care assistants (HCA).”
A patient we spoke with in endoscopy told us they had tried to book an appointment in August 2018. The patient said they had spent time calling the telephone number on the appointment reminder letter but could not get an answer from the ward. The patients’ next of kin visited the endoscopy unit in person to book the appointment. The patient said staff at the unit told them not to use the telephone number provided on the reminder letter as the telephone number was incorrect. Staff provided the patient’s next of kin with an alternative telephone number. However, this meant there was a risk of patients not booking appointments, as they were not provided with the endoscopy units correct contact details.

A dedicated home dialysis nurse provided training to haemodialysis patients to teach them skills in self-care and enable them in dialysing at home.

Is the service responsive?

Service delivery to meet the needs of local people

The Royal London Hospital (RLH) is a large teaching hospital. It provides district general hospital services for the City and Tower Hamlets and specialist tertiary care services for patients from across London and elsewhere. The hospital is a modern hospital, built under a private finance initiative (PFI), this means a private company, instead of the government, owns the building and leases it to the trust. The building opened to the public in 2012.

All wards at RLH had single-sex bays and side rooms so that patients with more complex needs could be appropriately cared for. Services provided reflected the needs of the population served ensuring flexibility, choice and continuity of care. For example, on wards 11E and 11F RLH had an acute admissions unit (AAU). The AAU was a 52-bed unit, with 26 beds each on ward. The AAU wards had a one to four staff to patient ratio, due to the AAU remit being to avoid long-term admissions. The AAU had eight cardiac monitors and could accommodate Non-ST-elevation myocardial infarction (NSTEMI) patients. A myocardial infarction is the medical term for a heart attack.

Some staff told us that due to the demography of patients attending RLH there were a high percentage of people with social care, mental health, substance misuse, and housing needs. Staff told us many of these patients had challenging behaviour. Staff had received training in conflict resolution, as of 4 June 2018 90% of nursing staff and 95% of medical had up to date training. There were procedures in place for staff to call the hospital security team if a patient became physically aggressive. Staff told us the hospital security team would not restrain a patient unless they were subject to a section under the Mental Health Act or had a Deprivation of Liberty Safeguards (DoLS) authorisation in place. Staff on ward 10E told us they regularly called the RLH security team to provide assistance with patients with mental health needs. Staff told us the hospital security team was responsive, but that the ward staff had been asked by security not to call them as frequently. Staff on the ward told us they felt disappointed by this response from security.

Staff told us patients increasingly had higher acuity. RLH had a complex discharge team. Staff from the complex discharge team told us they worked closely with the local authority on discharging homeless people. The team was made up of social workers and physiotherapists. The team manager told us the team would ideally have an occupational therapist (OT) and discussions were in progress in regard to the team employing an OT. The team manager told us sometimes patients were admitted longer than was necessary. This was due to a shortage of rehabilitation beds in the community for homeless people and people who misused substances.
Work was in progress on a strategy to reduce the risk of patients absconding from RLH. The safeguarding team had liaised with network rail and the community mental health team (CMHT) to look at methods of reducing the risk of patients absconding from the hospital.

Staff on ward 10E told us the ward took patients from a wide remit, such as patients with diseases of the liver, nutrition patients, neuro-gastro patients, inflammatory bowel disease, dermatology, and rheumatology. Staff on ward 10E told us they were seeing increasing numbers of patients with mental health needs. Staff said managing these was challenging. Staff on ward 10E said they tended to have younger patients and many of these patients had mental health needs. Staff said they could get a registered mental health nurse (RMN) or band 2 health care assistant (HCA) to provide one to one support for a patient receiving care under the Mental Health Act. However, staff said some RMN were male and would be allocated to provide care for a patient in an all-female bay overnight, which other patients may be uncomfortable with.

RLH worked closely with the Tower Hamlet’s Mental Health Liaison Service (RAID). The multidisciplinary team was provided by the department of psychological medicine and combined expertise in adult and older people’s mental health to provide assessment, treatment and management of mental health problems including anxiety, depression, dementia, schizophrenia and any other mental health or psychological problem in RLH ward settings or in the emergency department. Most staff across the wards we spoke with told us the RAID team was responsive. Although some staff said they thought the team could take some time to arrive following a referral.

Ward staff on 10E said they could not meet the psychological and emotional needs of patients diagnosed with personality disorders as these patients were not subject to the Mental Health Act and therefore not supported by the RAID team. Staff told us this was a particular problem on ward 10E. Staff said RLH was in the process of adding mental health care to the risk register. This was to support and enable RLH staff in supporting this group of patients. Staff on ward 10E said the ward needed a further band 5 nurse due to the acuity and complex needs of patients with mental health needs.

The AAU had a community liaison service that enabled GPs to speak directly to a consultant between 8am and 9pm, seven days a week. This enabled medical staff to work together to ensure referrals were appropriate.

Staff in sexual health services worked closely with local commissioners and non-profit organisations to ensure open-access services met the needs of the local population. This included reaching patients in high-risk populations with information to assist them in understanding the services provided. For example, community organisations attended the Ambrose King centre and Graham Hayton unit to provide support and advice in clinics and to work with RLH staff in meeting the increasingly complex needs of different population groups in east London. The Graham Hayton unit provided a six-day service, Monday to Saturday, which meant people could access sexual health services at the weekend.

Therapy staff told us they received extra money for winter pressures planning. However, staff said receiving the money in January or December delayed planning as therapies did not use bank staff and had to recruit staff to cover winter pressures. Staff said the trust did not understand that therapies did not recruit to a nursing model and if the money was released in September or October this would facilitate workforce planning.

Medical staff told us there had been an increase in the length of stay for patients due to the increasing acuity and complexity of the patients RLH saw. Medical staff said there were specific demographic factors which contributed to patients’ length of stay at RLH. For example, a doctor
told us young people who misused substances were the group with the highest rate of falls at the hospital.

From April 2017 to March 2018, the average length of stay for medical elective patients at the trust was 9.9 days, which is higher than the England average of 6.0 days.

Average length of stay for elective patients in cardiology and gastroenterology is lower than the England average across the trust, and average length of stay for elective patients in clinical haematology is higher than the England average:

![Bar chart showing average length of stay for elective patients across specialties.]

Note: Top three specialties for specific trust based on count of activity.

For medical non-elective patients, the average length of stay was 6.1 days, which is lower than the England average of 6.4 days.

Average length of stay for non-elective patients in general medicine is lower than the England average, and the average length of stay for non-elective patients in geriatric medicine and cardiology is higher than the England average:

![Bar chart showing average length of stay for non-elective patients across specialties.]

Note: Top three specialties for specific trust based on count of activity.

From April 2017 to March 2018, the average length of stay for medical elective patients at The Royal London Hospital was 20.4 days. Information provided by the trust indicated that the high elective average length of stay of 20.4 days was due to a data issue regarding a single patient. With this issue taken into account, the average length of stay was 4.8 days, which is lower than the England average of 6 days.

Average length of stay for elective patients in gastroenterology and nephrology is lower than the England average.
For medical non-elective patients, the average length of stay was 5.8 days, which is lower than England average of 6.4 days.

Average length of stay for non-elective patients in general medicine is higher than the England average and the average length of stay for non-elective patients in nephrology and stroke medicine is lower than the England average:

(Source: Hospital Episode Statistics)

Meeting people’s individual needs

Wards that provided care for patients with dementia had pictorial signs to help patients understand where the toilets and bathrooms were. In February 2018, RLH opened two dementia friendly garden rooms, with one on 14E ward and another on 14F. The rooms used wall murals, artificial grass, scent diffusers and patio furniture to create a calm atmosphere for dementia patients. The hospital was also hosting a dementia community roadshow for people affected by dementia on 20 September 2018.

The learning disability lead had produced comprehensive guidance for staff. This included a laminated checklist for staff when dealing with patients with learning disabilities. We saw the checklist displayed in staff rooms and offices across the wards and departments we visited.

Carers of vulnerable patients could stay overnight at James Hora House, this was a residential block on the RLH site which was owned by the trust. However, staff told us carers usually preferred to stay on a carers chair in their relatives or friends room.
Staff had access to Makaton symbols (this is a system of signing to help people communicate), and they could download the symbols from the RLH intranet to enable staff in communicating with people.

Hearing loops were available across the hospital for patients who were hearing impaired, this is a special type of sound system for use by people with hearing aids.

Staff could access both face to face and telephone interpreters for patients that did not speak English as a first language. Staff told us they would try to use the RLH diverse staff group as a first point of call for interpreting, if a staff member was not available interpreting services could be arranged with a telephone interpreting service or booked with a face to face interpreter. During our inspection we saw a doctor intervene during a ward round and request an interpreter for a Bengali speaking patient on ward 13E. The doctor’s intervention followed nursing staff informing the doctor that the patient’s family could act as interpreters. The doctor highlighted that using family members or friends as interpreters could compromise patient confidentiality. Following the doctors intervention, an interpreter was booked for the patient on the same day.

The hospital’s catering staff could prepare food according to patients’ religious specifications, as well dietary needs. For example, halal, kosher or vegetarian.

Across all wards and departments, we found there was a range of information on local services for patients and carers. For example, Ward 14E had easy read copies of guides for patients on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). The ward also had a range of information on accessing local services, including benefits advice and advocacy services. Ward 13E had a ‘patient information’ board which had information on the ‘Forget Me Not’ document for patients with dementia and an explanation of the dementia friendly checklist.

Printed information was available in other languages from the trust’s accessible communications team, this service was advertised on patient and carer information sheets which were widely available across the wards and departments. The leaflets gave information, in the most common languages used by patients and visitors, for example, Bengali and Polish, on how to access translations of written information. The leaflets had a telephone number patients and visitors could contact to request leaflets. The leaflets also informed patients and visitors on how information could be accessed in large print.

**Access and flow**

RLH had a range of well-established care pathways. For example, in the morning the acute medical team saw patients referred to the AAU from accident and emergency or their GP. At 9am there was a board round meeting which triaged these patients, consultants from specialist wards attended the meeting and would review patients allocated to them.

The DSU also acted as an escalation ward in the event of bed shortages due to higher levels of demand on the hospital for beds. The hospital provided data on the number of times the DSU had been used for escalation in the 12 months up to September 2018. For example, the DSU had patients overnight, (8.00pm to 8.00am), on 12 occasions in April 2018 and 15 occasions in May 2018. The DSU was not open as an escalation ward in June. In July 2018, the DSU had patients overnight on 19 occasions, and 11 occasions in August 2018. The DSU was not used as an escalation ward in September 2018. The largest number of patients staying overnight in the DSU was nine patients in August 2018. From April to August 2018, excluding June, the number of patients on the DSU overnight was between two and seven.
The length of stay at the AAU was 48 hours, during this time a decision would be made whether to discharge the patient or transfer them to a specialist ward. The AAU did not discharge patients at night.

Specialist wards had an 8.30am meeting and knew what beds were available on the speciality wards. Staff would then feed this information into the medicines and older people’s board round meeting at 9am. This reduced delays in staff across the service identifying bed availability.

At the time of inspection there were no medical outlying patients, these are medical patients placed in other wards different from a medicine ward due to a lack of beds, this can have an impact on patients’ outcomes. Staff told us outlying patients were usually cared for on the AAU. Staff said occasionally during winter pressures, patients would be out-liked to ward 3D, a short stay surgical ward. To minimise the risk of outlying patients being missed off medical lists the medical team had created a patient list on the clinical records system (CRS) to enable medical staff in tracking their patients. Staff told us this meant medical staff did not miss any patients allocated to their list. The AAU also occasionally took outlying patients from non-medical wards. Staff told us AAU nurses would be responsible for these patients nursing care, but the patient would be under the care of the consultant from the ward that had referred the patient. The patient would be on the referring ward’s consultant ward round list on CRS and could be easily tracked. General medicine outlying patients who did not have an allocated ward consultant would be allocated to the gastro consultants list. Nurses were aware that the gastro consultant provided care for patients who did not have a specialist consultant.

We found ward 13E used a whiteboard in the staff room which listed patients’ names, who their consultant was, whether the patient was a respiratory or cardiac patient, together with the patients expected date of discharge. The board also recorded discharge information for patients who had a confirmed discharge date, this included ‘what is being done today’ information, which recorded visits from therapists and information on patients who had ‘to take away’ (TTA) medicines. A nurse told us, “We start planning a patient’s discharge as soon as they get here. It’s part of the process.”

Medical staff told us there had been an increase in the acuity of patients over a 10 year period. However, RLH had introduced a number of initiatives to improve discharge planning. In response, the trust had introduced initiatives to assist patients discharge planning. This included a complex discharge team and a dedicated social worker who attended the 11.30am bed meeting. This meant patients ready for discharge had their community care needs identified and referred to social services quickly.

The RLH complex discharge team did not have eligibility criteria to access services. Wards referred patients requiring complex packages of care directly to the team. The complex discharge team manager told us the team were involved with around 50% of the RLH wards on a daily basis. The team reviewed the RLH discharge list in the morning and afternoon, and liaised with social workers in regard to patients discharge planning. The team had access to the local authority social services records system this meant they could monitor patients’ community care discharges in real time.

The trust set a standard of 20 patients at any time on the discharge list. Staff told us on the 12 September 2018, there were 25 people on the list waiting to be discharged. Staff told us nine of these people were homeless and six were for neurorehabilitation. Staff told us there were problems with community placements for homeless people and this tended to delay discharges. Staff said the team had explored specialist placements in the community for neurorehabilitation patients, but said there was a shortage due to these patients having specialist needs and needing
to receive the same level of neurorehabilitation in the community as they would in the hospital.

Staff told us these patients could wait several weeks for a suitable placement.

Staff told us there were sometimes delays under the Community Care (Delayed Discharges) Act 2003 Section 2 (S2) which requires an NHS body to notify social services of a patient's likely need for community care services after discharge and Section 5 (S5). This notifies social services of the proposed date of a patient's discharge. The complex discharge team said they were discussing with managers how the process could be sped up by the complex discharge team assisting ward staff by completing the S2 and S5 discharge notifications. S2 and S5 discharge notifications were automatically referred electronically to the complex discharge team and the patients' local authority social services.

Following our inspection, the trust provided us with data relating to delayed transfers of care from April 2018 to August 2018. We found delays were stable, but the rates were high at between 28% in July 2018 and 35% in May 2018.

Following our inspection, the hospital informed us that there were 17 initiatives to reduce the number of delayed discharges. This included: Multi-agency discharge events (MADE). These were monthly meetings that reviewed patients with a length of stay of seven days or longer and aimed to identify and resolve potential blocks to discharge. The meeting was attended by key decision makers from CCG, local authorities, mental health services, primary medical care services and the voluntary sector.

Staff said that they had good relationships with local authorities and could access the local authority electronic records system. Staff told us discharge delays had significantly reduced since the introduction of electronic referrals to the local authority.

The administrative staff team leader in the endoscopy unit reviewed cancellations and missed appointment slots on a daily basis as well as reviewing breaches of the two-week wait target.

Staff we spoke with recognised the risks associated with unnecessary patient bed moves. Staff told us patients were only moved when essential. From April 2017 to March 2018, 59% of individuals did not move wards during their admission, and 41% moved once or more. This was much worse than April 2016 to March 2017 when the rate for individuals who did not move wards during their admission was 81%.

Ward 10E:

From April 2017 to March 2018, 67% of individuals did not move wards during their admission, and 33% moved once or more.

Ward 13F:

From April 2017 to March 2018, 64% of individuals did not move wards during their admission, and 36% moved once or more.

Ward 9E:

From April 2017 to March 2018, 79% of individuals did not move wards during their admission, and 21% moved once or more.

(Source: RPIR Universal – ward moves tab)

From April 2017 to March 2018, there were 3,298 patients moving wards at night across 13 wards within medicine. During the reporting period, July 2017, February 2018 and March 2018 showed the highest number of ward moves at night (July: 329, February: 308, March: 297). The trend was a very slight decrease in the number of patients who were moved at night in the reporting period.
The top three wards with the highest moves at night were:

- Ward 11C: 489 moves at night
- Ward 13E: 450 moves at night
- Ward 13F: 335 moves at night

(Source: RPIR Universal – moves at night tab)

Following our inspection, the hospital informed us that night moves were recorded between the hours of 10pm and 8am. From April 2017 to March 2018, 311 moves at night were from the acute admissions unit (AAU), which was classed as a medical ward. The AAU was the main admitting area for non-elective medical admissions from the emergency department (ED). The hospital told us patient flow was necessary to maintain the ED statutory performance.

We saw a patient being admitted to ward 13E at 9.00pm on the 11 September 2018. The patient had been transferred from the accident and emergency department. Staff told us ward 13E had a 24-hour admissions policy due to its respiratory and cardiac specialisms. We saw that staff on the ward had discussions with porters at the nursing station and transferred the patient quietly to a bay to minimise the disturbance caused to other patients in the bay.

During our previous inspection we reported that waiting times in the Ambrose King centre walk-in clinics were sometimes variable. However, the service had introduced a web booking service that allowed patients to be allocated a time for their appointment. Patients we spoke with told us they were seen promptly. We did not see patients waiting for prolonged periods in the waiting room.

Staff in the emergency department and AAU used an ambulatory care pathway to make the most appropriate admission decision. This applied to 22 medical conditions where patients had a low national early warning score (NEWS) and were over the age of 18. This meant decisions about admission could be made safely while reducing pressure on the hospital to find inpatient beds unnecessarily.

**Learning from complaints and concerns**

From April 2017 to March 2018, there were 109 complaints across 17 wards within medical services at the Royal London Hospital. Medical services took an average of 33 days to investigate and close complaints, this was in accordance with their complaints policy, which states complaints should be completed between 10-60 days.

The top three wards with the highest number of complaints were:

- Ward 13D: 14 complaints
- Ward 11F: 10 complaints
- Ward 11C: eight complaints

51 complaints related to diagnosis/treatment.

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

A senior nurse on ward 10E told us, “We have only had two complaints in two years. This compares to at least two boxes of chocolates and two cards every week from patients.” We saw ‘Thank you’ cards from patients displayed in staff rooms or on ward based noticeboards across wards and departments.

From April 2017 to March 2018, there were 39 compliments given to Bart’s Heath NHS Trust. No site or core service breakdown was available.
Senior staff on most of the wards told us patients or carers could discuss issues with senior ward staff with a view to resolving complaints early. The patient advice and liaison service (PALS) visited wards to speak with patients and offered patients support in resolving issues.

Staff told us complaints were taken seriously and always investigated. Ward managers and senior divisional staff tracked complaints and addressed themes or trends, in addition to investigating each individual complaint.

Staff told us the RLH governance team had oversight of all formal complaints. Staff said the team would prompt staff on meeting timescales for the resolution of complaints.

Complaints were standard agenda items at divisional governance meetings, site level quality and safety committee meetings and divisional performance reviews.

Staff across the wards told us learning from complaints was disseminated to staff at handover meetings.

There were patient information leaflets and posters across the wards and departments informing patients and visitors of how to contact the patient advice and liaison service (PALS). PALS is an NHS body created to provide advice and support to NHS patients and their relatives and carers.

**Is the service well-led?**

**Leadership**

Leadership at the trust had been devolved to the trust’s hospital sites. Staff told us the move to a model of site based leadership had increased staff engagement at a local level. Although staff also told us the trust senior leadership were still visible at RLH. For example, a specialist team lead told us, “The trust leadership are still visible. I often see them on-site. I know them by name and my team would know them.”

Medicines were part of the specialist medicine division. This was led by a divisional director that reported directly to the trust’s board. A divisional nurse and divisional manager reported to the divisional director. Medical specialities had a triumvirate model of leadership. This included a clinical director, senior nurse, and general manager that reported to the divisional director. The triumvirate leaders had oversight of specialist clinical leads and service managers. Clinical leads and service manager were directly responsible for ward and departmental staff.

The triumvirate leadership model encompassed nursing, administration, and medical leadership. Triumvirate leaders attended a monthly leadership development meeting as part of the RLH clinical leadership programme.

Senior leaders told us the RLH leadership were committed to having “The right people in the right post.” Staff had been through a robust selection process. The divisional director for specialist medicine and network lead for older person’s services had completed a clinical director’s course at Aston University.

Staff said there was a ‘real ward to board’ ethos at RLH. Staff told us the board had a, “Can do attitude.” Staff said the use of social media was encouraged by the senior management team, with all staff having access to the RLH social media account. A specialist lead told us, “The chief executive and chief nurse get the agenda. If we had the old regime I wouldn’t be here now.”
Staff were supported to develop leadership skills. For example, clinical nurse specialists (CNS) had attended away days on leadership and general managers had attended an ‘aspiring divisional managers’ programme.

Staff told us the trust had introduced a ‘developing clinical leaders’ induction for registrars to enable them in developing as consultants.

During our previous inspection we found some staff told us they had concerns around the frequency of safety huddles and team meetings. However, during this inspection most staff told us they attended daily safety huddles and had access to regular team meetings.

During our previous inspection managers and senior nurses we spoke with described extensive delays between recruiting staff and completing their pre-employment checks. However, during this inspection staff told us the trust’s human resources (HR) had improved their pre-employment check processes and new staff received a starting date in a reasonable timescale. However, we did not request data which supported this.

Ward 13E did not have a ward manager at the time of inspection as the manager had left the trust in August 2018. Staff told us band 6 nurses were sharing ward leadership responsibility. Staff told us the band 6 nurses were supported by the band 8 nurse who visited the ward and reviewed incidents daily. Staff said the band 8 was also accessible for advice on the telephone throughout the day.

Therapy leads raised some concerns about the trust’s dual role model of leadership for therapies including: dietetics, occupational therapy (OT), physiotherapy, and speech and language therapy (SALT). Staff told us the model had trustwide professional leads that had specialisms in the branch of therapy they were trained and qualified in. For example, the trust lead for physiotherapy was a physiotherapist. However, the therapy leads also had a local site level operational remit where they managed all the therapists on a particular site. Therapy leads told us this meant therapy leads may be responsible for the supervision of staff on a site, where the lead did not have specialist knowledge in their specific professional field. Some therapy staff said the multi-professional model of management was not ideal, as practice was assessed and professional development reviewed by managers who were not profession specific. Therapy leads also raised concerns about therapies sitting within the clinical support services (CSS) directorate. Staff said there were a number of specialities in the CSS division and it sometimes made it difficult for therapies to get their voices heard, as there were a lot of specialisms competing for time at CSS divisional meetings.

Vision and strategy

The trust had published a five-year strategy for acute medicine; this was aligned to the strategy for ambulatory and emergency care. The strategy had been launched in November 2016. The strategy outlined how the trust would monitor how services were delivering on the trust’s strategic directives.

As part of the trust’s strategy, the trust had developed local clinical networks which reported to trustwide clinical boards. Managers told us clinical networks within the medicines board had localised the trust’s strategy. This involved each speciality producing a clinical strategy which was aligned to the trust’s clinical strategy. Staff told us the speciality strategies had been written in 2017 and were being rolled out and implemented in 2018. For example, the older people’s service had developed frailty training as part of the older people’s strategy. Senior staff told us the speciality strategies enabled teams to drive forward the trust’s goals whilst adapting these to their own services and patients’ needs.
RLH had a range of specialist leads with responsibility for aligning services with the trust’s vision and strategy. For example, there were leads for infection prevention and control (IPC) and learning disabilities. The learning disabilities lead told us their role was primarily strategic with an operational remit. The lead told us they were “Spreading themselves thinly.” However, the learning disability team were in the process of designing a business case for a further three nursing staff at band 7, band 6, and band 5, linked to the ‘capital nurse programme.’ This is a programme to ensure London has the right number of nurses, with the right skills in the right place.

There was a new appraisal document used at staff professional development reviews (PDR). This was aligned to the trust’s values. Managers told us they had received positive feedback about the new approach to appraisals. Managers said the new values based appraisal was more person-centred and more effective in engaging staff.

Staff told us the trust had worked on the process for business case submissions. Staff said the introduction of a central steering committee for business cases had clarified the process. A therapy lead told us, “There is good will from the board to help us.” A member of the medical staff told us, “Since the last CQC visit there has been a changed atmosphere in the hospital. There has been investment and support from above.”

Therapy staff said the trust’s model for therapies had an impact on the ability of therapy managers to be involved in business planning. This meant therapy managers were busy with operational tasks and did not have the time to be involved in the development of business cases. This meant some new business cases were developed without considering whether therapies had the capacity to meet the demands placed on them by new models of working.

Culture

During our previous inspection some staff told us there were pockets of bullying and harassment in the hospital. However, during this inspection staff without exception told us there had been a culture shift at RLH. Many staff told us they felt they were being listened to by the trust board. Staff across all services told us there had been improvements in staff morale across all areas of the hospital. However, some staff told us there were some wards that were slower to improve than others. For example, a clinical nurse specialist (CNS) told us, “I think the hospital has turned a corner. Standards overall are improving.” A specialist lead told us, “We are on a journey. But, care can still be inconsistent.”

Staff said the trust board were, “Enabling and empowering.” For example, a specialist lead told us the board had developed a ‘clinical senate’ that provided a voice for staff, where nurses and therapy staff could set the agenda. An example was the senate’s involvement in the production of a set of clinical nurse specialist (CNS) roles and expectations. RLH had adopted an approach for rapidly improving levels of staff engagement and empowerment in a way that had a direct impact on patient care called ‘We-improve’. This was a follow on from the trust’s ‘Listening into Action’ (LiA) initiative which we reported in our previous inspection report. ‘We Improve’ involved RLH putting into action improvements identified as part of LiA.

Staff told us things had been challenging at the trust due to financial restrictions. However, staff said they had been encouraged to consider creative alternatives to solving problems. For example, the hospital was under spending on staff pay. In response work was planned to review staff roles which had been vacant for a number of months to see if these roles were essential. The aim was to release funds that could be reallocated to areas where shortages were identified.

The trust had a ‘Freedom to Speak Up Guardian’ provided by the guardian service to encourage a supportive culture that encouraged staff to speak up about any issues of patient care, quality or
safety. The guardian service also provided guardians for junior doctors and attended ward level safety huddles. Staff we spoke with were aware of how they could access information on whistleblowing on the trust’s intranet.

Therapies staff told us there had been an increase in incident reporting in therapies as there had been a cultural shift in the trust to a ‘no blame’ culture. Junior doctors also told us they felt they could raise issues as reporting was encouraged. Senior medical staff said RLH had a “family” culture due to the number of consultant staff who had initially trained as doctors at RLH.

**Governance**

The trust had improved governance structures and processes since our last inspection in 2016. Although we found there were still inconsistencies in records audits outcomes on some wards when we reviewed patient records. We found staff on all wards were inconsistent in their recording of national early warning score (NEWS) scores. We also found inconsistencies on some wards in the recording of patient information and that records audits were not robust and addressing shortfalls in record keeping.

Governance processes included a series of monthly governance, safety and committee meetings and monthly individual ward meetings. A divisional quality, safety and governance meeting took place monthly. This reviewed quality and safety performance of all inpatient wards and acute medicine services. The meetings reviewed new incidents and the progress of previous incident investigations, complaints data, clinical effectiveness reviews as well as other measures of performance in the division such as audit data.

The medicines division had monthly medicines board meetings. Following the meetings the chair of the medicines board met monthly with the trust’s Chief Executive. The board meetings reviewed waiting lists, preventable breaches of timescales, serious incidents, near misses and never events, and complaints. This helped to establish a governance culture of problem-solving and idea-sharing. Actions identified in board meetings were tracked to ensure completion. For example, we viewed minutes from a board meeting dated 11 July 2018. Actions from previous board meetings that had been completed were highlighted in green on the action tracker to identify that these actions had been addressed. Actions which were still on-going would be carried over and monitored in subsequent board meetings.

There were regular band 7, ward manager and team meetings. For example, we reviewed nine sets of minutes from a selection of these meetings. For example, older people’s band 7 meeting minutes dated 24 July 2018 recorded staff being updated on new medicines management procedures. Minutes from the sisters and charge nurse meeting dated 1 August 2018 recorded actions services were taking during the trust’s ‘sepsis month’. Haemodialysis unit managers monthly meeting minutes dated 12 July 2018 recorded that incidents, training, infection prevention and control and any other business had been reviewed. The minutes had action logs that recorded actions services would take in response to meeting discussions. These were followed up at subsequent meetings.

Consultants led monthly morbidity and mortality meetings (M&M) by specialty and service and learning was shared through governance processes. We reviewed four sets of minutes from specialities and wards across the medicines division. For example, the ward 11C and diabetes M&M meeting dated July 2018, where we found the meeting had reviewed a patient and identified actions in response to discussions during the meeting.
Management of risk, issues and performance

We were not assured that all risks were identified and that action plans were in place to address identified risks. There was a divisional medicines risk register which fed into the corporate risk register. New risks to be included in the divisional risk register were assessed for inclusion on the register at the divisional risk meeting and assigned a level of risk. However, we identified ligature risks on ward 10E and these were not identified on the divisional risk register. Senior staff on the ward were not aware of whether there was a ligature risk assessment in place.

The risk register submitted to the CQC on 5 October 2018 contained 54 risks. All risks on the register were assessed and assigned a rating using a red, amber, green (RAG) traffic light system. All risks on the risk register had actions the hospital were taking to mitigate risks. All risks on the risk register were regularly reviewed. Risks were updated to reflect the impact of actions the hospital had taken to mitigate risks. All risks on the risk register had the name of the member of staff that took responsibility, or owned, the risk. When risks were resolved they were removed from the risk register. The risk register reflected what we found during the inspection. Although, ligature risks on ward 10E were not included on the risk register and staff were not aware of whether there was a ligature risk assessment in place.

There was a structure of divisional governance meetings which reviewed risks, quality and performance. These included monthly divisional and directorate performance reviews, monthly quality and safety meetings, and monthly mortality and morbidity meetings.

There were directorate performance review meetings monthly. The meetings reviewed performance across the directorate, including incidents and complaints and provided an opportunity to share learning from these across the directorate. The performance review meeting prioritised risks and reviewed all risks rated as high risk. The meeting could escalate risks to the trust’s board to ensure they were aware of potential high risks to services at RLH. Monitoring of quality and performance varied across wards and departments. Work was in progress on a performance review pack to enable wards and departments to benchmark their performance with other wards and departments. For example, we reviewed performance review packs for renal and diabetes services dated August 2018. This reviewed a range of performance information including infection prevention and control, risks, reducing harm, falls and pressure ulcers, and patient experience.

Staff told us there had been improvements in managing risk at RLH. Examples staff gave were the Friday serious incident (SI) meetings where SIs were reviewed, as well as incidents which did not meet the criteria for an SI, but staff considered the incident to have been significant. Staff told us the meetings gave staff the opportunity to both review and share learning from SIs.

A renal ward manager told us, “Staffing used to be an issue. In the previous CQC inspection we had a 50% vacancy rate. Our staffing rate is now regularly over 90% and stable. That provides us with a significantly different platform in terms of continuity of care.”

Therapies had introduced a RLH site level issues log. Staff could use the log to record issues and these would be discussed at the trustwide quality and safety meeting.

Information management

Staff told us the trust’s information, communication and technology (IT) systems had improved since our last inspection. However, most staff said there were still some issues with IT systems. Staff told us the trust’s IT department had improved communications with ward staff. For example, a ward manager told us, “IT is still a bit slow, but it doesn’t crash. The IT people give us a lot of notice if the system is going to be down for maintenance. It means we can prepare.”
The risk register for medical specialities and outpatient services identified a number of risks with the trust’s IT systems. All identified risks had actions in mitigation. For example, there was an identified risk due to neurological scans not being automatically uploaded onto the trust’s patient records system. In mitigation the risk register recorded that staff from neurology were in discussions with the trust’s IT team to resolve the issue.

Senior managers told us work was in progress on upgrading the hospitals computers. Staff told us there was a monthly working group to provide staff with the hospital’s move to paper light records systems.

Staff in renal dietetics told us they used an electronic recording system which was developed specifically for use in renal services. However, staff said the system had limitations. In response, work was in progress for the trust to develop the clinical records system (CRS) to incorporate renal care.

Therapy staff told us RLH did not have enough computers to meet service demands. Staff said the ward computers were usually in use and there were times when staff visiting the wards had to look around to access a computer.

We found the trust’s website displayed incorrect information on the services provided by ward 10F. Staff told us the wards had been reconfigured and the website had not been updated to reflect this. Ward 10F was a trauma ward and not ‘GI medicine and metabolic’ as noted on the trust’s website.

Engagement

RLH had ‘project search’ this involved young people with a learning disability being offered internships at the hospital which could lead to employment. Endoscopy had employed a member of staff in the decontamination area through this project.

Ward 14E had ‘Susan’s Café’ on Tuesdays. This was an opportunity for patients and their carers to attend a social event and also to promote patients’ independence skills, by encouraging patients to attend the café in their own clothing.

Renal services had a patient forum which was promoting patients’ self-management of their condition. For example, a member of the patient forum was working with the Muslim community to promote organ donation within this demographic.

Haemodialysis patients had taken part in an evaluation of patients’ information needs. This had involved the patient forum, a working group, and a survey. The survey had been completed by 188 haemodialysis patients in February 2018. As a result of the evaluation work was in progress on the production of new information leaflets for patients. Work was also in progress on rolling out the results of the evaluation to patients.

RLH had completed an evaluation of patients with irritable bowel syndrome (IBS) to establish patients’ panel projects. The patients’ panel was a forum for patients to feedback on services.

The trust had a range of networks to support staff, including a women’s network which had a remit of encouraging women to apply for senior roles. There were also LGBTQ, black, Asian and minority ethnic (BME) networks, to support staff in minority groups and provide peer support.

There had been a range of staff engagement activities to produce a ‘diversity and inclusion positive action charter’ for staff. The charter committed the trust to equality of opportunity, elimination of discrimination and good relations between all staff, regardless of age, disability, ethnic origin, sex, gender assignment, religion or belief systems, and sexual orientation. The charter had been developed from a suggestion from the LGBTQ network group.
The learning disabilities team had developed a passport for staff with disabilities. The passport idea was a result of the trust’s staff ‘disability network’. The passport was used as a prompt for managers to discuss the support needs of disabled staff.

The trust had ‘Barts Health Hero Awards.’ Staff or patients and carers could nominate RLH staff for a monthly award where staff actions, attitudes or behaviour had embodied the trust values; monthly award winners were automatically nominated for the trust’s annual awards.

Staff received regular newsletters and generic ‘round robin’ emails which conveyed information on news and events at the hospital and across the trust. For example, staff received a weekly ‘Thank You’ email, this included a comment from a patient or carer who had thanked staff for their or a family members care. There was also a newsfeed, ‘We Share’, on the trust’s intranet which communicated information to staff on a daily basis.

The trust had a charity which raised funds to support the trust. Members of the public could volunteer to work with the charity in staffing the charity hub, distributing leaflets and providing information for patients and visitors, and supporting volunteers who were taking part in fund raising activities. We saw Barts charity magazines were available to patients and visitors across the wards at RLH.

**Learning, continuous improvement and innovation**

The trust had developed a model of medical care which supported doctors. For example, doctors were initially employed in acute general medicine and encouraged and supported to develop skills in specialist medicine.

The Graham Hayton unit had launched a monthly clinic to support survivors of childhood abuse as a result of a research project which demonstrated that survivors of abuse preferred to access support from a hospital site. The unit had trained staff in interviewing survivors of abuse. Survivors could access counselling support at the clinic.

Sexual health services consultants had won a ‘Windrush 70’ award for ‘Reducing health inequalities.’

The research unit at the Grahame Hayton Unit offered clinical trials in several therapy areas, including: HIV and hepatology.

The research unit offered predominantly commercial clinical trials as well as portfolio trials. The trials offered novel, innovative treatments to some patients which would not be normally available on the NHS. Patients recruited to clinical trials received their treatment outside of the NHS budget resulting in significant cost savings.

The renal ward had received £1 million from the Barts charity to develop a diabetic and kidney centre. The aims of the centre were to provide opportunities for clinical research and innovative treatments. The plan was for the centre to become commercially funded within five years.

Older people’s services had a frailty academy to promote research, education and training for staff working with older people.

RLH wards and departments were involved in a wide range of research projects. These included a pan-London diabetes and obesity research project, gastroenterology being involved in a range of clinical research trials, and hepatology being involved in a range of research studies.
Facts and data about this service

The surgery core service at Royal London Hospital provides a wide range of secondary and tertiary surgical services including vascular, hepatobiliary, colorectal, gynaecological oncology, neurosurgery, urology, ENT, maxillofacial, ophthalmology, orthopaedics, plastics and transplantation. The site provides emergency, elective and ambulatory surgical services, primarily for the population of east London, and some tertiary care for south east England. The hospital is one of the largest major trauma centres in the UK. Within the surgery core service at Royal London Hospital there is a short stay surgery unit, a surgical assessment unit incorporating emergency surgical ambulatory care, seven surgical inpatient wards and a 26-bed ward looking after urology and renal transplant patients.

There are 26 operating theatres at the Royal London Hospital: 12 main theatres, eight-day case theatres (Ambulatory Care and Diagnostic ACAD), four paediatric, and two obstetric theatres. The main theatres provide inpatient emergency and major elective surgery and are supported by a 15-bedded recovery unit. Minimally invasive techniques are employed wherever possible across all surgical specialties, and this includes strong links with interventional radiology. The theatre complex is managed entirely within the surgery division, and the surgical specialties are managed across all divisions although the majority sit within the surgery division, peri-operative medicine and critical care and emergency care and trauma. Royal London Hospital is developing increasing numbers of ambulatory emergency care pathways through the new emergency surgery ambulatory care unit which opened in 2017.

There is also a pre-assessment clinic located in the outpatient department where staff pre-assess over 75% of elective surgical patients across nurse-led clinics, telephone clinics, and high risk anaesthetic led clinics. More than 25,000 surgical procedures were carried out at the hospital last year, and the trust is in the top quartile for surgical activity nationally. Ten percent of activity was emergency work, including complex poly-trauma, 60% was day case activity and 30% elective inpatient activity.

Barts Health Charity funded a new Davinci robotic programme which enabled the launch of a multidisciplinary robotic assisted surgery service including gynaecological oncology, urology, colorectal, and ENT in December 2017. This has already helped reduce length of stay for some patient cohorts.

(20180517 RPIR Acute - NUH Documents – Context)

The trust had 54,372 surgical admissions from April 2017 to March 2018. Emergency admissions accounted for 15,410 (28.3%), 29,246 (53.7%) were day case, and the remaining 9,716 (17.8%) were elective.

(Source: Hospital Episode Statistics)
Is the service safe?

Mandatory training

The trust set a target of 85% for completion of mandatory training.

A breakdown of compliance for mandatory courses as of the 4 June 2018 for nursing staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality and Diversity</td>
<td>429</td>
<td>433</td>
<td>99%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness</td>
<td>427</td>
<td>433</td>
<td>99%</td>
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<tr>
<td>Working at Barts Health</td>
<td>424</td>
<td>433</td>
<td>98%</td>
<td>85%</td>
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<tr>
<td>Conflict Resolution</td>
<td>423</td>
<td>433</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
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<tr>
<td>Health and Safety</td>
<td>423</td>
<td>433</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Security</td>
<td>421</td>
<td>433</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fraud Awareness</td>
<td>420</td>
<td>433</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Investigation of Incidents</td>
<td>61</td>
<td>63</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Clinical Documentation</td>
<td>419</td>
<td>433</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Privacy and Dignity</td>
<td>417</td>
<td>433</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Harms - Pressure Ulcer Prevention</td>
<td>416</td>
<td>433</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Harms - Slips, Trips and Falls (Patients)</td>
<td>415</td>
<td>433</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Harms – VTE</td>
<td>415</td>
<td>433</td>
<td>96%</td>
<td>85%</td>
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<tr>
<td>Emergency Planning</td>
<td>415</td>
<td>433</td>
<td>96%</td>
<td>85%</td>
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<tr>
<td>Nutritional Care</td>
<td>414</td>
<td>433</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
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<td>4 Harms - Catheter Acquired Infections</td>
<td>413</td>
<td>433</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
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<tr>
<td>Complaints</td>
<td>413</td>
<td>433</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Early Warning Systems</td>
<td>410</td>
<td>433</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>347</td>
<td>373</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling - Patient Handling Practical</td>
<td>394</td>
<td>425</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk Assessment for Managers</td>
<td>58</td>
<td>63</td>
<td>92%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Nursing and midwifery staff exceeded the 85% completion target for all of the 28 mandatory training modules.

A breakdown of compliance for mandatory courses as of the 4 June 2018 for medical and dental staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality and Diversity</td>
<td>252</td>
<td>316</td>
<td>80%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety</td>
<td>251</td>
<td>316</td>
<td>79%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>4 Harms – VTE</td>
<td>250</td>
<td>316</td>
<td>79%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>250</td>
<td>316</td>
<td>79%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>219</td>
<td>277</td>
<td>79%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Dementia Awareness</td>
<td>248</td>
<td>316</td>
<td>78%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Consent</td>
<td>245</td>
<td>316</td>
<td>78%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fraud Awareness</td>
<td>244</td>
<td>316</td>
<td>77%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling - Patient Handling Low Risk</td>
<td>243</td>
<td>316</td>
<td>77%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Security</td>
<td>243</td>
<td>316</td>
<td>77%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Early Warning Systems</td>
<td>242</td>
<td>316</td>
<td>77%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>4 Harms - Catheter Acquired Infections</td>
<td>241</td>
<td>316</td>
<td>76%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>4 Harms - Pressure Ulcer Prevention</td>
<td>241</td>
<td>316</td>
<td>76%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>
Medical and dental staff failed to meet the 85% completion target for all 24 mandatory training modules.

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

During our visit the leadership team provided us with updated information. We saw that there had been an improvement in compliance with mandatory training within the surgery service, with an overall compliance rate of 96%. We looked at records that showed an overall compliance rate amongst managers of 97%. Compliance amongst medical and dental staff was 88%. Managers told us this was because some modules were not relevant to dentists. Compliance with basic life support training was between 80 and 85% which was below target. Managers told us this was due to limited availability of training places and that corrective action would be taken.

The leadership team told us there were elements when doctors and dentists were not meeting mandatory training, in particular fire safety and basic life support needed improvement, however they felt that new starters as well as imminent retirement had affected compliance rates, skewed from retired staff and new trainees, and that they needed to improve the relevance of assigned training to staff.

All staff received monthly updates regarding their compliance with mandatory training and one-to-one support was given. Staff told us that mandatory training was discussed as part of their annual appraisals. Reminders were given to nursing staff regarding their mandatory training compliance which was included on the electronic roster.

**Safeguarding**

The trust had policies and procedures in place to safeguard children and vulnerable adults at risk of abuse. Nursing staff located this policy easily on the trust’s intranet system. Staff we spoke with knew how to contact the safeguarding leads and told us they were easily accessible.
Staff on the wards and theatres told us they were trained to level two for adults and children and had completed on-line and face to face training. All staff we spoke with were clear about what constituted a safeguarding concern and how to escalate a safeguarding referral.

We saw evidence of safeguarding procedures being correctly followed for patients during our inspection. These included reporting concerns, daily reviews carried out by the safeguarding team and working collaboratively with other agencies such as the local authority and charities.

The trust set a target of 85% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses as of the 4 June 2018 for nursing staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Level 1</td>
<td>429</td>
<td>433</td>
<td>99%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>423</td>
<td>433</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>412</td>
<td>423</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>414</td>
<td>433</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 3</td>
<td>46</td>
<td>54</td>
<td>85%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Nursing and midwifery staff met or exceeded the 85% completion target for all five safeguarding modules.

A breakdown of compliance for safeguarding courses as of the 4 June 2018 for medical and dental staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>279</td>
<td>316</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 1</td>
<td>279</td>
<td>316</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>243</td>
<td>310</td>
<td>78%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>240</td>
<td>316</td>
<td>76%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical and dental staff exceeded the 85% completion target for two out of four safeguarding modules.

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

Cleanliness, infection control and hygiene

Infection prevention and control (IPC) principles and responsibilities were set out in an up to date trust policy (2016), and were applied consistently across the service. Staff followed the required precautions to minimise the risk of infection to others, and sought and acted upon advice from the trust specialist IPC team where needed. Patients who had a known or suspected infection were
nursed in isolation, with appropriate signage in place to alert staff and visitors of action they needed to take.

Details of the patients’ infection status laboratory results, and treatment were documented in their records.

All patient areas we visited were visibly clean. Housekeeping staff actively cleaned and tidied according to cleaning schedules and other requests. Staff in the operating theatre department cleaned surfaces before surgery began and before patients arrived. Staff told us a deep clean in the operating theatres was undertaken at the end of each day and after an infectious patient to prevent the transmission of diseases in accordance with the Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidance.

At our previous inspection in 2016 we found five clinical waste bags in the main operating theatre were not disposed of in accordance with the trust policy and meant staff could not identify the bag contents. We also found overfilled bags which could present a risk of infection cross contamination. We informed the trust they should improve processes to ensure all staff understood how to label and dispose of clinical waste safely, and that clinical waste bags should be tagged to ensure traceability and stored in locked bins.

During our inspection we found two storage bins used for this purpose in the main theatre department and the day theatre department were unlocked. We found five bags without an identification number, date, case number or theatre number in the main theatre disposal area. We brought these issues to the attention of the matron and infection control nurse specialist who told us corrective action would be taken.

Patients were screened for Meticillin resistant staphylococcus aureus (MRSA), either prior to admission as an elective patient, or on admission as an emergency patient. MRSA decolonisation is a procedure to reduce the presence and risk of transmission of MRSA. Patients were rescreened during their admission when their length of stay was longer than a week.

Separate clean and dirty utility areas were allocated in patient areas to ensure that the risk of infection transmission was minimised. Clinical and domestic waste was appropriately segregated and there were arrangements for the separation and handling of high-risk dirty linen. Disposal of sharp instruments complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.

In order to measure compliance with trust policies, the infection prevention team (IPT) carried out regular audits. The standard precautions audit incorporated source isolation (a strategy used to prevent the spread of contagious infectious diseases), sharps safety, availability and appropriate use of personal protective equipment (PPE) and measurable elements of the MRSA policy.

All infection prevention and control concerns would be highlighted to the nurse in charge. An action plan was formulated by the clinical team leader and concerns reported at site meetings. The action plan was reviewed by the matron to ensure all concerns had been addressed.

There was access to hand washing, hand sanitiser and drying facilities in patient areas and a good supply of personal protective equipment (PPE) was seen and in use which included disposable gloves and aprons. However, we saw an absence of hand sanitisers between bed spaces on ward 13D.

We observed staff wash or cleanse their hands before, between and after patient care. We saw that staff followed best practice guidance when giving intravenous fluids and medicines. All staff were observed as bare below the elbow for effective hand washing.
Staff followed National Institute of Health and Care Excellence (NICE) clinical guidelines [CG74] 2008 surgical site infections prevention and treatment within theatres. Theatre staff were observed to adhere to best practice principles for ‘scrubbing up’, prior to surgery and wore correct theatre attire.

The standard admission criterion for patients admitted for elective orthopaedic wards laid out the procedures for reducing the incidence of infection due to mixing both elective orthopaedic patients and medical outliers (medical patients placed in other wards due to a lack of space in specific wards).

We saw that all equipment used by patients was visibly clean and appropriate for use. ‘I am clean’ stickers indicated where equipment had been cleaned.

Throughout the service, all privacy curtains were disposable. The disposable curtains had dates on them indicating when they were put up and routine changes were scheduled in accordance with Health Building Note (HBM) 00-09: Infection control in the built environment regulations which states; there should be a local policy on the changing of privacy curtains, both for routine changing when the curtains become soiled and after the discharge of a patient with a known or suspected infection.

Deep cleans were arranged following the discharge or transfer of patients with infections. Cleaning schedules advised staff what type of cleaning to organise when a patient was discharged or transferred.

The trust policy for clinical waste disposal was written in line with The Safe Management of Healthcare Waste Memorandum (HTM 07-01) issued by the Department of Health. This recommends the segregation of clinical waste occurs at the point of production using colour coded waste receptacles and outlines a best practice waste segregation colour coding scheme for producers of waste to follow.

We saw separate colour coded bins used for general, clinical and sharp waste. Bins were not overfilled and risk assessments were in place for needle stick injuries. Spill kits were readily available in each area we visited, which allowed staff to safely collect and dispose of bodily fluids.

The trust monitored the ventilation systems within theatres and these met with the health building regulations at the time they were commissioned.

Theatre equipment was decontaminated and sterilised after use. The sterile instrument store was spacious and sterile instruments were stored appropriately with sufficient stock levels to meet service needs.

Single use sterile instruments and other disposables were stored appropriately and all checked were within their expiry dates.

The National Institute for Health and Care Excellence (NICE) 2008 guidance states that all personnel entering or leaving the operating department should wear specific non-sterile theatre wear. All theatre staff knew the practices regarding theatre uniform and the procedures to follow when leaving this area. During the visit we did not see any theatre staff wearing theatre attire in non-clinical areas. There were spacious staff changing rooms and a sufficient supply of theatre scrubs and shoes.

Senior nursing staff we spoke with were aware of the trust policy regarding tap flushing for legionella infection prevention. Legionella is a waterborne bacterium, which causes Legionnaire’s disease. Infrequently used taps and showers were flushed on a daily basis and recorded to
monitor compliance. The ward manager or sister reviewed the checks weekly to ensure compliance.

**Environment and equipment**

The design, maintenance and use of facilities and premises were appropriate. Patient areas were safe as access was limited to specific staff using digital keypad access or an intercom for visitors.

At our previous inspection in 2016, we found unavailable instrumentation as the highest reported incident type in the surgery division. This was impacting on surgeons’ ability to treat patients effectively and led to cancellations and inefficient running of theatre lists. At that time staff told us they did not feel confident the service would be able to respond if there was a major incident. We informed the trust they must ensure sufficient availability of sterile surgical equipment in theatre at all times to ensure the safety of service users and to meet their needs.

During our inspection we spoke with a range of staff who all confirmed there had been a significant improvement in availability of surgical instruments and they currently felt entirely satisfied with the service provided. From April 2017 to March 2018 there were three incidents (0.011%) of cancelled surgery because of a lack of instruments. The leadership team spoke positively about the financial investment in surgical kits since 2016, as well as the improved decontamination service from their external provider.

All staff we spoke with told us they had the required equipment to care for patients’ needs. All anaesthetic machines within the anaesthetic room and theatres conformed to the Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidance which was seen attached to each machine. We saw that anaesthetic machines were checked at the start of each operating list by staff trained to do so. However, AAGBI guidelines: Safe management of anaesthetic related equipment, 2009, state a replacement programme which defines equipment life and correct disposal procedures should be in place. It is recommended that anaesthetic equipment must be condemned and replaced before it becomes unreliable and endangers the patient, should be phased over a number of years, and is continuously updated. As a guide electrical equipment should be considered at five years and mechanical equipment at eight years.

We saw that the ageing stock of six anaesthetic machines had been identified as a risk on the trust risk register because replacement parts for faulty equipment might not be available. This had been identified on the trust risk register since February 2016 and had been reviewed monthly. Following our inspection data provided by the trust informed us three machines were at the end of their life. Funding had been agreed in 2017 and a procurement process for new anaesthetic machines had been initiated. Mitigation included being able to borrow equipment from other theatre departments across the trust, having a technical support team based in the operating theatre department, and that all relevant staff were aware of the risk.

Tests to ensure electrical equipment and appliances were safe to use were carried out at least yearly and visually when the equipment was in use.

In all patient areas we visited, staff had access to emergency resuscitation equipment, including an automated external defibrillator (AED). An AED is a portable electronic device used to diagnose life threatening cardiac conditions and enable treatment controlled electric shocks to re-establish a normal heart rhythm. Staff completed training in the use of AEDs and other emergency resuscitation equipment as part of mandatory life support training.

Resuscitation trolleys and emergency call bells were checked regularly by staff that were competent to do so. Resuscitation trolleys were locked with a breakable seal, which demonstrated the trolley had not been opened or equipment used or tampered with since it was last used.
Records we looked at showed that the resuscitation trolleys were all checked daily with stocks of equipment and consumables maintained by designated staff.

There was piped oxygen and suction equipment in each bed space in the ward and in consultation rooms and recovery areas. Medical gas supplies were filled and turned off when not in use, and suction equipment was clean, working and ready for use.

All surgical procedures took place in facilities that complied with department of health building note (HBN) 26: facilities for surgical procedures: volume 1, 2004, which provides guidance for surgical procedures in all health settings, including for minimally invasive techniques.

Maintenance of equipment was provided ‘in-house’ or by product manufacturers for specific equipment. Staff knew how to raise faults or concerns about facilities or equipment and reported high levels of satisfaction with the maintenance services provided.

Staff showed us national safety alerts displayed on noticeboards that they had acted upon in relation to medical equipment and medicines, and provided recent examples of where these had been communicated to all staff by email.

The difficult airway society launched guidelines for management of unanticipated difficult intubation in 2015. Intubation is the placement of a flexible plastic tube into the windpipe to maintain an open airway. We saw trolleys in the main theatre area and the day care theatre area, which contained emergency intubation equipment. The contents of the trolleys met national guidance and current best practice, and we saw daily checks were completed in line with trust policy.

Control of Substances Hazardous to Health (COSHH) was in line with the Control of Substances Hazardous to Health Regulations 2002. We found hazardous cleaning fluids stored in locked cupboards away from patient areas. COSHH information was available on the intranet and in data sheets.

Piped oxygen and suction equipment was available at each bed space, as well as call buttons for emergency use.

**Assessing and responding to patient risk**

Medical and nursing staff completed risk assessments when patients were admitted for surgery.

From March 2018, National Safety Standards for Invasive Procedures (NatSSIPs) were applied in the RLH theatre departments. Multidisciplinary training, including human factors training and in situ theatre coaching for NatSSIPs had been completed by 200 theatre staff across the trust.

RLH had also introduced local safety standards (LocSSIPs) for 15 invasive procedures from March 2018, with further work underway for other procedures. There was an identified speciality lead and appropriate procedure for every applicable LocSSIP. Staff informed us that once LocSSIPs implementation was fully completed its adoption and effectiveness would be regularly audited with changes made in response as appropriate.

Integrated care pathways or general admission assessments were completed with individual patient recorded and acted upon. Nursing staff used nationally recognised risk assessment tools to assess patients' needs, for example: risk of developing pressure ulcers, nutritional risks, falls, and risks associated with moving and handling. We saw that risks were reviewed regularly and measures were taken to reduce risks to patients where necessary, such as the use of equipment, specialist staff, and following care pathways.
There were arrangements in place for emergency access to medical care 24 hours a day including following discharge. Each patient’s fitness for surgery, any invasive procedure, and anaesthetic was assessed using a recognised classification.

The World Health Organisation (WHO) five steps to surgical safety checklist were used to check and approve all safety elements of a patient’s procedure. This included, checking it was the correct patient, the correct operating site, and that all the staff were clear in their roles and responsibilities. We observed active involvement of all team members when following the checklist. The WHO checklists were reviewed at daily safety huddles as well as on a weekly basis during operating department team meetings.

The use of the WHO checklist was audited by reviewing 100 cases a month through reviewing documents. Paper checklists were completed by theatre staff in addition to entering electronic data. The outcomes were displayed on the divisional governance dashboard and reviewed at the surgical divisional board and perioperative governance meetings. The results showed in 2017-2018 that debrief was the only step reported as not consistently meeting at least 98% compliance.

The surgical service met the Association for Perioperative Practice (AfPP) guidance for assessing and responding to patient risk for all surgical areas which included; ward admission, anaesthesia, surgery and recovery. There were sufficient theatre staff on duty during surgical procedures which included surgeons, anaesthetists, theatre nurses and operating department practitioners. This was in line with AfPP guidance which meant the service had assessed the risk to patients undertaking surgery.

Patients for elective surgery attended a pre-operative assessment consultation prior to their operation in line with national guidance. During the assessment required tests were undertaken; for example, meticillin resistant staphylococcus aureus (MRSA) screening and any specific blood test and risk assessments. The service used the American Society of Anaesthesiologists (ASA) classification system to grade a patient’s level of risk. For example, ASA 1 was low risk. Nursing staff and anaesthetists recorded the levels of risk during pre-assessment and on admission for surgery.

Procedures and processes were in place to manage patient implants which included breasts, hips and vascular. We observed operating theatre processes with no issues or concerns identified.

We observed that patients identified at risk were monitored more frequently by staff to reduce the risk of harm and that the risks were discussed at departmental based safety briefings.

NICE guidance (NG89) for March 2018 states that all surgical and trauma patients should be assessed to identify the risk of VTE and bleeding as soon as possible after admission to hospital or by the time of the first consultant review and that reassessments for VTE and bleeding should be at the point of consultant review or if their clinical condition changes. We looked at 16 records and found that all patients had received their initial assessment; however, review of the assessment in 24 hours was not documented.

The trust audited the percentage of patients having a VTE assessment and reported on these in their quality performance record.

The trust had a hospital wide approach to managing deteriorating patients. The national early warning score (NEWS) was used to identify deteriorating patients in accordance with NICE Clinical Guidance (CG) 50: ‘Acutely ill adults in hospital: recognising and responding to deterioration’ (2007). Staff used the NEWS to record routine physiological observations, such as blood pressure, temperature, heart rate and the monitoring of a patient’s clinical condition. There were clear directions for actions to take when patients’ scores increased, indicating a deterioration and
members of staff spoken with were aware of these. The trust critical care outreach team visited surgical patients upon referral, to help with interventions to stabilise them and prevent them becoming more ill.

We reviewed 16 sets of surgical notes and found NEWS was recorded and acted upon appropriately in all cases.

There was 24-hour access to emergency surgery teams, including theatres and doctors. During the night, there was a junior doctor present who covered the surgical wards and was supported by an on-call anaesthetist and an on-call consultant for surgery.

Sepsis is a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs. Since our previous inspection in 2016, a sepsis nurse specialist had been appointed to ensure continuity and compliance with NICE guidelines. Staff felt supported by the nurse specialist and confident in their knowledge, expertise and advice. Staff recognised the signs and actions to take where sepsis was suspected, and had access to a sepsis trolley which contained all the equipment required to manage such an emergency. The four sepsis trolleys we saw had all been checked daily to ensure they were fit for purpose and ready for use.

All staff completed sepsis awareness in their early warning score training. Sepsis was also discussed as part of the Ward 3D/ Day Surgery ‘away day’ in September 2018 which was attended by the sepsis nurse specialist. Additional training was completed by sepsis champions who provided a link between the departmental staff and the sepsis nurse specialist.

Posters in patient areas alerted staff and the public to the signs of sepsis. The trust policy on managing sepsis incorporated a sepsis tool with a red and amber flag system for staff to detect the deteriorating patient. The tool enabled staff to record when they had not followed the plan and used alternative treatments. We saw the tool had been fully completed and reviewed on those patients who had become unwell with a possible indication of sepsis. Staff we spoke with had a good understanding of the actions required.

**Nurse staffing**

At our previous inspection in July 2016, we found high levels of nursing vacancies across wards and theatres. There were more vacancies than substantive staff in theatre and a heavy reliance on agency staff to cover gaps. We informed the trust they should improve recruitment processes to facilitate more rapid employment of new members of staff and reduce vacancies on wards and theatres.

Following our inspection, the trust had updated its safe staffing policy for nurses and midwives and required that staffing establishments be reviewed at least every six months.

Royal London Hospital reported the following nurse staffing numbers for surgery in March and April 2018. The trust’s fill rate was below 90% in March and April 2018.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>428.4</td>
<td>511.5</td>
<td>83.7%</td>
<td>432.0</td>
<td>530.2</td>
<td>81.4%</td>
</tr>
</tbody>
</table>
The fill rate of 81.4% reflected the first month of an amended and increased establishment as a result of business case approval in budget setting. In March 2018 it was 85% which reflected the subsequent change in establishment.

From May 2017 to April 2018, Royal London Hospital reported a vacancy rate of 20.1% for nursing staff in surgery; this was higher than the trust’s target of 6.3%.

However, we saw significant improvements had been made in staffing levels of wards and theatres.

The leadership team told us recruitment and retention remained a priority and as of September 2018 there was a 95% fill rate across all theatre nursing teams. This was a significant increase from 2016 when the theatre nursing vacancy rate was 36%. RLH had designed and gained approval for an in-house anaesthetic nursing course, accredited with the University of Greenwich 15 credits at level 6 as part of its recruitment and retention strategy, allowing for a more flexible workforce.

Every shift in recovery was staffed with a nurse trained in high dependency. In addition, all recovery staff were trained in immediate life support, and had completed simulation training to rehearse the skills they would need in managing critically ill patients. Recovery nurses worked closely with anaesthetists, the critical care practice development team and critical care outreach team to ensure review of patients requiring critical care was carried out by staff with the right skills and experience.

From May 2017 to April 2018, Royal London Hospital reported a turnover rate of 12.6% for nursing staff in surgery; this was similar to the trust’s target of 13%.

From May 2017 to April 2018, Royal London Hospital reported a sickness rate of 3.6% for nursing and midwifery staff in surgery; this was higher than the trust’s target of 3%.

From May 2017 to April 2018 the Royal London Hospital had a total of 32,355 nursing staff shifts. A breakdown of bank and agency usage and unfilled shifts is shown below:

<table>
<thead>
<tr>
<th>Bank and agency</th>
<th>Number of shifts (% of total shifts)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank</td>
<td>17,537 (54.2%)</td>
</tr>
<tr>
<td>Agency</td>
<td>6,940 (21.4%)</td>
</tr>
<tr>
<td>Not filled</td>
<td>1,130 (3.5%)</td>
</tr>
</tbody>
</table>

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

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

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

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

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

Royal London Hospital reported the following medical staffing numbers for surgery in March and April 2018. The trusts fill rate was above 90% in March and April 2018.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>330.2</td>
<td>350.7</td>
<td>94.1%</td>
<td>335.8</td>
<td>340.5</td>
<td>98.6%</td>
</tr>
</tbody>
</table>

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

From May 2017 to April 2018, Royal London Hospital reported a vacancy rate of 2.9% for medical and dental staff in surgery; this was lower than the trust’s target of 6.3%.

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

From May 2017 to April 2018, Royal London Hospital reported a turnover rate of 2.8% for medical and dental staff in surgery; this was lower than the trust’s target of 13%.

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

From May 2017 to April 2018, Royal London Hospital reported a sickness rate of 0.2% for medical and dental staff in surgery; this was lower than the trust’s target of 3%.

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

From May 2017 to April 2018, Royal London Hospital had a total of 8,064 medical staff shifts. A breakdown of locum and agency usage and unfilled shifts is shown below:

<table>
<thead>
<tr>
<th>Locum and agency</th>
<th>Number of shifts (% of total shifts)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Locum</td>
<td>2,851 (35.4%)</td>
</tr>
<tr>
<td>Agency</td>
<td>527 (6.5%)</td>
</tr>
<tr>
<td>Not filled</td>
<td>278 (3.4%)</td>
</tr>
</tbody>
</table>

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

From March 2018 to March 2018, the proportion of consultant staff and junior (foundation year -2) reported to be working at the trust were lower than the England average.

Staffing skill mix for the whole time equivalent staff working at Barts Health NHS Trust:
Records

Staff used a combination of paper and electronic patient care records. Staff told us this could be confusing at times, and that temporary staff did not have personal access to the electronic patient care records. It was recorded on the surgery risk register that the hybrid notes, part paper, part electronic and lack of availability of old paper notes could lead to patient harm through delayed or missed information being available to clinicians.

Further information on the risk register described a lack of all available patient information had led to clinicians not being able to fully review a patient accurately, make a diagnosis, review a current or previous treatment plan or review potential complications that may have occurred previously.

Patient records were often kept off site. Staff we spoke with were aware of the risk of paper records being difficult to locate on occasions. We saw planning was well under way at RLH towards a full electronic health record system to be in place in 2019.

As part of our inspection, we reviewed the records of 16 patients. All those reviewed included patient biographical details, medical history and a range of clinical risk assessments such as cognitive functioning, screening to identify risks associated with dementia, pressure ulcers, nutrition, and falls. The records also included assessment tools to measure the patient’s performance in activities of daily living. However, in all of the records we looked at we saw no indication that activities of daily living were discussed with patients or that care plans were updated to include all identified care needs. In particular emotional, psychological and social needs were not included in patient records. Staff confirmed this was normal practice as the focus was on risk assessment. We brought this to the immediate attention of the matron who told us corrective action would be taken and subsequently showed us this had happened.

Staff we spoke with told us there was no regular audit of compliance with record keeping, however we saw some early work in progress with an application for mobile devices which enabled 65
questions about record keeping to be reported on, although this was not yet embedded. We observed the questions were largely related to physical observations such as risk assessments and early warning scores and did not include monitoring documentation of individual psychological or emotional needs.

Patient care records were securely stored in lockable trolleys that were accessed using a digital code known only be authorised staff. Computer screens were attended when displaying patient information. Personal data was only accessible with a password or smart card access.

Nursing, therapy and medical notes were transferred with the patient, for example, when they attended other hospital departments; notes were tracked when being transferred to medical records for storage.

Signature legends (a list of names written legibly with an identifying signature), were available in all the nursing admission documentation we looked at and for authorisation for ordering medicines.

Pre-operative checklists were documented which included a record of consent. These checklists ensure certain safety elements were completed prior to any surgical procedure. For example, patient identification, allergies, correct consent and the time of last food and drink.

All of the wards we visited had a whiteboard displaying information about the patient including clinical alerts such as existing medical conditions, length of admission and predicted discharge date. They acted as a tracking system to identify what was preventing discharge when patients were medically fit to leave hospital. The boards were only uncovered when staff met for the board round and huddle and were not left unattended when the information was displayed. Privacy screens were used whilst the board round took place ensuring confidentiality.

Discharge summaries were sent to patients’ GPs to ensure continuity of care in the community. We also saw evidence that details of surgery including any implant used was included in the discharge letter to patients and their GPs.

**Medicines**

The commitment to, and arrangements for, safe prescribing, dispensing (including pharmacist review), storage, administration and disposal of medicines was set out in the trust corporate medicines management policy (2016).

All medicines were procured and distributed through the hospital pharmacy. Medicines were ordered by qualified personnel and would only be supplied against an authorised signature of a suitably qualified person. Stationery used to order medicines was locked away.

Medicines were generally stored securely in locked cupboards; however, in the ambulatory care and diagnostic ACAD theatre department we found medicines stored in three unlocked cupboards in a storage room that could be accessed by all staff. This included medicines to be used for the emergency treatment of severe allergic reactions known as anaphylaxis. We also found intravenous infusions that were stored outside of the cardboard boxes they were supplied in, which could lead to confusion, and four loose ampoules of medicines that were not in their original packaging. We brought this to the immediate attention of the theatre co-ordinator and matron who told us corrective action would be taken. We saw all of these issues had been identified in medicines audits in July 2017, September 2017 and May 2018, and remained unresolved.

The three unlocked cupboards in the ACAD department were untidy, overstocked, and were not labelled. Medicines were not stored in accordance with the trust policy as they were not always in alphabetical order. Staff we spoke with were unclear what system was in place to store the medicines and told us it was sometimes difficult to identify what was held in stock.
Medicines audits carried out by the pharmacy team in 2017-2018 had consistently rated theatre 6 ACAD as inadequate, partly due to insecure storage issues. We found medicines were not always securely stored in the main theatre complex, including ACAD theatre 6.

We found a cardboard box in an unlocked intravenous therapy store in the ACAD day surgery theatre department that contained a range of oral medicines and injections, including a loose ampoule of and an anaesthetic agent not in its original packaging. We were told these had been transferred from a medicines storage cupboard in an anaesthetic room (theatre 6) as there was no lock on the cupboard door. Staff told us the lock had been missing for at least a year and were unsure of why it had not been fixed. We brought this to the attention of the matron who told us the room was used by the interventional radiology team for at least four days a week and by other surgical teams one day a week. The room was not in use when we visited. We were told a request for the lock had been raised with the maintenance department. We observed the matron telephone the maintenance department in response to our observations to request the lock to be fixed as a matter of priority. We saw the maintenance team arrive to take corrective action.

We looked at random samples of medicines in all areas we visited and saw that they were all within the expiry date.

Medicines that required refrigeration were kept at the correct temperature in designated medicines fridges. Staff checked and recorded the fridge temperatures daily in all clinical areas and these were all found to be within the required range. This ensured medicines that were temperature sensitive were stored correctly. Ambient room temperature levels for medicines stored in medicines cabinets and trolleys were monitored centrally. Temperatures outside of the correct range were reported and acted upon.

We found unlocked fridges in the surgical assessment unit, Ward 3D and the ACAD day surgery theatre department and brought this to the immediate attention of the matron who locked the fridges and told us that staff would be reminded of this requirement. We also found an empty drugs fridge in the ACAD (day care) theatre area which staff told us was out of order. However, it was not labelled as such and could therefore be used in error.

Pharmacy staff were responsible for monitoring medicines stock and reporting any discrepancies. However, we found cupboards were very full and there was no stock list for nurses to refer to.

Pharmaceutical waste was segregated from pharmacy stock and promptly disposed of in specially allocated bins in line with trust and national policies.

Pharmaceutical supplies surplus to requirement would be returned to pharmacy and stored in a locked bin. On the first day of our inspection we saw there was no bin available for this purpose on Ward 3D. We brought this to the immediate attention of the matron and saw a bin was then supplied and used.

Staff understood the processes in place for the safe transportation and storage of medical gases. We saw designated storage areas for this purpose with appropriate signage on the doors. However, we found two empty oxygen cylinders on the floor in an anaesthetic room in the day surgery theatre area that were not stored in accordance with the trust policy. We brought this to the immediate attention of the matron who removed them and placed them in the designated oxygen storage room so that they could be removed.

Total parenteral nutrition is a way of supplying all the nutritional supplements of the body by bypassing the person’s natural digestive system by infusing the solution through the veins (intravenously). The trust had an Adult Parenteral Nutrition Policy for the administration of total parenteral nutrition (TPN) which was published in 2013 and was due to be reviewed in 2016. The
policy had not been reviewed since 2013. We brought this to the attention of the matron who told us corrective action would be taken.

During our inspection three patients on Ward 13D were being fed by TPN. We looked at their records and saw that nursing staff administered and recorded each dose of TPN. However, in one patient’s record we saw the correct proforma was not being used and that it was unclear in three out of four doses given which nurses had set the TPN feed up or which nurses had checked the feed. We brought this to the attention of the nurse in charge and matron who told us corrective action would be taken.

We reviewed 16 medicines administration records and found they were completed in accordance with the trust medicines management policy. Medicines would only be dispensed against an instruction by an authorised prescriber, created or written on the Barts approved document system. Staff clearly recorded known allergies in all of the patient records we reviewed, and relevant action was taken to ensure they were acted upon.

Medicine incidents were reported via the electronic incident reporting system. From April 2017 to March 2018, there were 409 medicines incidents recorded, of which three related to security of medicines. The lead pharmacist told us there were no unresolved medicines incidents at the time of our inspection.

Controlled drugs (CDs) (medicines that require additional security controlled under the misuse of drugs legislation 2001), were stored appropriately in locked cupboards. The keys to the controlled drugs cupboard were kept by the nurse in charge, separately from the keys to the main medicines cabinet in accordance with local and national policy requirements.

In all clinical areas we visited, two registered health care professionals checked the actual stock of the CDs against the stock level recorded in the CD register(s) at least daily. CDs brought in by patients were also securely stored, checked daily, and recorded in a separate part of the controlled drugs register(s). Controlled drugs destruction kits were available and staff we spoke with correctly described the processes they would follow and showed us a complete record of destroyed CDs.

Audits of the processes governing CDs were reported every quarter by the pharmacy department in accordance with the trust policy. Audits showed consistent errors mainly related to stock balance checks and alterations, and obliterated or erased entries in the CD register(s).

In all areas we visited, medicines to be used in an emergency were stored on the resuscitation trolley in tamper proof packaging and were all in date. There was a separate box for medicines used if patients suffered a severe allergic reaction known as anaphylaxis.

Staff highlighted expiry dates on medicines due to expire within six months to ensure these were replaced as required and remained ready for use. Stock was rotated to ensure that medicines due to expire first were at the front of the storage area.

Staff we spoke with, including the leadership team, told us all nurses involved in medicines administration were required to complete medicines management training and competencies at induction and on at least an annual basis. Agency nurses also had to complete medicines competencies prior to any medicines administration.

**Incidents**
At our previous inspection in July 2016 we found there was limited evidence of shared learning from incidents across sites within the trust. We informed the trust they should review incident governance processes to ensure learning from incidents was shared systematically across the trust and effectively disseminated to staff.

During our inspection staff in all departments we visited provided several recent examples of where incidents had been reported, investigated and learning about incidents had been shared with staff during handovers, emails, safety huddles, departmental team meetings and the weekly surgery divisional governance meetings.

All staff we spoke with were aware of the incident reporting policy and felt comfortable with the electronic reporting system. We saw staff access the reporting system and those we spoke with felt confident in the processes.

At our previous inspection, we also found a varying degree of understanding about the duty of candour amongst more junior staff: some staff in theatre did not understand processes or the meaning of duty of candour and thought it related to patient privacy and dignity. All staff we spoke with were able to correctly describe the principles and provide examples of when the duty of candour had been applied.

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

At our previous inspection in 2016, there was a high number (27) of never events reported within the trust for the previous year. From August 2017 to July 2018, the trust reported three incidents classified as never events for surgery at Royal London Hospital.

- Medication incident meeting criteria.
- Surgical/invasive procedure incident meeting SI criteria.
- Surgical/invasive procedure incident meeting SI criteria: the wrong tooth was extracted from three year old patient.

(Source: NHS Improvement - STEIS)

We observed discussion of a never event at a safety briefing and saw shared learning about never events displayed on staff notice boards.

In accordance with the Serious Incident Framework 2015, the trust reported 18 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from August 2017 to July 2018.

The types of incident reported were:

- Diagnostic incident including delay meeting serious incident (SI) criteria (including failure to act on test results): four incidents
- Medication incident meeting SI criteria: three incidents
- Sub-optimal care of the deteriorating patient meeting SI criteria: three incidents
- Treatment delay meeting SI criteria: three incidents
- Surgical/invasive procedure incident meeting SI criteria: two incidents
- Medical equipment/devices/disposables incident meeting SI criteria: one incident
- Unauthorised absence meeting SI criteria: one incident
- VTE meeting SI criteria: one incident

(Source: NHS Improvement - STEIS)

We saw three examples of investigation and independent root cause analysis of serious incidents, and that learning from the incidents and investigations had been shared.

**Safety thermometer**

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

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

Data from the Patient Safety Thermometer showed that the trust reported 31 new pressure ulcers, 14 falls with harm and eight new catheter urinary tract infections from June 2017 to June 2018 for surgery:

1. **Total Pressure ulcers**
   - (31)

2. **Total Falls**
   - (14)

3. **Total CUTIs**

1. Pressure ulcers levels 2, 3 and 4
2. Falls with harm levels 3 to 6
3. Catheter acquired urinary tract infection level 3 only
NHS England requires the NHS to plan for and respond to a wide range of incidents and emergencies that could affect health or patient care. The major incident plan was clearly displayed on notice boards and in files with clear instructions of who to contact.

At our previous inspection in July 2016, senior nurses recognised there was variable awareness amongst staff about major incident plans. Some staff told us they did not know where to access information and there was limited awareness of major incident protocols. There had been no recent major incident exercises or simulations at the hospital. We informed the trust they should improve awareness of major incident plans, and policies and protocols for all staff groups and grades.

However, since our last visit the trust had been a key participant in responding to the London Bridge terror attack in June 2017. The leadership team felt this had been managed successfully and that it had increased staff awareness of the processes they needed to follow and how to access relevant information.

Staff we spoke with demonstrated a good understanding of the major incident plan; some described their first-hand experience of putting the plan into action the London Bridge terror attack. The leadership team told us there were monthly emergency planning meetings, regular simulation exercises and that the major incident policy had been reviewed following the London Bridge terror attack. Staff we spoke with confirmed this happened.

**Is the service effective?**

**Evidence-based care and treatment**

The service provided care and treatment based on national guidance and evidence of this effectiveness. They assessed staff compliance with guidance and identified areas for improvement.

The surgical service participated in research activities and supported the National Institute for Health Research (NIHR) studies.

A wide range of trust policies and guidelines were available and accessible on the staff intranet. They were based on national best practice guidance and supported by references. Updates on new policies were communicated via e-mails and through staff meetings.

Surgical enhanced recovery protocols are a national initiative that set out pre, peri-operative and post-operative care to help patients recover sooner and safely after surgery. The key elements of enhanced recovery protocols (ERP) included a multi-disciplinary approach to pre-operative counselling, optimisation of nutrition and pain relief and early mobilisation. At our previous inspection in 2016, the surgery service did not use ERP. Staff told us this resulted in a lack of clarity about likely discharge dates. We informed the trust they should investigate the introduction of enhanced recovery after surgery protocols to help patients achieve early recovery after surgical procedures.

The leadership team told us that ERP had been introduced in the gynaecology, colorectal and orthopaedic surgical specialties and described it as work in progress. Staff we spoke with were positive about the introduction of ERP and told us that outcomes were being monitored locally but not yet formally audited.
We saw the introduction of ERP to accelerate recovery after hip and knee replacement surgery. This standardised intervention process involved the multi-disciplinary team working together to optimise the rehabilitation procedure and reduce the time patients spent in hospital. ERP involved discharge planning from the pre-operative stage, patients mobilising on the day of surgery, the re-establishment of patient medicines on the day of surgery and a follow up telephone call 48 hours after discharge from hospital.

The surgery service used the American Society of Anaesthesiologists (ASA) grades as a guide to assessing a patients’ fitness to undergo an anaesthetic. This was in line with NICE guidance. The ASA physical status classification system is a simple scale describing fitness to undergo an anaesthetic. For example, ASA1 or ASA2 are relatively low risk patients. ASA3 patients have a higher risk of complications during anaesthesia due to other comorbidities they may have.

Staff showed us a range of integrated care pathways and protocols in use to standardise practice and improve outcomes for patients. These included a urinary catheter pathway, guidance on the prevention of venous thrombo-embolism (blood clots following surgery, often referred to as VTE, and a fractured hip care pathway. In all the patient records we looked at, venous thromboembolism risk assessments were undertaken on admission but not reviewed 24 hours later, as required by the trust policy. We brought this to the attention of pharmacy staff and clinical team leaders who told us corrective action would be taken.

**Nutrition and hydration**

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary and referred patients to the trust nutrition team as required. All referrals and treatment were documented in patients’ individual care records. Nursing staff told us that although a dietician did not visit the wards daily they knew how to contact them and the nutrition team if necessary, and that they were satisfied with the service provided. If patients had swallowing difficulties they would be referred to a speech and language therapist within the trust.

Dietary adjustments were made for patients for religious, cultural, personal choice or medical reasons when required. A daily record of special dietary needs was maintained in patients' individual care records and in the ward pantry areas which were accessed by staff only.

Patients’ nutrition and hydration needs were assessed by nursing staff using the malnutrition universal screening tool (MUST). This was in line with NICE guidance QS15 Statement 10: "Physical and psychological needs" 2012. The MUST tool calculates the overall risk of malnutrition. Patients considered a lower risk of malnutrition were scored and a prompt was given for nurses to assess and monitor, then repeat the assessment after three days. The assessment and MUST tool offered a guide to assist the nursing staff in deciding if a dietician referral was required. We saw the assessments were reviewed and up to date in all patient records we looked at.

We saw fluid balance charts were in place to monitor patients’ hydration. We reviewed six fluid intake and output charts and found that all were fully completed. This meant that patients’ fluid requirements were monitored accurately.

We saw evidence in the patient medical notes following the nutrition team reviews where feed prescriptions were changed according to blood test results and requesting further monitoring. The team also recorded their contact details and the date they were going to next review the patient.

Prior to surgery, patients were given information about when to stop eating and drinking before their operation. Depending on the surgical procedure, patients could drink clear fluids up to two
hours before surgery and eat up to four hours before surgery. Patients were instructed not to eat for six to eight hours before a general anaesthetic and were encouraged to drink sips of water up to two hours prior to a surgical procedure. Staff confirmed patients would be encouraged to drink when ready, providing there were no contraindications.

Staff had access to snacks and drinks for patients between meal times. This helped to support patients’ nutritional intake and hydration. Patients we spoke with were happy with the food provided.

We observed two meal times on different wards and saw all staff engaged with the distribution of meals and provided assistance to patients where required. Patient mealtimes were protected to ensure patients could eat their meals without interruption.

Patients with nausea or vomiting were prescribed antiemetic medicine (a drug effective against vomiting and nausea). Patients were given antiemetic medicine intravenously in the recovery area if they complained of nausea post-operatively.

Patients had jugs of water within reach on their bedside tables. We observed that these were regularly refilled. Intravenous fluids were also prescribed and recorded appropriately.

**Pain relief**

Pain was managed effectively. We saw patients provided or offered pain relief regularly and without delay.

All the patients we spoke with said they were asked if they were in any pain usually during most interactions with staff. We observed staff discussing pain during handovers and any concerns would be raised with relevant clinicians.

Pain was risk assessed and recorded using the National Early Warning Score (NEWS) and we saw assessments were completed. We observed staff asking patients if they were in any pain.

There was a dedicated pain team to support patients with epidurals (an injection in the back to stop you feeling pain in part of your body) who were cared for on the surgical wards. In addition, an anaesthetist was accessible for pain management advice out of hours.

Staff chose appropriate pain relief using the ‘pain hierarchy’ (starting with common medicines and moving to more powerful medicines some of which were controlled drugs). Commonly used medicines were prescribed routinely but if these were not effective, the pain team could be contacted for advice and additional medicines to be prescribed to ensure patients were pain free and comfortable.

**Patient outcomes**

From March 2017 to February 2018: Urology patients at Royal London Hospital had a lower than expected risk of readmission for elective admissions when compared to the England average.

- Colorectal and plastic surgery patients at The Royal London Hospital had a higher than expected risk of readmission for elective admissions when compared to the England average.
All patients at Royal London Hospital had a higher than expected risk of readmission for non-elective admissions when compared to the England average.

- General surgery, colorectal surgery and neurosurgery patients at Royal London Hospital had a higher than expected risk of readmission for non-elective admissions when compared to the England average.

(Source: Hospital Episode Statistics)

In the 2017 National Hip Fracture Audit, the risk-adjusted 30-day mortality rate was 10% which was within the expected range. The 2016 figure was 7.1%.

The proportion of patients having surgery on the day of or day after admission was 53.5% which failed to meet the national standard of 85%. This was in the bottom 25% of trusts. The 2016 figure was 56.6%.

The perioperative medical assessment rate was 85.9%, which failed to meet the national standard of 100%. This was in the bottom 25% of trusts. The 2016 figure was 95.2%.

The proportion of patients not developing pressure ulcers was 75.8%, which failed to meet the national standard of 100%. This was in the bottom 25% of trusts. The 2016 figure was 13.6%.

The length of stay was 27.3 days, which falls within the bottom 25% of trusts. The 2016 figure was 37.1 days.

(Source: National Hip Fracture Database 2017)
In the 2017, Bowel Cancer Audit, 76.3% of patients undergoing a major resection at Barts Health NHS Trust had a post-operative length of stay greater than five days. This was worse than the national aggregate. The 2016 figure was 85.5%.

The risk-adjusted 90-day post-operative mortality rate was 0% which was within the expected range. The 2016 figure was 3.7%.

The risk-adjusted 2-year post-operative mortality rate was 22.2% which was within the expected range. The 2016 figure was 19%.

The risk-adjusted 30-day unplanned readmission rate was 14.4% which was within expected range. There was no 2016 figure.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 44.8% which was within the expected range. The 2016 figure was 45.4%.

(Source: National Bowel Cancer Audit)

In the 2017, National Vascular Registry (NVR) audit, the Barts NHS Health Trust achieved a risk-adjusted post-operative in-hospital mortality rate of 2.7% for Abdominal Aortic Aneurysms. The 2016 figure was 2.2%.

Within Carotid Endarterectomy, the median time from symptom to surgery was 9 days, better than the audit aspirational standard of 14 days.

The 30-day risk-adjusted mortality and stroke rate was 4.2%; this was within the expected range.

(Source: National Vascular Registry)

In the 2017, National Oesophago-Gastric Cancer Audit, the age and sex adjusted proportion of patients diagnosed after an emergency admission at Barts NHS Trust was 24.4%. Patients diagnosed after an emergency admission are significantly less likely to be managed with curative intent. The audit recommends that overall rates over 15% could warrant investigation. The 2016 figure was 25%.

(Source: National Oesophago-Gastric Cancer Audit 2016)

The National Emergency Laparotomy audit awards three ratings for each indicator. Green ratings indicate performance of over 80%, amber ratings indicate performance between 50% and 80% and red ratings indicate performance under 50%.

In the 2016 National Emergency Laparotomy Audit, at The Royal London Hospital achieved an amber rating for the crude proportion of cases with pre-operative documentation of risk of death. This was based on 104 cases.

The Royal London Hospital achieved an amber rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 90 cases.

The Royal London Hospital achieved an amber rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on 80 cases.

The Royal London Hospital achieved a green rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 57 cases.

The risk-adjusted 30-day mortality for The Royal London Hospital was within the expected range based on 104 cases.

(Source: National Emergency Laparotomy Audit)
Patients undergoing elective hip and knee replacements had on-going quarterly surveillance for surgical site infection (SSI) and results were reported to Public Health England. This demonstrated no SSIs over the last year) in 182 cases.

Local audit of patients undergoing cranioplasty showed a high infection rate. A new protocol for peri-operative care had been instituted and the result of re-audit was awaited.

SSIs were audited in ambulatory general surgical patients in 2017. A telephone questionnaire was conducted in patients who had cholecystectomy, hernia surgery and minor skin and subcutaneous tissue surgery. The infection rate was 5.6% in the sample of 71 Patients. The leadership team reported poor compliance with issuing patients with dressing packs on hospital discharge (only 46% being discharged with additional dressings). This has been communicated to the nursing staff. The results were to be presented at a forthcoming audit meeting to discuss additional techniques to minimise wound infections.

SSI was recorded on departmental (General Surgery, Oncology) morbidity databases and discussed in the Morbidity and Mortality meetings. The general surgical team identified that there was no robust method for recording SSI presenting in the community and had now set up an nhs.net email portal for all healthcare professionals, both within and outside the trust so that a record of incidents could be collated.

At the time of our inspection, more detailed qualitative data collection on how well the surgical safety checklists were used, broken down by subspecialty and site, was being piloted using a Smart Survey app on smartphones. If successful, it was intended to move this data collection onto a trust web-based platform in the future.

Hand hygiene audits were undertaken to measure compliance with the World Health Organisation’s (WHO) ‘5 Moments for Hand Hygiene’. These guidelines are for all staff working within healthcare environments and define the key moments when staff should be performing hand hygiene in order to reduce risk of cross contamination between patients. In data displayed on the surgical areas, compliance was consistently 100% which met the trust target of 100%.

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin hernias
- Varicose veins
- Hip replacements
- Knee replacements
Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.

In 2016/17, performance on groin hernias was better than the England average.
For varicose veins, performance was better than the England average.
For hip replacements, performance was better than the England average.
For knee replacements was better than the England average.

(Source: NHS Digital)

**Competent staff**

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service. Staff participated in ongoing continuing professional development through a structured learning and development programme delivered face to face or on-line.

At our previous inspection the high vacancy rate in theatres resulted in temporary staff being used on a daily basis, particularly operating department practitioners. There were frequent instances of agency staff without specific surgery skills, anaesthetic training or experience. There were not enough recovery staff suitably trained in high dependence support and advanced life support to ensure safe care for patients in theatres at all times. Staff felt this put patients with complex needs or high maintenance patients at risk.

We informed the trust they must ensure sufficient numbers of suitably qualified, competent and skilled and experienced staff to meet the needs of patients in all clinical settings, and to ensure there were enough recovery staff suitably trained in high dependency support and advanced life support to safely care for post-operative patients at all times.

At our inspection we found that there were enough recovery staff suitably trained in high dependence support and intermediate life support and that they had immediate access to anaesthetists and colleagues from the critical care outreach team with advanced life support qualifications in the event of a medical emergency.

Staff told us they completed a comprehensive induction when they commenced work at the trust. This included a trust wide induction and local induction. The local induction included a welcome pack, orientation to their work area and local competencies. Three new staff working at different levels within the surgery service told us they found the induction useful and welcoming. The trust wide induction training included an introduction to the trust vision and values and a range of topics
such as information governance, incident reporting, infection prevention and control, moving and handling and fire safety.

Student nurses had a qualified nurse mentor who worked alongside the student to ensure essential skills were learnt and safety was maintained. Nursing students had skills booklets and competencies to be achieved in each area. We were unable to speak with student nurses during our inspection as there were none on duty.

Ward staff and theatre staff told us they had access to the practice development facilitators who provided and supported training across the service. We saw the practice development facilitators were visible and accessible and provided information on staff notice boards and the intranet. They also supported colleagues by working alongside them in clinical areas, particularly at induction and when working towards new competencies.

Link champions received extra training and attended regular information sessions with relevant specialist practitioners which enabled them to update other staff in their work area. For example, in specialist practice, such as end of life care, drug and alcohol dependence, pain management, infection prevention and control, patient safety, safeguarding, wound management, sepsis and diabetes.

From April 2017 to March 2018, 215 members of medical and dental staff were eligible to receive an appraisal, they achieved 93% completion rate against a trust target of 90% (201 members of staff received an appraisal).

We asked for a breakdown for non-medical staff by core service, however this was not available and therefore we are unable to include completion rates.

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

**Multidisciplinary working**

Therapy staff including physiotherapists and occupational therapists, worked alongside the nursing staff to assess plan and deliver care.

A pharmacist or pharmacy technician visited patient areas daily from Monday to Friday to review medicines administration records, and monitor stocks of medicines. This included reviewing the use of antibiotics, PRN (when required) medicines, and reconciliation of medicines where the patient was a new admission.

Dietitians and speech and language therapy staff were provided for people who had difficulty feeding, chewing or swallowing; for example, through referrals following a patients’ initial admission assessment or when their condition or needs changed.

Details of consultations, including appropriate clinical information were sent to each patient’s GP following agreed protocols for the transmission of patient data.

**Seven-day services**

The service was working towards seven-day services. Patients requiring elective surgery received a pre-anaesthetic and pre-operative assessment dependent on the procedure and their clinical needs. The pre-assessment service was nurse led, in conjunction with consultant anaesthetic colleagues and was available Monday to Friday 8am to 5pm.

The surgical service provided consultant cover by surgeons and anaesthetists seven days a week. There was a rota for out of hours and weekends to cover emergencies. There was a consultant on call 24-hours a day, seven days a week.
Pharmacy services were available on weekdays from 8:30am to 6pm. There was an on-call pharmacist available on site out of hours. They could be contacted for advice regarding or supply of medicines.

Diagnostic services including interventional radiology services were available 24 hours a day, seven days a week. Interventional radiology refers to a range of techniques which rely on the use of radiological image guidance, such as x-ray fluoroscopy, ultrasound, computed tomography (CT) or magnetic resonance imaging (MRI) to precisely target therapy.

The surgical assessment unit (SAU) is open Monday to Friday 8am to 8pm. The SAU service is an acute unit where they assessed patients for emergency surgical problems.

Staff we spoke with gave examples of where they had been supported with the immediate management of deteriorating patients by the trust’s critical care outreach team outside of hours.

**Health promotion**

Staff supported patients to manage their own health, care and well-being and to maximise their independence following surgery and according to individual needs.

Nurses in the pre-assessment clinic provided patients with information on how they could promote their fitness before their surgical procedure. For example, eating a healthy diet, moderating alcohol intake, increasing physical activity and giving up smoking.

Weekly smoking cessation clinics were available for patients and staff by appointment.

Health promotion information was readily available for patients, and their families and members of the public visiting the hospital. For example, flu vaccination, and recognising signs of sepsis.

During our visit we saw specialist nurses provided information in the main reception of the hospital on identification and treatment of sepsis in children and adults as part of World Sepsis Day events. This appeared to be well attended.

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

Staff understood their roles and responsibilities under, the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Consent to care and treatment was obtained in line with legislation and guidance, including the MCA. Staff understood their responsibilities and the procedures in place to obtain consent from patients prior to undertaking surgical procedures. This was in line with the consent for examination and treatment policy which gave clear guidance for staff. We saw completed and signed (authorised) forms for treatment and exploratory investigation during the inspection.

Medical and nursing staff we spoke with explained the consent procedures and what to do if a person lacked capacity to consent to care and treatment. They were able to outline the principles of the MCA and the implications for their practice.

Patients we spoke with told us they were given all the information they needed in order to make a decision about the treatment being provided. They felt medical and nursing staff had fully explained the procedure at their initial appointment, they were given further information at their pre-operative assessment and when they were admitted for surgery it was explained again. This meant that when a patient was due to sign their consent form they had been provided with clear, concise information about the procedure and the associated risks and benefits.

The Deprivation of Liberty Safeguards (DoLS) protect people who are not able to make decisions and who are being cared for in hospital or in care homes. People can only be deprived of their
liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Training in MCA and DoLS was included within safeguarding training.

Staff said that elective patients with a learning disability or those living with dementia would be involved in a pre-operative meeting with the carer or family member in order to ensure there was a plan in place for their admission. Staff said that carers or family members were encouraged to stay with the patient and operating lists would be adjusted to suit patient needs.

Is the service caring?

Compassionate care

Staff cared for patients with compassion. During our inspection we spoke with 14 patients, who consistently described staff as kind and informative. Patients felt treated with respect. One patient described the physiotherapists on Ward 10F as ‘first rate’.

At our previous inspection in July 2016, patients gave us variable feedback about the quality of care they received, particularly from some agency nurses. We saw some examples where care could be improved. Some patients and their relatives did not feel they were proactively kept informed by hospital staff. We informed the trust they should take further steps to improve the patient experience of nursing care on their wards.

We observed staff were caring and compassionate with patients and their relatives throughout our inspection. Patients we spoke with praised staff for their kindness and their understanding of their needs. Staff members spent time with the patients, and interacted with them during tasks and clinical interventions. We saw staff explained what was happening and what actions were planned, and that patients’ questions and concerns were addressed. Staff responded compassionately to pain, discomfort, and emotional distress in a timely and appropriate way, and answered call bells without delay.

Staff used their first name when introducing themselves to patients. Patients told us they were informed of what to expect on the ward or theatre which put them at ease.

Feedback from patients confirmed that staff treated them very well and with kindness. Staff respected patients’ privacy and dignity both on the wards and in theatres. We observed staff maintaining patient’s dignity prior to going into theatre, during and post-surgery.

Nursing staff pulled curtains around the bed space during personal intervention. We attended a patient handover on the ward and board rounds which were held in quiet areas away from the patients so that personal information discussed was not be overheard by other patients.

The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether their patients are happy with the service provided, or where improvements are needed. The FFT response rate for surgery at Barts Health NHS Trust was 15% which was worse than the England average of 25% from June 2017 to June 2018.

A breakdown of response rate by site can be viewed below:
FFT data was displayed on notice boards in patient areas we visited. Generally, the percentage was within the recommended performance and England average. The data showed some variation over a 12-month period in 2017-2018 from 66% to 100%. No data was available for the trust for November 2017.

**Emotional support**

Patients felt staff were approachable and provided emotional support when required. Patients told us staff responded to their needs and they felt able to speak openly about any concerns.

Patients’ spiritual needs were taken into account irrespective of any religious affiliation or belief. There was a trust wide multi-faith chaplaincy service available for patients, their families and staff which enabled delivery of spiritual, pastoral and religious care. The chaplaincy liaised with communities to ensure they accommodated patients of all faiths.

Staff understood the emotional stress of patients having an anaesthetic prior to surgery. We observed staff being supportive and reassuring patients before their anaesthetic to minimise their anxiety and stress. Post-operative care within the recovery area was empathetic and staff did everything they could to ensure patients were comfortable and free from any pain.

Patients and staff were supported by a range of clinical nurse specialists across the surgical areas when specific emotional needs were identified.

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

Prior to having surgery, we observed patients being given a clear explanation by nurses, surgeons and anaesthetists of surgical procedures and what they may expect. We saw examples of this in the pre-assessment clinic and in the anaesthetic room before sedatives or anaesthetic agents were administered.
Patients we spoke with were very satisfied with the explanations given to them and felt they had sufficient opportunity to ask questions before and after surgery and after discharge.

Is the service responsive?

Service delivery to meet the needs of local people

The trust planned and delivered services to meet the needs and demands of local people. Senior leaders worked with the local clinical commissioning groups to improve patient care and access to services.

To avoid unnecessary inpatient admission or waiting for appointments, there were anaesthetist and nurse led surgical pre-assessment clinics. Patients residing in particularly local areas had access to an intravenous antibiotic service at home.

There was a bed capacity manager and complex discharge team who maintained daily contact with the wards and supported patients with their discharge plans. This included support for patients with specific needs, for example the homeless population.

A daily site meeting to assess theatre capacity for the following day was held which enabled services to remain flexible and be fully utilised. Staff we spoke with told us this worked well.

Patients undergoing minor ear, nose and throat surgery were able to walk in and wait to be seen in a ‘one stop’ service as they were assessed and underwent diagnostic tests at the time of their consultation without having to attend another appointment.

From April 2017 to March 2018, the average length of stay for all elective patients at the trust was 4.9 days, which is higher compared to the England average of 3.9 days.

- Trauma and orthopaedics elective patients at the trust was 4.4 days, which is higher compared to the England average of 3.9 days.
- Cardiothoracic surgery elective patients at the trust was 8.3 days, which is higher compared to the England average of 7.8 days.
- Urology elective patients at the trust was 2.5 days, which is as expected compared to the England average of 2.5 days.
Elective Average Length of Stay – Trust Level:

The average length of stay for all non-elective patients at the trust was 5.3 days, which is higher compared to the England average of 4.9 days.

- General surgery non-elective patients at the trust was 4.8 days, which is higher compared to the England average of 3.8 days.
- Trauma and orthopaedics non-elective patients at the trust was 8.5 days, which is as expected compared to the England average of 8.8 days.
- Ear, nose and throat (ENT) non-elective patients at the trust was 2.1 days, which is as expected compared to the England average of 2.2 days.

Non-Elective Average Length of Stay – Trust Level:

From April 2017 to March 2018 the average length of stay for all elective patients at The Royal London Hospital was 4.6 days, which is higher compared to the England average of 3.9 days.

- Trauma and orthopaedics elective patients at The Royal London Hospital was 4.6 days, which is higher compared to the England average of 3.9 days.
- Urology elective patients at The Royal London Hospital was 2.4 days, which is as expected compared to the England average of 2.5 days.
- Maxilla-Facial Surgery elective patients at The Royal London Hospital was 1.6 days, which is lower compared to the England average of 3.4 days.
Elective Average Length of Stay - The Royal London Hospital:

The average length of stay for all non-elective patients at The Royal London Hospital was 5.9 days, which is higher compared to the England average of 4.9 days.

- General surgery non-elective patients at The Royal London Hospital was 6.1 days, which is higher compared to the England average of 3.8 days.
- Trauma and orthopaedics non-elective patients at The Royal London Hospital was 8.6 days, which is as expected compared to the England average of 8.8 days.
- Colorectal surgery non-elective patients at The Royal London Hospital was 4.8 days, which is as expected compared to the England average of 4.4 days.

Non-Elective Average Length of Stay - The Royal London Hospital:

(Source: Hospital Episode Statistics)

Meeting people’s individual needs

A large team of clinical nurse specialists supported other clinical staff and in many cases provided treatment themselves.

There were systems in place to aid the delivery of care to patients in need of additional support. For example, patient needs associated with dementia or a learning disability were included in the nursing assessment and care record, and referred to specialist services within or outside of the trust where appropriate.
Staff we spoke with knew which patients were living with dementia and identified their needs and planned their care accordingly.

When a patient with a learning disability used the service, they would be routinely offered a ‘hospital passport’. This was designed to help hospital staff understand each patient’s needs, likes, dislikes and interests. During our inspection we did not see any people with a learning disability using the service. We were therefore not able to fully assess the impact of this.

We saw a patient with challenging behaviour had been referred to the psychiatric liaison service within the trust and that based on an individual risk assessment of the patient one to one care and supervision was provided by an agency specialist mental health nurse.

Information leaflets about a wide range of topics were available and could be provided in other languages upon request. Interpreter services were available and accessible.

**Access and flow**

At our previous inspection in July 2016, the flow within the surgery service from admission through theatres, wards and discharge was not managed effectively. There were problems with bed management and bed availability, which caused late theatre start times and frequent short notice cancellations of surgical procedures. There were inefficiencies and under usage of operating theatres. For example, for the period of February to April 2016 there was under usage of main theatres and ACAD theatres at 47% and 42% respectively. Theatre utilisation had significantly improved to 82% main theatres and 86% ACAD in September 2018.

This was partly as a result of implementing a revised theatre scheduling process known as 642 which was designed to ensure lists were fully utilised and surgical kits and staffing requirements were confirmed. Staff we spoke with and data we reviewed also showed that the operating theatre scheduling process had reduced cancellations, improved theatre utilisation and reduced fallow sessions and wasted theatre time.

Staff told us another contributory factor that led to improved patient flow was the introduction of a patient pathway for patients who attended as a day case and had procedures under local anaesthetic. This was aimed at improving the patient experience and increasing the throughput of patients through high turnover theatre lists. In order for this to happen, patients were prepared for surgery in a ‘holding bay’ which ensured they were ready at the operating list start time as there would be no delay in transferring them from other wards. In addition, six recovery recliners had been purchased to maximise the physical space in the recovery area and it meant patients could then be discharged from the recovery area without needing transfer to a ward. Efficient use of the holding bay and recovery area meant that there was improved utilisation of inpatient beds.

Board rounds were held in all wards we visited at least three times each day and at least twice a day in the operating theatre department. During our inspection we observed three ward board rounds and two theatre board rounds the ward board rounds were attended by nurses, allied health professionals and service managers to ensure all patients had a review by a senior clinician, an expected discharge date and clinical criteria for discharge. The board rounds enabled monitoring of efficiency rates and early escalation of any concerns to be highlighted to the manager of the day, who attended the hospital bed capacity meeting three times daily. Red2Green is a national visual management system used to assist in the wasted time in a patient’s journey, as part of the SAFER patient flow bundle. We saw this in use in all wards we visited. The SAFER patient flow bundle is a national initiative which provides guidance about review, discharge planning, and managing patient flow.
The ‘642’ theatre scheduling process set specific dates for confirmation of session usage and surgeons, offering dates to other specialties where confirmation was not received against time lines. Between February 2018 and August 2018, there was an increase from an average of 90 elective and 650 day-cases a week to 130 electives and 700 day-cases a week.

The ten elective theatres ran a mix of two and three session days six days a week, with the two emergency theatres available 24 hours seven days a week.

At our previous inspection in 2016, we informed the trust they should continue to reduce referral to treatment (RTT) backlogs.

The leadership team told us referral to treatment times had not been reported between 2014 and 2018. As of September 2018, the surgical service was meeting 50% of the target times for non-cancer referrals. The leadership team were aware of these delays. Weekly meetings were held with the executive management team to work towards solutions with the relevant speciality services. Action plans were implemented by named staff.

From July 2016 to September 2018 the percentage of cancelled operations at the trust showed a trend of decline, whilst Q2 2016/17 showed that of the 365 cancellations, 2% weren’t treated within 28 days, the remaining reporting periods have generally been worse than the England average.

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

Below is a graph showing the percentage of patients whose operation was cancelled and were not treated within 28 days across the trust:
Below is a graph showing cancelled operations as a percentage of elective admissions across the trust:

Over the two years, the percentage of cancelled operations, although they were higher, generally followed the trend of the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

(Source: NHS England)

Learning from complaints and concerns

From April 2017 to March 2018, there had been 111 formal complaints about surgical services at Royal London Hospital. The trust took an average of 37.5 days to investigate and close complaints. The surgical service averaged 41 days. This was in line with their complaints policy, which states complaints should be completed between 10 to 60 days.

The three surgical wards with the highest number of complaints were:

- Ward 3D Short stay surgery: 53 complaints
- Ward 12F: 9 complaints
- Ward 13C: 8 complaints

46 complaints related to diagnosis/treatment. The general themes from the complaints related to the delays in operations, poor care received by staff, lack of information relating to procedures and poor staff attitude.

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

The leadership team demonstrated that 86% of complaints in the surgery service had been resolved in August 2018 within the agreed time scale. This was a significant improvement from 23% in June 2018. This had been attributed to: early negotiation of an extension to deadlines where needed, and staff offered a face to face meeting where appropriate.

From April 2017 to March 2018 there were 39 compliments made to Barts Heath NHS Trust. No site or core service breakdown was made available.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)
Is the service well-led?

Leadership

The surgical service was one of four divisions within RLH. It was led by a divisional director, associate director of nursing (ADON) and a divisional manager for surgery. They were supported by matrons, service managers and clinical team leaders with the right skills and abilities to enable the service to provide high quality sustainable care.

The leadership team had implemented a comprehensive action plan to address the concerns highlighted at our last inspection. We saw evidence of improvements to the surgical service to make it safer for patients, as well as significant improvements to make it more responsive to their needs. We reviewed a sample of clinical governance meeting minutes provided by the trust across a range of surgical specialities and found evidence of a clear structure and set agenda and where improvements had been made.

These included improved shared learning from incidents, better utilisation of theatre time and ward access and flow, the introduction of a discreet pre-assessment service, the reintroduction of an emergency surgical ambulatory care unit, addressing equal opportunities and inclusivity and an improved staff culture.

At our previous inspection in 2016, site based divisional leadership had recently replaced the cross site management structure and was therefore not embedded. Staff told us the site based approach now felt fully embedded, and that they preferred this approach. They felt there was good communication with the surgical leadership teams at the other two hospital sites within Barts Health NHS Trust, an improved sense of local accountability, and better collaboration between managers and staff. Staff told us managers were visible and responsive to any concerns raised, and we observed many examples of this throughout our inspection.

Each division worked with clinical boards that were responsible for strategy and learning. The board was made up of a number of senior clinicians as well as a patient representative.

Staff we spoke with were consistently positive about management changes and the pace of change.

Managers arranged ward or departmental unit meetings regularly to ensure staff were kept up-to-date with information about their service. There were various methods of communication across the teams, including meetings, and notes of meetings, notice boards and e-mail. Areas routinely covered included; patient safety, staffing and staff vacancies and ward performance.

Junior doctors told us they felt supported and there was always a consultant available to contact, including out of hours.

All staff on wards and in theatres knew the chief executive and the director of nursing by name, but had not seen them regularly walking in patient areas. The leadership team felt engaged with the executive team and felt supported by them.

Vision and strategy

The trust had developed its vision with involvement from staff, patients, and key groups representing the local community. The vision was: “to be a high performing group of NHS hospitals, renowned for excellence and innovation and providing safe and compassionate care to our patients in east London and beyond”.

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The trust had also developed ‘WeCare’ values with staff and patients to shape every interaction with staff, patients, families and partners. These were: welcoming, engaging, collaborative, accountable, respectful and equitable. The values were clearly displayed in patient areas including on a welcome table mat in the surgical assessment unit, and were evident in appointment letters sent to patients. Staff demonstrated the trust values and told us they were reinforced at in-house training sessions and discussed at their appraisal.

Staff, including the leadership team, understood what the surgery service strategy was. They recognised there were a number of work streams occurring in the surgical division that aligned to this, and the national ‘Getting it Right First Time’ (GIRFT) initiative. For example, audits of surgical site infection, the extended use of the surgical emergency ambulatory care unit, which had reopened in 2017, and a focus on improvements in patient flow and reduced occupancy of shorter stay patients.

Culture

At our previous inspection in 2016 staff told us there were challenges with the organisational culture within the surgery service. Some staff did not feel well supported by their peers or managers and reported unprofessional behaviours in the operating theatre department. We informed the trust they should take action to improve and address the perceived culture of bullying and harassment, and ensure that equal opportunities for black, Asian, and minority ethnic (BAME) staff were addressed.

The leadership team told us a BAME network was established within the trust in 2018 to address equal opportunities and inclusivity. It had recently held its first meeting which was well attended. We spoke with three staff that had actively participated in the BAME network, who felt positive about its purpose and approach. Staff who were not members were aware of and supportive of the network and felt it would achieve its aims. We saw several posters on staff notice boards providing information about the network.

All staff we spoke with told us the culture and morale in the surgery service were much improved since our previous inspection. They felt positive about the direction taken, and described the current culture as inclusive, safe, open to challenges and conducive to change. They felt there was an improved sickness policy aimed at helping staff and described the well-being of staff as a priority, providing examples of support by the occupational health and chaplaincy services. They praised the emotional and psychological support provided by the trust following the London Bridge terror attack in June 2017.

Staff felt able to raise concerns and were aware of the speak up guardian service, which was publicised on notice boards and gave examples of when they had used the service to good effect.

The allocation of rostered shifts was generally described by staff as ‘fair and with plenty of notice’ usually around eight weeks in advance.

Several staff we spoke with had worked at the trust for many years, and had achieved career progression in clinical, nursing or management roles through education and support provided by the trust. Newer members of staff spoke positively about the welcome they had been shown and described their induction as individually tailored, welcoming, well organised and relevant and felt the service was keen for new ideas and willing to listen.

Governance

The governance structure for the surgery service included departmental governance meetings, mortality and morbidity reviews, weekly governance reviews, quality and improvement meetings,
clinical leads’ meetings and operational and senior nurses’ meetings. These groups reported to the surgery board.

We reviewed a range of minutes from the governance meetings and reviews which demonstrated Matrons consistently supported clinical team leaders and ward managers so they could focus on quality improvement.

**Management of risk, issues and performance**

A risk register was held within each division within the trust. The risk register was discussed at divisional monthly governance meetings with particular emphasis on risks scoring 15 or above. This was to ensure they were re-evaluated and any gaps in controls could be addressed. Risks included a description, controls in place to mitigate the risk and a summary of actions taken. The leadership team and clinical team leaders had a good knowledge of the risks contained within this register. The risks reflected those identified through our discussions with the leadership team.

Departments within the surgical service were assessed on their performance in relation to quality dashboards and through a quality and safety trigger tool for health care settings, using an app for mobile devices known as PerfectWard. We saw this used on Ward 3D and found it allowed clinical staff to collect and review quality data using customised questions for a range of staff, patients and relatives. Staff we spoke with were positive about the benefits of being able to create a live report which allowed them to act on information and give feedback to relevant members of the team. It was felt to save time as staff did not have to reproduce data in other formats once it was inputted on to the live system.

The app allowed each of the measures to be classified as red, amber or green. Red meant the audit needed to be repeated; amber indicated a new metric and green meant the issue had been resolved. Where scores indicated a repeat measure they would be discussed at safety briefings, and ward managers met with the matron to discuss any required actions to improve the quality and service provided.

**Information management**

Information technology systems were used effectively to monitor and improve patient care. There were arrangements in place which ensured data was submitted to external providers as required, such as serious incidents and RTT performance. All permanent staff had access to up-to-date, accurate and comprehensive information on patients’ care and treatment using a secure records system that they could update. However temporary staff could only access IT systems in the presence of a permanent staff member. This provided a secure system, however it was time-consuming for staff.

The leadership team spoke of a number of ongoing hardware and network access problems. The leadership team told us since August 2017 monthly meetings to solve problems were facilitated by the RLH ICT group.

Prior to our inspection, the trust IT system had been victim of a cyberware attack in July 2017. Since then the computers were all now remote which meant they were more secure.

**Engagement**

The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively. The leadership team spoke of a positive relationship with commissioners of the service and felt involved in planning community services to improve access and flow and ongoing work on repatriation from the major trauma centre to other areas within the trust and neighbouring hospitals.
Patient’s views were gathered and acted on. The trust provided support for patients to be involved with and contribute to decisions about their own care, and to engage in a way which supported involvement from all communities.

We saw ‘you said, we did’ noticeboards in patient areas provided feedback on what each department was doing about patient complaints or suggestions for change made by patients and visitors. For example, improvements had been made to food supply and choice, communication with families, discharge from hospital at earlier times in the day, and day room facilities.

Information about audits, such as hand hygiene and infection control, was also displayed in patient waiting areas.

There were no regular newsletters for staff, however staff told us they received regular email updates and felt well informed at departmental safety huddles and board rounds. A staff safety huddle or a board round took place at least twice daily for sharing and learning purposes. Staff told us this was a good opportunity to find out what was going on and discuss important issues. We observed this happened in practice in the ward, pre-assessment clinic and operating theatre departments.

The service had undergone a staff health and wellbeing review following some difficult trauma cases and major incidents. A trust staff wellbeing survey was signed off and was due to be sent to all staff in October 2018. following our inspection.

Staff were also invited to weekly clinical governance meetings to get updates about their department. In the education hub there were also updates about learning from incidents, audits and other departmental issues.

The trust had an awards programme (Barts heroes) to recognise individuals and teams for hard work and contributions to high quality care. Any member of staff could nominate a colleague or team for an award. The ‘Hero of the Month’ award winner was posted on social media.

The surgery service had also introduced a ‘tree of success’ to celebrate individual achievements by staff, where photographs of nominated individuals were displayed. Staff felt motivated by the awards schemes.

**Learning, continuous improvement and innovation**

The service was committed to improving services by learning from when things go well and when they go wrong: promoting learning and development, and research and innovation. Staff were positive about the support they received to challenge existing practice and try out new ideas.

In September 2017, RLH launched its robotic assisted surgery programme. The programme included gynaec-oncology, ENT, hepatobiliary, colorectal and renal surgical specialities. The programme had attracted extensive media publicity and academic presentations at specialty specific national conferences. As well as clinical benefits to patients, there were reputational and research benefits for the trust.

From September 2017 to August 2018, one hundred patients underwent robotic assisted surgery and had benefited from this type of less invasive procedure. Advantages for patients were reported as reduced pain, fewer complications and a quicker recovery time – allowing for more patients to be treated. There was a 40% reduction in average length of stay. The robotics team spoke positively about the collaborative working with colleagues within the surgical division, and the work streams underway to expand the service to other surgical specialties.

All departments we visited had worked collaboratively to reduce delays and improve patient flow. The trust identified they struggled with continuing operational pressures and used escalation
scheduled care beds when demand necessitated. Staff within specialities understood the importance of ensuring all patients waiting had their risk of harm reviewed.

The surgical service had recruited research training fellows who focused on medical education. We saw examples of research activity underway on the trauma unit undertaken by medical staff, and that the service was regarded as a centre of excellence internationally with regular visits by overseas research fellows within the last year, including from Holland and the USA.

### Services for children and young people

#### Facts and data about this service

The Royal London Children’s Hospital provides secondary and tertiary specialist care to neonates, children and young people. The hospital provides care to children in the east of London and further afield. Based on the 6th, 7th and 8th floors, there are five paediatric outpatient clinics, five paediatric inpatient wards, a paediatric critical care unit, paediatric short stay assessment unit, day care unit and neonatal intensive care unit. There are 60 inpatient beds and 25 day case beds.

The hospital has a comprehensive portfolio of secondary and tertiary services including but not limited to, allergy, critical care, dermatology, endocrinology, respiratory, neurology, gastroenterology, haematology, oncology, urology and surgery. The surgical team deliver more operations as day care procedures than comparable providers. The hospital has 39 clinical specialists supporting children with long term and chronic conditions.

The 37 cot level three neonatal unit has a mortality rate 10% below the national average and hosts the neonatal transfer service for London facilitating the transfer of some of the sickest neonates to specialist providers.

Recent innovations in the service include the appointment of a specialist nurse for children and young people with a focus on the improvement of transition between paediatric and adult services. The hospital also has a rapid access clinic enabling general practitioners to obtain specialist paediatric advice and rapid review of patients without an A&E attendance.

*(20180517 RPIR Acute - NUH Documents – Context)*

The trust had 16,184 spells across all sites from April 2017 to March 2018. Emergency spells accounted for 56% (9,060 spells), 36% (5,882 spells) were day case spells, and the remaining 8% (1,242 spells) were elective.

Percentage of spells in children’s services by type of admission and site, from April 2017 to March 2018, Bart’s Health NHS Trust:
Total number of children’s spells by site at Barts Health NHS Trust:

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Royal London Hospital</td>
<td>9,389</td>
</tr>
<tr>
<td>Whipps Cross University Hospital</td>
<td>3,852</td>
</tr>
<tr>
<td>Newham University Hospital</td>
<td>2,817</td>
</tr>
<tr>
<td>St Bartholomew's Hospital</td>
<td>121</td>
</tr>
<tr>
<td>This trust</td>
<td>16,184</td>
</tr>
<tr>
<td>England average</td>
<td>1,114,797</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode statistics)

We visited children and young people’s services over three days during our announced inspection on the 11 -13 September 2018. We visited children’s inpatient wards, outpatient clinics, day care unit, paediatric critical care unit, paediatric short stay assessment unit, children’s discharge lounge and the neonatal unit.

We reviewed 12 patient care records and observed care provided. We spoke with four families, seven patients and 44 members of staff including nurses, matrons, play specialists, physiotherapists, consultants, healthcare assistants, housekeepers, teachers and administrative staff. We also reviewed the trust’s performance data and looked at trust policies for paediatrics.

Is the service safe?

Mandatory training

The trust provided a structured induction and mandatory training programme for staff. This consisted of mandatory training modules which included investigation of incidents, equality and diversity, conflict resolution, fraud awareness, emergency planning, early warning systems, nutritional care, medicines management, basic life support and fire safety.

Staff received their mandatory training through face-to-face sessions and online courses and received protected time during their induction to complete the courses. However, staff told us they did not receive protected time to complete ongoing mandatory training updates and refresher
courses. Some staff were able to show us their completed training record on the trust’s electronic learning management system.

The trust set a target of 85% for completion of mandatory training.

A breakdown of compliance for mandatory courses as of 4 June 2018 for nursing staff/ medical and dental staff in children and young people’s services is shown below:

Nursing staff:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/ No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investigation of Incidents</td>
<td>70</td>
<td>70</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>286</td>
<td>287</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
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<tr>
<td>Working at Bart’s Health</td>
<td>286</td>
<td>287</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness</td>
<td>284</td>
<td>287</td>
<td>99%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk Assessment for Managers</td>
<td>69</td>
<td>70</td>
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<td>85%</td>
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<tr>
<td>Conflict Resolution</td>
<td>282</td>
<td>287</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fraud Awareness</td>
<td>282</td>
<td>287</td>
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<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Emergency Planning</td>
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<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety</td>
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<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Security</td>
<td>281</td>
<td>287</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
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<td>286</td>
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<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Harms – VTE</td>
<td>280</td>
<td>287</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling - Inanimate Loads</td>
<td>116</td>
<td>119</td>
<td>97%</td>
<td>85%</td>
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</tr>
<tr>
<td>4 Harms - Catheter Acquired Infections</td>
<td>279</td>
<td>287</td>
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<td>85%</td>
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</tr>
<tr>
<td>4 Harms - Pressure Ulcer Prevention</td>
<td>279</td>
<td>287</td>
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<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Harms - Slips, Trips and Falls (Patients)</td>
<td>279</td>
<td>287</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Early Warning Systems</td>
<td>279</td>
<td>287</td>
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<td>85%</td>
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<tr>
<td>Nutritional Care</td>
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<td>287</td>
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<td>85%</td>
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</tr>
<tr>
<td>Privacy and Dignity</td>
<td>279</td>
<td>287</td>
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<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Complaints</td>
<td>278</td>
<td>287</td>
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<td>85%</td>
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</tr>
<tr>
<td>Information Governance</td>
<td>276</td>
<td>287</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>214</td>
<td>226</td>
<td>95%</td>
<td>85%</td>
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</tr>
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</table>
Nursing and midwifery staff exceeded the trust’s 85% completion target for all 28 mandatory training modules.

Medical staff:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality and Diversity</td>
<td>122</td>
<td>142</td>
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<td>85%</td>
<td>Yes</td>
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<tr>
<td>Clinical Documentation</td>
<td>84</td>
<td>98</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Privacy and Dignity</td>
<td>84</td>
<td>98</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>120</td>
<td>142</td>
<td>85%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety</td>
<td>120</td>
<td>142</td>
<td>85%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling - Patient Handling Low Risk</td>
<td>119</td>
<td>142</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>116</td>
<td>142</td>
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<td>85%</td>
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</tr>
<tr>
<td>Consent</td>
<td>113</td>
<td>142</td>
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<tr>
<td>Infection Prevention and Control – Clinical</td>
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<td>142</td>
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<tr>
<td>Security</td>
<td>109</td>
<td>142</td>
<td>77%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fraud Awareness</td>
<td>108</td>
<td>142</td>
<td>76%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>108</td>
<td>142</td>
<td>76%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Working at Bart’s Health</td>
<td>108</td>
<td>142</td>
<td>76%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Emergency Planning</td>
<td>107</td>
<td>142</td>
<td>75%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>107</td>
<td>142</td>
<td>75%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Dementia Awareness</td>
<td>103</td>
<td>142</td>
<td>73%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Medical Gas Safety</td>
<td>30</td>
<td>51</td>
<td>59%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>
Medical staff exceeded/met the trust’s 85% completion target for five out of the 18 mandatory training modules; the lowest scoring module was resuscitation – basic life support with 54%.

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

The trust provided mandatory training in key skills to all staff however, completion rates were low for medical staff in modules such as basic life support and medical gas safety. This was similar to what we found at the last inspection. Divisional leaders were aware of the low levels of mandatory training compliance among medical staff and said they had implemented basic life support drop in sessions to make it easier for medical staff to update their training. Divisional leaders also said that medical staff would not have their study leave signed off and would not have honorary contracts renewed if they were non-compliant with their mandatory training. However, there was no clear plan for ensuring attendance of mandatory training for medical staff.

There was a week-long induction process for all new starters which included corporate and local induction where mandatory training was undertaken. Temporary (agency) staff had a local induction process which included orientation on the wards. Student nurses commented that the induction process was very thorough and showed us a seminar room on one of the inpatient wards where regular teaching and learning sessions took place.

Staff also undertook a study day with the practise education team. We saw competency workbooks which staff received on induction which included sections on sepsis and working on paediatric intensive care unit.

The service had implemented bespoke training provided by a neighbouring mental health trust to help improve the competencies and confidence of front line staff caring for children with mental health conditions.

Safeguarding

We reviewed the trust’s safeguarding children policy which was available on the trust intranet. We found that the policy was last reviewed in May 2015. The policy stated that a review was required every three years, however there was no evidence that this had been done and the policy was still due for review. The policy detailed individual responsibilities and processes for reporting and escalation of concerns about child welfare.

There was a lead named children safeguarding nurse, a named children safeguarding nurse, named designated doctor and safeguarding children advisors who were all contactable by telephone. There was also 24 hour on call safeguarding support staffed by the named nurses working on a rotational basis.

All staff we spoke with demonstrated a good understanding of safeguarding children and young people. Staff were able to identify the potential signs of abuse, the process for raising concerns and what would prompt them to make a referral. We were given examples of concerns they had identified and where referrals were made. Staff knew who the named safeguarding leads were and how they would raise safeguarding concerns or seek advice. Staff we spoke with had good awareness and knowledge about female genital mutilation (FGM) which was now part of mandatory training within safeguarding and knew how to escalate concerns to the senior nurse and safeguarding team. Staff also told us they had taken part in the preventing radicalisation of vulnerable people programme (PREVENT) which had started this year.
Safeguarding information was recorded on the electronic patient record system. However, we were told that agency staff were not able to access electronic records. Records of children admitted with safeguarding concerns were appropriately flagged and we observed detailed documentation which showed a multidisciplinary approach taken to support the child to remain safe while on the ward. The safeguarding team were also notified when a young person between the age of 16 – 18 was admitted to an adult ward.

There was a children’s safeguarding committee and weekly psycho-social meetings held with a wide range of internal and external practitioners such as health visitors and child and adolescent mental health services to help coordinate the care of vulnerable children and young people.

Between April 2017 to March 2018 the Royal London Hospital reported 917 safeguarding referrals to the relevant local authority. The safeguarding team at the hospital went through all referrals for quality assurance and cases were discussed at the weekly psycho-social meetings.

Child protection information including social care information received from the local authority, was recorded on the electronic patient record system. Since March 2018, the trust had started using the Child Protection Information Sharing project (CP-IS), a secure system by which social services shares child protection information with the NHS to support early identification and alerting of partner agencies. The safeguarding team also used information from the police to record when a child was known to be at risk of child sexual exploitation (CSE); however, not all staff were aware of this.

The safeguarding team had now increased access to safeguarding supervision. The supervision model consisted of monthly named nurse drop in sessions on a nominated ward, psycho-social meeting attendance, ad hoc responses to concerns and safeguarding case reviews at monthly mortality and morbidity meetings. At the time of inspection we were told access to safeguarding supervision was at 78% compliance among staff. To ensure attendance, ward managers had been monitoring attendance using a red, amber, green rating (RAG) and staff who had not completed their supervision were followed up.

Medical staff had access to safeguarding supervision with the named safeguarding children doctor. Safeguarding supervision is a Department of Health requirement, as detailed in ‘Working Together to Safeguard Children’ (2015).

A breakdown of compliance for safeguarding courses as of 4 June 2018 for nursing staff/ medical and dental staff in children and young people’s services is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/ No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Level 1</td>
<td>285</td>
<td>287</td>
<td>99%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>282</td>
<td>287</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>279</td>
<td>287</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
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<tr>
<td>Safeguarding Adults Level 2</td>
<td>267</td>
<td>287</td>
<td>93%</td>
<td>85%</td>
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<tr>
<td>Safeguarding Children Level 3</td>
<td>245</td>
<td>285</td>
<td>86%</td>
<td>85%</td>
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</table>
Nursing and midwifery staff exceeded the trust's 85% completion target for all five safeguarding training modules.

Medical staff:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
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</thead>
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<tr>
<td>Safeguarding Children Level 1</td>
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<td>142</td>
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<td>85%</td>
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<td>85%</td>
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<tr>
<td>Safeguarding Children Level 3</td>
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<td>73%</td>
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<td>101</td>
<td>142</td>
<td>71%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical staff exceeded the trust’s 85% completion target for three out of five safeguarding training modules. However, safeguarding children level 3 compliance still did not meet the trust target for medical staff. While the safeguarding team had a data base which could identify ‘hot spots’ for clinicians who had not accessed level 3 training, this had not yet been utilised.

Divisional leaders had acknowledged that training compliance levels for medical staff needed to improve. Divisional leaders were in the process of addressing this and had now identified the medical staff who were non-compliant in their safeguarding training and told us that this would be picked up at their appraisals, study leave would not be signed off and honorary contracts would not be renewed if they did not keep their training up to date.

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

The trust did have an abduction policy which was in date. Staff were able to articulate what they would do in the case of a missing child and described training they had received around infant abduction. We observed robust security arrangements on the children’s wards with buzzer entry and double doors to access some wards. We also observed staff actively asking people including inspectors to identify themselves on the wards.

**Cleanliness, infection control and hygiene**

All of the children and young people clinical areas we visited were visibly clean and free of clutter. Hand sanitisers were available in all areas including at the point of entry to wards. There was signage informing visitors to use hand sanitisers, however some hand sanitisers at entrances to inpatient wards were placed high up on the wall which was not child friendly and made it harder for younger visitors to use.

Throughout our inspection all staff were observed to be ‘bare below the elbow’ and adhered to infection control procedures, such as hand washing and using hand sanitisers when entering and exiting wards and bed spaces. Staff told us they felt confident to challenge colleagues to ensure they were ‘bare below the elbow’. There was easy access to personal protective equipment (PPE), such as aprons and gloves throughout the wards and at the entrances to cubicles. We witnessed staff using PPE effectively and advising parents and visitors when aprons needed to be used before entering a cubicle.
Infection prevention control (IPC) was part of mandatory training and trust records showed a compliance rate of 94% for nursing staff which was above the trust target of 85%. However, the compliance rate for medical staff stood at 77% completion and below the trust target of 85%.

All nursing and medical staff we spoke with were able to articulate the IPC training they had received and identify the IPC link nurse for their area. IPC compliance was audited monthly and the senior sister attended monthly meetings where the data was discussed. Actions would then be disseminated to the team for example to improve handwashing compliance for medical staff on the neonatal unit, weekly practical learning sessions had been implemented with attendance recorded.

Hand hygiene audit results across the service over the last three months were consistently above 90%.

Results of monthly compliance audits including IPC, staffing levels and incidents were displayed on whiteboards on wards for staff and visitors to view. For example, the whiteboard on the gastroenterology ward showed 94% compliance for environmental cleaning, 89% for hand hygiene and one incident over the last month.

IPC standard operating procedures were accessible by staff on the hospital intranet. We reviewed a sample of policies such as the ‘Cleaning and decontamination of medical devices’, ‘Hand hygiene’ and ‘Infectious diarrhoea’ which were all up to date.

There was a dedicated housekeeper for each inpatient ward. We observed housekeepers working throughout the day following protocols and a detailed schedule of cleaning tasks to maintain the cleanliness of the ward.

We reviewed patient areas across the children's hospital including waiting areas, dirty utility rooms, treatment rooms and play areas. All areas we checked were visibly clean. Parents we spoke with were satisfied with the level of cleanliness.

We observed staff using hand gel between patients and play workers using antibacterial wipes to clean toys that had been used by patients. Play workers showed us a cleaning schedule and checklist for the playrooms and explained that toys would be cleaned with antibacterial wipes after each use to adhere to IPC procedures.

The service used green ‘I am clean’ stickers to identify equipment that had been cleaned and was ready for use. We inspected various items of equipment including a commode, blood pressure cuffs, bed tables and hoist slings and found a good level of cleanliness. We also checked a sample of toilets and shower rooms and found them to be visibly clean.

Isolation procedures were in place for patients with infections and cubicles were marked clearly to alert staff and visitors. Posters about handwashing were displayed on doors on the wards.

Waste management was handled appropriately, with different colour coding for general waste, and clinical waste. All clinical bins were seen to be operated with lids and were not overfilled. Waste management and removal including those for contaminated and hazardous waste was in line with national standards.

There were no reported cases of MRSA bacteraemia from March 2018 to August 2018. There was one reported case of Clostridium difficile from March 2018 to August 2018 in children’s services at the hospital.

In the CQC Children and Young People’s Survey 2016 the trust scored 8.42 out of ten for the question ‘How clean do you think the hospital room or ward was that your child was in?’ This was about the same as other trusts.
Environment and equipment

All of the paediatric inpatient wards, neonatal unit, day care unit, paediatric short stay assessment unit and outpatient units had secure entry with buzzers to let visitors in. We observed staff checking before letting visitors in and actively asking people including inspectors to identify themselves to maintain security on the ward.

The environment on the children’s wards and neonatal unit was bright, spacious and child friendly. The walls in all areas of children’s services were now decorated with colourful designs and cartoon characters to make the environment more welcoming and child friendly. The waiting areas in the children’s outpatient unit had colourful chairs and a play area for younger children.

Children’s theatres had a separate paediatric recovery area which provided children and young people with a private, dedicated space away from adult patients after surgery.

Treatment rooms were locked with a keypad lock to prevent unauthorised entry. However, the transfusion room in the day care unit did not have a keypad lock.

Linen cupboards and storage rooms were appropriately stocked and tidy. However, nurses commented that the storage room on the paediatric critical care unit did not have sufficient space for stock and we saw some boxes on the floor.

Playrooms contained CD players, toys and books for a range of ages and could accommodate wheelchair users. Electrical plug sockets in playrooms and waiting areas were covered to prevent access by young children. We observed high door handles, rounded corners and slam protection on doors to ensure the environment was safe for young children. There were signs on the playroom doors reminding parents not to bring hot food or drinks into the room.

An emergency trolley was available on every ward, neonatal, short stay, day care and outpatient unit. They were secured with a plastic snap lock so it was clear if someone had accessed the resuscitation equipment. Trolleys were checked daily and a log was signed to confirm checks had been made. Equipment and consumables were provided in a range of sizes suitable for all age ranges. Consumables and equipment were appropriately stored and labelled. We checked various consumables such as fluids and found them to be in date and sealed. However, we found one trolley on the outpatient unit on the sixth floor which contained equipment that had not been packaged. This was pointed out to a staff member and rectified immediately. In the day care unit, an emergency trolley did not have a plastic snap lock. This was raised with a member of staff and rectified. In the paediatric critical care unit milk was stored in the same fridge as enteral feeds and there was no freezer for breast milk.

We saw evidence that equipment had been serviced and calibrated regularly. We checked various items of equipment such as the defibrillator, suction machine and blood pressure monitors and found they had been safety tested.

Fire extinguishers and oxygen tanks were stored securely and were in date.

We inspected four sharps bins and found them to be correctly labelled and not filled above the maximum fill line.

Staff used side rooms to help support children with sensory, behavioural or mental health needs. At the previous inspection staff on the neonatal unit told us that they were unable to override the lifts in emergency transfers. This had now been rectified and staff had access cards which allowed them to do this. There were also dedicated lifts in children’s services for staff only which were clearly signposted.
During our inspection we witnessed one public access lift for the children’s services had broken down. We fed this back to the director of estates and this was rectified during the day. However, on the third day of our inspection, some parents accessing children’s services with their children told us that the same lift had stalled and they were not confident of the system.

**Assessing and responding to patient risk**

The trust had just appointed a deteriorating patient lead nurse for children’s services but we were unable to find a deteriorating patient policy on the trust intranet. However, staff we spoke with were aware of escalation protocols for deteriorating patients and the use of paediatric early warning scores (PEWS). Paper PEWS charts contained management and escalation instructions for staff. Staff had also received training on early warning systems as part of their mandatory training curriculum.

10 out of the 12 sets of notes we reviewed had paediatric early warning score (PEWS) charts completed, however two records had PEWS charts which had not been completed in full. PEWS charts were used for all children and included escalation for higher scoring children using the situation, background, assessment recommendations (SBAR) tool. SBAR is a structured method for communicating critical information that requires immediate attention and action. We observed medical and nursing handovers and found them to be detailed and comprehensive with discussion of PEWS as well as the holistic needs of the child. Handovers took place twice a day with additional safety huddles to discuss any issues or incidents.

The neonatal unit supported babies on the transitional care unit where babies required additional monitoring but did not need to be in the neonatal unit. Neonatal early warning scores were used for babies in transitional care. The neonatal unit took part in a bed conference call twice a day at 10am and at 10pm with the three hospital sites to assess capacity and staffing requirements.

Staff we spoke with said they had received training in sepsis on their induction and the sepsis six care bundle which consists of three treatments and three tests for the management of patients with presumed or actual sepsis. On one of the days of our inspection the trust was rolling out additional training on sepsis recognition and management and a new children’s sepsis tool across paediatrics.

There was lack of overarching consultant oversight on the day care unit. Children were seen by multiple specialist consultants and the matron escalated clinical issues to an on-call consultant but felt that with the increase in complexity and number of patients being sent to the day care unit, a dedicated medical lead with oversight of acute medical problems was necessary. Divisional leaders were aware of this and discussions to address this was ongoing.

We observed a surgical procedure during which we saw that World Health Organisation (WHO) surgical safety checks were completed. The latest audits as at September 2018 showed 100% compliance for WHO checklist completion.

There was always at least one member of staff on duty trained in paediatric immediate life support (PILS) on wards. There was a paediatric ‘crash team’ available 24 hours a day and consisted of a paediatric anaesthetist, paediatric consultant and operating department practitioner, however there was no paediatric nurse attached to the team. A senior nurse would hold a bleep out of hours but they were not supernumerary and would not always be able to attend a call.

At the last inspection we were not assured that there was sufficient oversight of young people admitted to adult wards. The trust now had a comprehensive admission policy for 16 to 18 year olds which stated that children aged 16 and above could choose to be cared for on adult wards or
stay on children’s wards. Young people on adult wards were now flagged at daily site safety
huddles. The paediatric matron, hospital school and safeguarding team were always informed
when a young person was admitted to an ward. A clinical nurse specialist had also been appointed
to oversee the care of children transitioning from children to adult services. All incidents involving
children up to the age of 18 were now reviewed by the associate director of nursing and discussed
at the monthly children’s hospital governance meetings.

The hospital now had a clear policy to ensure same sex accommodation on the wards. Children
over the age of 11 did not share bays with children of the opposite gender. We saw that this had
been adhered to on the wards. However, some young people commented that they did not like
sharing bays with very young children of the same gender.

In the last inspection we identified ligature risks particularly on the paediatric short stay
assessment unit. During this inspection we found that appropriate risk assessments had been
completed and the risks that were found at the last inspection had been addressed. Children at
risk of self-harm also received a mental health environment assessment and were supported by
the children’s community nursing team. Staff said they were able to access the paediatric liaison
team (the in-house psychiatry and psychology team) and children’s community nursing team for
mental health support in a timely manner. Out of hours, mental health cover for paediatrics from
the neighbouring mental health trust was provided from A&E.

In the CQC Children and Young People’s Survey 2016 the trust scored 7.98 out of ten for the
question ‘Were the different members of staff caring for and treating your child aware of their
medical history?’ This was about the same as other trusts.

In the CQC Children and Young People’s Survey 2016 the trust scored 9.82 out of ten for the
question ‘Were you given enough information about how your child should use the medicine(s)
(e.g. when to take it, or whether it should be taken with food)?’ This was better than other trusts.

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Nurse staffing

Royal London Hospital reported the following nurse staffing numbers for children and young
people’s services in March and April 2018.

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Services for Children’s and Young People</td>
<td>294.5</td>
<td>359.3</td>
<td>82%</td>
<td>288.0</td>
<td>342.2</td>
<td>84%</td>
</tr>
</tbody>
</table>

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

From May 2017 to April 2018, the Royal London Hospital reported a vacancy rate of 18.8% for
nursing staff in children and young people’s services, this was higher than the trust target of
6.3%.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)
From May 2017 to April 2018, the Royal London Hospital reported a turnover rate of 12.3% for nursing staff in children and young people’s services, this was lower than the trust target of 13%.

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

From May 2017 to April 2018, the Royal London Hospital reported a sickness rate of 2.9% for nursing and midwifery staff in children and young people’s services, this was similar to the trust target of 3%.

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

From May 2017 to April 2018 the Royal London Hospital had a total of 10,897 nursing staff shifts. A breakdown of bank and agency usage and unfilled shifts is shown below:

<table>
<thead>
<tr>
<th>Bank and agency</th>
<th>Number of shifts (% of total shifts)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank</td>
<td>6,981 (64%)</td>
</tr>
<tr>
<td>Agency</td>
<td>1,095 (10%)</td>
</tr>
<tr>
<td>Not filled</td>
<td>692 (6%)</td>
</tr>
</tbody>
</table>

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

Children and young people’s services now used the safer care nursing tool (SCNT) to determine staffing levels on a ward and the right skill mix. The SCNT is an evidence based tool which helps nurses decide on safe nurse staffing for acute wards based on patients’ level of sickness and dependency. There was a minimum of 70:30 registered to unregistered staff with a higher proportion of registered nurses in areas such as paediatric critical care. Staff also had access to the ‘perfect ward application’ which measured staffing numbers and audit results for each area of children’s services. During our inspection, we checked the expected and actual staffing levels for each ward and found them to be accurate.

The neonatal unit used guidance from the British Association of Perinatal Medicine (BAPM) to monitor staffing levels. Nursing ratios within the unit were 1:1 in the intensive care unit, 1:2 in high dependency and 1:4 in the special care unit in accordance with BAPM guidance.

Nurses in charge were supernumerary allowing them to focus on leading the ward. However, at night and out of hours, the nurse in charge was not supernumerary. There was access to a senior children’s nurse for advice.

Staff commented that there was a period where agency nurse use had been high in order to mitigate the shortage in nursing staff and cover sickness in teams. Parents also commented that they had noticed the increase in agency nurse use.

Staff on the wards had said staffing had increased recently and divisional leaders also commented that while recruitment had been a challenge, nursing staffing vacancies had now been filled and by the end of September 2018, they would be mostly fully recruited to. We received a nursing staffing trajectory from the trust which showed this was the case with the exception of band 2 staffing vacancies which showed a 10% vacancy by October 2018. Divisional leaders told us that student nurses were returning to the trust after they had qualified but that they were unable to secure the last cohort of student nurses. This had resulted in the previous vacancies and reliance on agency as mitigation. As part of the recruitment strategy, the trust had signed up to a capital student nurse recruitment programme for qualifying students.
Royal London Hospital reported the following medical staffing numbers for children and young people’s services in March and April 2018. The trusts fill rate was over establishment in March 2018.

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Services for Children’s and Young People</td>
<td>124.1</td>
<td>118.6</td>
<td>104.6%</td>
<td>121.6</td>
<td>122.0</td>
<td>99.6%</td>
</tr>
</tbody>
</table>

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

From May 2017 to April 2018, the Royal London Hospital reported a vacancy rate of 0.9% for medical and dental staff in children and young people’s services, this was lower than the trust target of 6.3%.

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

From May 2017 to April 2018, the Royal London Hospital reported a turnover rate of 3.9% for medical and dental staff in children and young people’s services, this was lower than the trusts target of 13%.

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

From May 2017 to April 2018, the Royal London Hospital reported a sickness rate of 1.6% for medical and dental staff in children and young people’s services, this was lower than the trusts target of 3%.

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

From May 2017 to April 2018, the Royal London Hospital had a total of 1,240 medical staff shifts. A breakdown of locum and agency usage and unfilled shifts is shown below:

<table>
<thead>
<tr>
<th>Locum and agency</th>
<th>Number of shifts (% of total shifts)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Locum</td>
<td>545 (44.0%)</td>
</tr>
<tr>
<td>Agency</td>
<td>10 (0.8%)</td>
</tr>
<tr>
<td>Not filled</td>
<td>83 (6.7%)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P21 Medical Locum)
In March 2018, the proportion of consultant staff and proportion of junior (foundation year 1-2) staff reported to be working at the trust in the children and young people’s core service were both lower than the England average.

Staffing skill mix for the 183 whole-time equivalent staff working in children’s services at Bart’s Health NHS Trust:

<table>
<thead>
<tr>
<th>Staffing Category</th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>35%</td>
<td>42%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>3%</td>
<td>7%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>59%</td>
<td>44%</td>
</tr>
<tr>
<td>Junior*</td>
<td>3%</td>
<td>6%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen speciality
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Divisional leaders were aware that the service was not meeting the Royal College of Paediatric and Child Health standards for 24 hour paediatric consultant cover seven days a week and this was on the divisional risk register. However, they were mitigating this by having consultant cover provided from A&E 24 hours a day, seven days a week and four out of the eight weekends were covered by a paediatric consultant. There was a general paediatric consultant available until 10pm from Monday to Thursday, a paediatric critical care consultant available Monday to Friday until 9pm and weekends until 3pm or as needed. On call paediatric consultants would either be on site or available to return to site within 30 minutes. Wards also had access to a direct phone line to a consultant paediatrician for advice 24 hours a day.

Doctors we spoke with felt there were adequate numbers of doctors during the day and night. We saw consultants undertaking daily ward rounds which happened twice a day. Staff told us rotas were planned and manageable. In the previous inspection there was a high use of locum medical staff in the neonatal unit. The neonatal unit medical staff were now all substantive.

Junior doctors and registrars were available across children’s wards. Wards and units also had a direct phoneline to a consultant paediatrician for advice. However, the neonatal transfer team told us that securing medical cover could sometimes be difficult and they could not always run two ambulances as a result.

The service was not auditing if children admitted to the paediatric department with an acute medical problem were seen by a middle grade doctor within 4 hours and by a consultant paediatrician within 14 hours of admission. The trust later told us that during weekdays all children
were seen by a consultant within 14 hours but could not assure this for weekends. Weekend cover was on the risk register and the trust told us they would start auditing consultant reviews within 14 hours.

**Records**

Children’s services were in the process of moving fully to the use of electronic records but at the time of the inspection was still in transition and using a mixture of paper and electronic notes. On some wards it was difficult to ascertain whether a patient admission booklet had been fully completed due to some information being recorded by hand and some information being recorded on the electronic system. The neonatal unit had not transitioned to electronic records and still used paper notes throughout. All paper clinical notes were stored securely behind the nurses station.

We reviewed 12 sets of records in children’s inpatient wards and found that completion was variable on different wards. Two of the 12 records we viewed did not have paediatric early warning scores (PEWS) fully inputted and three of the 12 records we reviewed did not record pain scores. The quality of the records were variable but electronic notes were found to be more comprehensive. Audits of admission booklets showed a compliance rate of 82% against a target of 95%. Audits of PEWS observation charts showed a compliance rate of 90% against a target of 95%. Matrons acknowledged that audits of documentation did show there were gaps in quality of completion and that better understanding was required from staff to fully input information into all documentation. We were told by matrons that the process would be simplified once the full transition to electronic records was made in October 2018 but some staff expressed concerns that uptake of the new ‘paper light’ policy was still low.

Therapists and play specialists also commented that with some information being recorded on paper and some electronically, it could sometimes be hard to retrieve the relevant information in a timely manner. Agency staff also told us that they were not able to access electronic notes and felt this limited their access to a child’s clinical records.

Care plans were in place and there was evidence that these were reviewed daily. Allergies, weight and height were also recorded on drugs charts. Records also noted children’s additional needs such as if the child had a learning disability. The use of a learning disability hospital ‘passport’ was also encouraged. Records did not always capture the child’s religious needs.

The electronic record system displayed specific symbols to alert staff to looked after children and those with child protection plans. Paper records also contained flags to alert staff to information such as safeguarding concerns.

Personal child health records (red books) were used and staff now actively encouraged parents to bring the book to their child’s appointments.

Care summaries could be accessed by general practitioners (GPs) and the children’s community nursing team through a shared IT system. Consultants sent letters to GPs after a child visited the outpatient clinics detailing attendance and outcome information. If a child did not attend an appointment, the consultant would also notify the GP.

Information governance formed part of mandatory training for nursing and medical staff. Compliance was 96% for nursing staff against a target of 85%. Medical staff compliance was below the trust target at 76%.

**Medicines**

Suitable arrangements were in place for the ordering, dispensing, prescribing, recording and handling of medicines.
Medications management was part of mandatory training and compliance was 93% for nursing staff which was above the trust target of 85%. Matrons attended monthly medications management group meetings where audits and medications incidents were discussed.

Medicines were stored safely in locked cupboards and fridges within keypad locked treatment rooms. Checks for expired medicines were completed as well as the daily temperature checks of the room and the fridge used to store medicines. The fridge temperature logs that we checked were all within acceptable range, however there was a recording gap of four days for the fridge in the paediatric critical care unit. We also found that the fridge in the paediatric critical care unit had not been locked but was within a locked treatment room. The ambient room temperature where medicines were stored were checked daily and did not exceed recommended levels.

Nursing staff were aware of the policies on the administration of controlled drugs (CDs) (medicine that is controlled under the ‘Misuse of Drugs Act’ (2001). CDs were stored in line with required legislation and recorded in a controlled drugs register. The register containing details of the contents of the CD cupboard was stored within the cupboard and identified the expected stock of medicine. Two members of staff checked the CD stock levels. We checked the CD stock levels and found them to be accurate and the medicine in date. The keys for the CD cupboard was held by the lead nurse on the ward. CD audits were carried out on a monthly basis and standards were mostly adhered to. CD audits included comments where improvements needed to be made with details of whom the improvement action had been allocated to.

Microbiology protocols for the administration of antibiotics were available on the hospital intranet and staff knew how to access these. We viewed the antimicrobial policy which was in date and available on the trust intranet.

Medications records for children and young people showed that the child’s weight and height was clearly documented when medication was prescribed. Allergies were clearly documented in prescribing documents. Prescription pads were stored securely and only accessed when required by a clinician.

Medicines to take away (TTA) were stored securely until the patient was discharged. The children’s discharge lounge also kept TTAs securely in a cupboard or in a fridge as necessary until a child was ready to leave the hospital. At the previous inspection, discharge information was given verbally. We saw that discharge information was now given in written form as well as explained by the nurse. We observed a nurse in the discharge lounge use the translation service to assist with explaining the written discharge information to a parent.

There was a paediatric pharmacist and staff told us they were always available to provide advice and guidance. The paediatric pharmacist visited the wards on a daily basis and checked prescription charts and CD books. An on-call pharmacy service was available at nights and weekends.

Incidents

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

From August 2017 to July 2018, the Royal London Hospital reported no incidents classified as never events for children and young people’s services at Royal London Hospital.

(Source: NHS Improvement - OBIEE NRLS STEIS)
In accordance with the Serious Incident Framework 2015, Royal London Hospital reported two serious incidents (SIs) in children and young people’s services which met the reporting criteria set by NHS England from August 2017 to July 2018.

The types of incident reported were:

- Failure to obtain appropriate bed for child who needed it: one incident
- Pressure ulcer meeting SI criteria: one incident

(Source: NHS Improvement - OBIEE NRLS STEIS)

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. Staff knowledge and awareness of the duty of candour had improved since our last inspection and staff were able to explain the duty of candour fully. One incident required the application of the duty of candour between June 2018 to August 2018.

From June 2018 to August 2018, there were 383 incidents reported within the children and young people’s service including neonatal and the neonatal transfer service at the Royal London Hospital. Of these, 338 were categorised as ‘no harm’, 44 as ‘low harm’ and one as ‘moderate harm’.

The trust used an electronic incident reporting system to report incidents. Staff were aware of their responsibilities for reporting incidents and were able to explain how this was done. Staff told us they were encouraged to report incidents and always received individual feedback for the incidents they had reported. Investigation of incidents was part of mandatory training for staff. For those eligible, the completion rate was 100% against a trust target of 85%.

Learning from incidents was shared via email, during handovers and daily safety huddles on wards and in newsletters. The children’s outpatient department had a monthly newsletter which also shared learning from incidents. We also viewed monthly governance meeting minutes which discussed incidents within children’s services.

At the last inspection, staff told us that they did not feel well informed about the incidents that happened outside of children’s services. There was now a hospital wide meeting every week which discussed serious incidents across the hospital and matrons reported that this was a good opportunity to be informed about incidents across the hospital and share learning with their teams.

We viewed the minutes for monthly divisional mortality and morbidity meetings which were held for the children and young people’s service and neonatal unit. Staff told us these meetings were always well attended by both clinical teams and therapies teams. The meetings provided an opportunity for serious incidents to be presented and discussed, and lessons to be learned. Minutes of the meetings were recorded and shared within teams and sent out in an email.

On the neonatal unit, consultants took turns in taking on a ‘governance week’ where they would summarise incidents and learning points to present at the unit’s weekly team meetings.

**Safety thermometer**

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

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

Data from the Patient Safety Thermometer showed that the trust reported one new pressure ulcer, zero falls with harm and zero new urinary tract infections in patients with a catheter from June 2017 to June 2018 for children’s services.

(Source: NHS Digital)

The trust had introduced the ‘perfect ward’ application initiative to help improve quality of care on children’s wards. The application could be downloaded on mobile phones or accessed through a computer. Weekly audits looking at a range of indicators such as infection, prevention and control, staffing, falls and pressure ulcers were undertaken using the application and provided the trust with up to date and live data of the wards’ performance.

Is the service effective?

Evidence-based care and treatment

The trust delivered care in line with national clinical guidelines. Staff had access to policies and procedures based on national guidance. Matrons regularly reviewed outcome data such as hand hygiene and medicines management audits and shared these results at clinical governance meetings.

Policies and guidelines were available for staff on the trust intranet and instructions on how to access policies were stuck onto computer monitors. However, some policies we reviewed such as information governance, violence and aggression and safeguarding, had exceeded their review date. We were unable to find epilepsy guidance for children on the intranet.

We reviewed a sample of trust policies and found that they were comprehensive and made appropriate reference to national guidance and best practice such as that recommended by the National Institute for Health and Care Excellence (NICE) and the Royal Colleges. Policies contained appropriate guidance for screening referrals and specific interventions. There was an extensive range of paediatric and neonatal protocols and guidelines as well as corporate policies and guidance on various clinical interventions such as the transition of young people from children to adult services, neonatal unit current guidelines on congenital diaphragmatic hernia, paediatric acute sickle cell pathway and guidelines for treating acute pain in paediatric inpatients.

The hospital participated in a number of national clinical audits including the national paediatric diabetes audit, the national neonatal audit programme, paediatric intensive care network audit, diabetes and asthma.

Adherence to and understanding of NICE guidelines was embedded and evidenced through the use of audit programmes to benchmark practice. There was a comprehensive audit plan for paediatric therapies which included, among others, audits for assessing the use of nebulised hypertonic saline in the paediatric cystic fibrosis population, acute paediatric physiotherapy record keeping audit, kangaroo care practice on the neonatal unit other.
NICE guidelines and audit compliance was discussed at monthly clinical governance meetings. Matrons were also able to use the perfect ward application to monitor live data for ward compliance on a number of areas from hand hygiene to documentation audits.

The service had completed an assessment against the ‘15 Step Challenge’ which is a toolkit which helped to explore quality from the patient’s perspective by involving patients, carers and families in quality assurance processes. Members are asked to about their first impressions of a ward from the perspective of a service user for example recording how it appears, looks, sounds and smells. Feedback from the assessment was mostly positive. Comments included, “Family friendly and staff always saying hello”, “Patient information is always available” and “More staff would be better”.

The children’s hospital was also committed to the Situation Awareness For Everyone principles promoted by the Royal College of Paediatrics and Child Health (RCPCH). Situation awareness takes the perspective of everyone involved in the child’s healthcare to enable the clinical team to make the best decisions.

The trust had achieved UNICEF ‘Baby Friendly’ level 3 accreditation. Baby friendly accreditation is based on a set of interlinking evidence-based standards for maternity, health visiting, neonatal and children’s centres services. The neonatal unit had achieved level 3 accreditation which meant that the unit supported parents to have a close and loving relationship with their baby, enabled babies to receive breastmilk and to breastfeed when possible and valued parents as partners in care.

**Nutrition and hydration**

There were appropriate processes in place to ensure patients’ nutrition and hydration needs were met on the wards. Children’s services had dedicated dietitians to support feeding and nutritional planning for children and young people. All children on admission received dietetic support where required.

Records we checked now included nutrition and hydration assessments as part of care planning, which was an improvement from the last inspection. Wards displayed posters informing visitors of protected meal times. This meant that non-urgent activities would stop to allow nurses and staff to support children to eat their meals where necessary.

There were food menus for young children, older children and different patient groups including those with specific dietary requirements such as allergies and intolerances. There was also the option for softer food that was easier to chew. Sandwiches, fruit and snacks were available for day care patients after their surgery.

On the neonatal unit, breastfeeding was promoted to new parents. There were two breast feeding specialists who supported new mothers on the unit. The freezers and fridge where breast milk was kept had temperature logs which were recorded on a daily basis and were within range. Bottles containing breast milk were named and dated appropriately. Feeding advisors helped ensure parents were competent and confident with parental feeding before they were discharged. In the previous inspection we found that there was no dedicate dietetic support in the neonatal unit. This had now improved and there was a dedicated full time dietitian on the neonatal unit.

The service used evidence based tools to screen for malnutrition such as the STAMP (Screening Tool for the Assessment of Malnutrition in Paediatrics) which is a nutrition screening tool for use in hospitalised children aged 2-16 years. STAMP assessments were audited regularly with action points for wards which had low compliance rates such as additional training for staff and regular re-audits. Between May 2017 and August 2018, the average compliance rate for fully completed
STAMP assessments across the five children’s wards was 61.3%. This was similar to what we found at the last inspection.

**Pain relief**

Children’s and young people’s pain was managed effectively. There were effective processes in place to ensure patients’ pain relief needs were met and managed.

Staff used standardised pain assessment tools to measure children’s pain. There were different pain assessment tools for different ages and needs. The service used a tool which was child friendly and included a choice of smiley and sad faces that children could choose from. The service also used a numbering system from zero (no pain) to 10 for older children and a face, legs, activity, cry, consolability (FLACC) scale for babies and children who were unable to verbally communicate their pain. We found that pain assessments had mostly been completed. The service audited the completion of pain assessments on a monthly basis. Results for August 2018 and September 2018 for receiving analgesia in a timely manner were 100% and 87.5% respectively.

There was an up to date policy and guidelines for treating acute pain in paediatric inpatients which was accessible on the hospital intranet. The children and young people’s service had a dedicated pain management team who supported the inpatient wards. Nurses told us they could call upon the pain team if they needed additional support and advice in managing patients’ pain. There was a multidisciplinary approach to pain management which included doctors, nurses and allied health professionals including play specialists who provided children with distraction and relaxation techniques to help manage their pain. Play specialists also used a device specifically designed for children which vibrated when placed above an injection site and decreased the sharp pain felt from injections.

Patients we spoke with told us that their pain was managed effectively and staff were responsive to requests for additional pain relief. Most care plans we reviewed took account of pain management and were personalised to the individuals’ needs.

**Patient outcomes**

The trust contributed to relevant national audits including paediatric diabetes, national neonatal audit programme, asthma and cystic fibrosis. We requested the results of audits for asthma and cystic fibrosis but were not provided with this information.

The children’s hospital undertook regular monthly audits including paediatric early warning scores (PEWS) observation charts, admission documentation, hand hygiene, resuscitation trolley, appraisal rates and identification bands. The service used a performance dashboard to monitor compliance and rated red, green or amber to show when performance levels were meeting the trust target or not. For the month of March 2018, five indicators were green, four were amber and one was red. The red rated indicator was for admission documentation completion which was 82% compliant against the target of 95%.

The service participated in the National Diabetes Inpatient Audit (NaDIA). HbA1c levels are an indicator of how well an individual’s blood glucose levels are controlled over time. The proportion of patients receiving all key care processes annually was 18.6%. This was worse than expected when compared to the national aggregate of 35.5%, and the hospital was a negative outlier. The hospital’s previous year’s score was 32%.

The average HbA1c value (adjusted by case-mix) at the hospital was 62.4%, which was better than expected when compared to a national aggregate of 68.3%, and the hospital was a positive outlier. The hospital’s previous year’s score was also a positive outlier.
The median HbA1c value recorded amongst the 2015/16 sample was 61, which was a clinically significant improvement from the hospital’s previous year’s median, which was 66.

(Source: National Paediatric Diabetes Audit 2015/16)

The leadership team was aware of its performance for patients receiving all key care processes annually in the National Diabetes Inpatient Audit and this was on the risk register. Actions included a review of the list of annual reviews to ensure that patients were scheduled for an appointment accordingly and the running additional clinics.

The data shows that from February 2017 to January 2018 no specialities, for the under one-year age group, within this core service had six or more readmissions within two days of discharge following elective admission. For the one to 17 years age group, the paediatric ear, nose and throat specialty had seven readmissions. The readmission rate was 0.5%, which was slightly better than the England average of 0.6%

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Barts Health NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readmission rate</td>
<td>Discharges (n)</td>
<td>Readmissions (n)</td>
</tr>
<tr>
<td>Paediatric Ear Nose and Throat</td>
<td>0.5%</td>
<td>1,505</td>
</tr>
</tbody>
</table>

The tables below show the percentage of patients (by age group) who were readmitted following an emergency admission. The tables show the three specialities with the highest volume of readmissions and only those specialities where six or more readmissions recorded are shown in the table.

The data shows that from February 2017 to January 2018, there was a lower percentage of under ones readmitted following an emergency admission compared to the England average, and a lower percentage of patients aged one to 17 years old readmitted following an emergency admission compared to the England average, with the exception of paediatric oncology, which had a higher percentage than the England average.
From February 2017 to January 2018, the trust performed better than the England average for the percentage of patients under the age of one who had multiple readmissions for asthma.

The trust performed worse than the England average for the percentage of patients aged one to 17 years old who had multiple readmissions for asthma and diabetes. The trust performed better than the England average for the rate of multiple readmissions for epilepsy.

Note: for reasons of confidentiality, numbers below 6 and their associated proportions have been removed and replaced with ‘*’.

(Source: CQC analysis of Hospital Episode Statistics February 2017 to January 2018)
In the 2017 National Neonatal Audit, Royal London Hospital’s performance in the four measures relevant to children and young people’s services was as follows:

- **Do all babies <32 weeks gestation have a temperature taken within an hour of admission that is 36.5ºc-37.5ºc?**

  There were 66 eligible cases identified for inclusion, 87.5% of babies who had their temperature measured within an hour of admission had a temperature measurement between 36.5°C and 37.5°C.

  This was above the national average where 64.4 0% of babies who had their temperature measured within an hour of admission had a temperature measurement between 36.5°C and 37.5°C.

  The hospital did not meet the audit’s recommended standard of 90% for this measure.

- **Is there a documented consultation with parents by a senior member of the neonatal team within 24 hours of admission?**

  There were 515 eligible cases identified for inclusion, 96.6% of these cases had a first consultation with parents by a senior member of the neonatal team within 24 hours of admission.

  This was above the national average where 94.6% of cases had the first consultation within 24 hours of admission.

  The hospital did not meet the audit’s recommended standard of 100% for this measure.

- **Do all babies < 1501g or a gestational age of < 32 weeks at birth receive appropriate screening for retinopathy of prematurity (ROP)**

  There were 81 eligible cases identified for inclusion, 95.7% of babies with a weight of < 1501g or a gestational age of < 32 weeks at birth received the appropriate ROP screening.

  This was within expected range when compared to the national aggregate where 94.2% of cases received the appropriate ROP screening.

  The hospital did not meet the audit’s recommended standard of 100% for this measure.

- **Do all babies with a gestation at birth <30 weeks receive a documented follow-up at two years gestationally corrected age?**

  There were 30 eligible cases identified for inclusion, 53.3% of babies with a gestation at birth of <30 weeks received a documented follow-up at two years gestationally corrected age.

  This was in the middle 50% of hospitals when compared to the national aggregate where 61.2% of babies with a gestation at birth of <30 weeks received a documented follow-up at two years gestationally corrected age.

  The hospital did not meet the audit’s recommended standard of 100% for this measure.
Clinical audit results and plans were discussed at regular clinical governance meetings in order to monitor issues and identify quality improvements.

**Competent staff**

From April 2017 to March 2018, 80 members of medical and dental staff were eligible to receive an appraisal, and they achieved 93% completion rate against a trust target of 90% (74 members of staff received an appraisal).

We received updated information from the trust which showed that appraisal completion rates for nursing staff in paediatrics was 88%, neonatal staff was 80% and 97% completion for administrative staff in paediatrics. Nurses we spoke with said they were fully informed of their annual appraisal dates in advance and found them useful. Therapies staff took part in a 360 degree review with their team lead. 360 degree review is a method of performance appraisal which gathers feedback from a number of sources, including peers and line managers. Staff reported that this was a positive and helpful exercise.

Nurses told us they received one to one clinical supervision and there was an open door policy with their supervisors and nurses had the choice to go to another team for their clinical supervision if they wanted. Clinical supervision compliance rates for nursing staff for paediatrics and neonates was 76.6%.

Nursing staff we spoke to on the wards during the inspection told us they had completed PILS training. Matrons confirmed that there was always at least one paediatric immediate life support trained staff member on the wards, day care unit, short stay assessment unit and outpatient clinics. We requested data on paediatric immediate life support (PILS) training which showed 95.2% of the 42 staff in PICU had completed PILS training. We did not receive a breakdown of the number of staff trained in PILS on other wards and outpatient areas. 56% of 25 medical staff in paediatrics had received PILS training. The trust also informed us that 100% of the 33 paediatric trainee doctors who had started in September had received PILS training.

All consultant anaesthetists were required to maintain competence in paediatric anaesthesia and advanced paediatric life support.

The trust supported the continued professional development of staff (clinical and non-clinical) including formal qualifications, training, conference attendance and secondment opportunities. There was a supportive environment for newly qualified staff and student nurses told us they enjoyed working at the trust as there were many opportunities for learning.

Staff we spoke with during the inspection commented on good access to development opportunities and training courses. Staff on the paediatric critical care unit (PCCU) were also offered secondments to other children’s hospital PCCUs to build on experience and received simulation training on the ward.

Student nurses told us they experienced a supportive and encouraging learning environment with good exposure to different patients and conditions. There were dedicated practice development nurses and staff on the paediatric short stay assessment unit, who told us they were supported to take advanced nurse practitioner qualifications. There were plans to bring training for the neonatal unit in-house however it was unclear when this would begin.

67% of nurses on the neonatal unit were qualified in speciality (QIS), this was below the level of 70% recommended by the British Association of Perinatal Medicine. This was on the risk register
and discussed at monthly governance meetings. The trust told us that additionally, 10 members of staff were on module 2 of the QIS course which was due to finish in April 2018 and 10 were on module 1 of the QIS course.

Revalidation was introduced by the Nursing and Midwifery Council (NMC) in 2016 and is the process nurses and midwives must follow every three years to maintain their registration. The trust provided monthly sessions to support staff to enable them to evidence requirements of NMC revalidation such as practice related feedback and reflective accounts. As at September 2018, 86 nurses who were required to revalidate had done successfully.

The trust checked that medical staff were registered with the General Medical Council and completed the re-validation training. Medical re-validation was introduced in 2012 to ensure all doctors were up to date and ‘fit to practice.’

Consultant paediatricians told us they enjoyed working at the children’s hospital at the Royal London Hospital and had a high level of consultant input and supervision. Junior doctors in the children’s outpatient department attended informal learning sessions where consultants would discuss a case study.

**Multidisciplinary working**

We saw evidence of good multidisciplinary team working within the children and young people’s service. We observed a ward round and saw that there was a collaborative approach between clinical specialties and departments with inclusive discussions about each child.

We saw evidence of close working relationships between nurses and medical staff. Nursing staff said that medical staff were approachable and listened to their opinions. Nursing staff said that consultants were always available for advice and support and there were no hierarchical relationships.

We observed very good working relationships between the nurses and consultants on the neonatal unit. Staff within the neonatal unit also worked with the maternity department and supported the transitional care unit.

We observed multidisciplinary approaches to care planning for patients and families. Patient records demonstrated input from the full clinical team of doctors, nurses, allied health professionals (AHPs) including physiotherapists, play specialists and dietitians.

Staff said they received good support from the paediatric pharmacist who visited the wards on a daily basis and the on call service at night and at weekends.

Staff throughout the children and young people’s service reported good working relationships and timely input from occupational therapists, physiotherapy staff and speech and language therapists. Therapists attended the ward on a daily basis from Monday to Friday to assess patients.

There was evidence of effective multidisciplinary partnership working with external agencies and professionals. Letters were sent to a child’s general practitioner (GP) following outpatient clinics to share outcomes and discharge information. Discharge planning meetings included clinicians, therapists, community teams and parents.

Psycho-social meetings were held weekly and attended by consultants, safeguarding team, health visitors, paediatric liaison team, the play worker, staff from the ward and a social worker where appropriate. The meetings were used to discuss the health and wellbeing of children and to help coordinate the care of vulnerable children and young people.

There were now good arrangements and clear pathways for young people on adult wards. The children’s hospital were flexible about treating young people on children’s wards until they felt
comfortable to transition to an adult ward. The adult ward team liaised closely with the paediatric matron, nurse specialist in transition, hospital school teacher and safeguarding team when there was a young person on an adult ward.

Staff commented on the close relationships they had with the surgical teams in the hospital. For example, paediatric surgeons worked closely with trauma surgeons who treated young people with gang related injuries and staff worked together to ensure patients were kept safe on the ward. The safeguarding team, education team, psychologist and paediatric surgeon were made aware when a young person was admitted to the trauma ward and the paediatric surgeon would often also attend theatres with the trauma surgeon.

In the CQC Children and Young People’s Survey 2016 the trust scored 8.36 out of ten for the question ‘Did the members of staff caring for your child work well together?’ This was about the same as other trusts.

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Seven-day services

The hospital delivered a full inpatient service for children and young people over seven days. The service used a ‘consultant of the week’ model to ensure continuous consultant cover over seven days. A senior nurse was on duty on the ward at all times.

The children’s outpatient department was open from 8.30am to 5.30pm Monday to Friday. Evening clinics were available for children of school age to avoid missing large parts of the school day.

Paediatric operating theatres had elective lists five days a week.

The neonatal intensive care unit (NICU) had access to 24 hour on-site cover of neonatologists, neonatal nurses and respiratory therapists.

The discharge lounge operated from Monday to Saturday from 7.45am to 8.15pm. However, staff commented that the discharge lounge could not always be kept open on Saturdays due to staffing levels.

Physiotherapists worked Monday to Friday with an on-call provision out of hours and at weekends. The play therapy team also worked Monday to Friday but tried to ensure that any procedures that required their assistance would be done during the weekday in order to meet the needs of the child.

The rapid access clinic (RAC) was open from Monday to Friday.

Patients and their families could access their clinical nurse specialist for advice and support on the telephone at any time. Oncology patients could call the paediatric short stay assessment unit at any time for advice and a cubicle was set aside in case a child needed to be admitted.

Health promotion

There was a comprehensive range of information and support in the form of leaflets and posters throughout the children’s hospital.

Parents’ kitchens displayed posters on support groups, basic life support training courses, smoking cessation and healthy eating. There were a variety of leaflets available in the children’s outpatient clinic areas for conditions such as asthma, tuberculosis, diabetes and cystic fibrosis.

There were examples across paediatrics of staff supporting patients and those close to them to manage their own health. For example, feeding advisors in the neonatal unit supported mothers
with breastfeeding. We spoke with a clinical nurse specialist who described how they supported children to manage their asthma. There were also dedicated dietitians in children’s services and neonatal unit who supported nutritional planning.

The service now encouraged the use of personal child health record books (red books) to document children’s measurements to monitor the growth and development of the child. The service also encouraged the use of learning disability ‘passports’.

The team on the paediatric short stay assessment unit had created an overnight pack with health promotion information, a toothbrush and water bottle as well as a booklet to help parents and carers understand where to seek healthcare information and when to take their child to hospital.

There was a well-equipped gym which was used by physiotherapists to support children in their rehabilitation. The gym was also used to promote children’s fitness and was equipped with a variety of equipment such as balls and hula hoops to encourage children to find a sport or exercise that they could continue with when they returned home.

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

Staff knowledge of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) had improved since the last inspection.

We requested compliance rates for Mental Capacity Act level 1 and level 2 training for medical and nursing staff however we were not provided with this data.

We requested compliance rates for Deprivation of Liberty Safeguards training for nursing and medical staff however we were not provided with this data.

Staff we spoke with were aware of their responsibilities for obtaining consent for treatment and their roles and responsibilities under the Mental Capacity Act 2005 (MCA).

We observed staff obtaining consent and procedures being explained to patients, parents and carers. Staff we spoke with understood the importance of shared decision-making with patients.

All patient records we reviewed demonstrated consent was sought and clearly recorded in the patients’ notes. We saw examples of records where children’s mental health needs were recorded and staff reported that they felt well supported by the paediatric liaison team and could call at any time for assistance and that support would be provided in a timely manner.

All medical and nursing staff we spoke with understood the Fraser and Gillick competencies which helped assess whether a child has the maturity to make informed decisions about treatment without consent of a parent. Staff were aware of situations where these principles would be applied.

Medical and nursing staff were aware of the MCA and the implications for young people above the age of 16. They told us they would contact the safeguarding team if an MCA referral was required.

The trust performed better than other trusts for one question and about the same as other trusts for the remaining four questions relating to effectiveness in the CQC Children and Young People’s Survey 2016.

Q54: Did hospital staff play with you or do any activities while you were in the hospital: 6.11 – better than other trusts.

*(Source: CQC Children and Young People’s Survey 2016, RCPCH)*
Is the service caring?

Compassionate care

We observed all staff to be caring and compassionate with patients and their relatives without exception during the inspection. Feedback from patients and parents confirmed that staff treated them well and with kindness. Comments included, “Words cannot explain how supportive and caring they are to our daughter” and “Fabulous care by the nurses”. We observed thank-you cards displayed on wards and staff offices.

Nursing staff promoted privacy and patients were treated with dignity and respect. However, we observed two isolated cases where medical staff did not draw the curtains around patients when conducting examinations.

We observed staff talking to patients, explaining what was happening and responding compassionately to pain, discomfort, and emotional distress in a timely and appropriate way. We observed nurses attend to call bells quickly and patients commented that both nursing and medical staff took the time to explain procedures in a way they could understand. Patients commented that nurses and play specialists spent time with them when their parents were not there.

Staff showed understanding and a non-judgmental attitude when caring for or talking about patients with mental health needs, learning disabilities or autism. Play specialists and play workers supported children in both inpatient and outpatient settings by providing support during clinical interventions using distraction techniques. A complex needs specialist was also available to support children with learning disabilities. Parents commented that nurses always kept them updated and were grateful for the support they received from the nursing team. Staff were passionate about their work toward children and their families and were focused on delivering child centred care.

There were brightly coloured comment boxes at nurses’ stations where feedback forms could be submitted. Feedback was also displayed on the walls in the wards. The board displayed comments such as ‘staff are friendly and understanding’ and ‘all the toys were good’. A ‘tree of good wishes’ was displayed on the wall of the neonatal unit with positive comments from parents. Parents spoke highly of how supportive the staff were.

A child friendly cartoon ‘monkey feedback’ form was available for children to complete by ticking smiley or sad cartoon monkey faces. A different feedback form was used for the children’s outpatient eye service which consisted of boxes for children to tick on how they were likely to recommend the service. Results from the feedback forms across children’s services showed 87% of the 90 respondents were extremely likely to recommend the service.

The trust performed about the same as other trusts for the 10 questions relating to compassionate care in the CQC Children and Young People’s Survey 2016.

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Emotional support

We found a high level of emotional support provided by staff in all areas of the service.

We observed staff spending time supporting a young patient with learning disabilities who was undergoing a surgical procedure. The multidisciplinary team recognised that the child was anxious and spent extra time ensuring the child was comfortable and relaxed at each stage of the process. A play specialist used distraction methods and the team utilised sensory equipment to help relax
the patient. The parent was allowed to accompany their child to the anaesthetic induction room and we observed nurses sensitively supporting the parent by providing regular updates.

Most parents commented that they felt confident leaving the ward and their child’s care with the staff on the ward.

Psychological support for children was available from a dedicated paediatric clinical psychologist. Parents also had access to psychological support and a psychologist would visit the neonatal unit three days a week. There was a parent’s champion and volunteers from a charity for babies born prematurely who supported parents and families on the neonatal unit.

The play therapy team supported children during clinical interventions but also provided a high level of emotional support to children on wards. They organised a variety of activities to help create a stimulating environment for children who had been in hospital for long periods of time. We saw children engaging in art therapy and play workers explained to us how they would use art and music to help children relax in the hospital setting. Play workers explained that therapy dogs visited the ward and an orchestra would come to the hospital twice a year which contributed to the emotional wellbeing of patients and also parents who spent a long time with their children in the hospital.

Children’s services had visits from entertainers and children’s charities in both inpatients and outpatient settings. We observed an entertainer in the outpatient clinic who engaged with both children and parents. He created a light-hearted atmosphere and alleviated children’s boredom while waiting for their clinic appointments.

Play specialists also attended handover meetings where the psychological and emotional needs of the patients were discussed. Every child and parent we spoke with praised the support provided by the team. A parent in the outpatient clinic described how the phlebotomy play specialist helped calm her child down when she was feeling nervous about the procedure which in turn helped the parent feel at ease as well. We observed many positive interactions between the play team and patients throughout the inspection.

Spiritual support was offered by multi-faith chaplains and staff could call upon the team if parents and patients requested.

A parent support group took place each week on the neonatal unit offering new parents both emotional and practical support. The trust were in the process of securing a bereavement nurse for the inpatient ward. Staff on the paediatric critical care unit helped families fill bereavement boxes with mementos such as handprints and footprints, according to the family’s wishes. Staff also received debriefs and support for difficult cases.

Schwartz rounds are a structured forum where all staff come together regularly to discuss the emotional and social challenges of caring for patients. Schwartz rounds had been introduced at the hospital and were held every month. Staff told us they found these a helpful opportunity to share experiences and support one another.

The trust performed about the same as other trusts for the five questions relating to emotional support in the CQC Children and Young People’s Survey 2016.  
(Source: CQC Children and Young People’s Survey 2016, RCPCH)
Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

We observed nurses communicating with young children in an age appropriate way and listening to parents’ views and concerns. Parents told us that nurses explained what they were doing, and asked for permission and agreement first. They told us they were always involved in care plans and decisions about their child’s care.

Parents and carers felt they received sufficient information about the care and treatment of their child. We observed a nurse sensitively explaining to a parent the infection control procedures required for their child. We also observed good rapport between a consultant and a young patient during a consultation.

Staff worked with children to promote their understanding and empower them to play an active role in their treatment and care. Play specialists used communication aids such as photobooks to help patients understand procedures. There was a sense that patients were encouraged to be partners in their care and treatment and the multidisciplinary team were all engaged in ensuring this occurred.

Divisional leaders told us about the ‘superhero programme’ which was aimed at eight to 15-year old children with chronic health needs. The trust hosted a day where children would attend with their parents or carers and learn about positive reframing to help them feel more confident and build self-esteem.

Older children felt comfortable asking their consultant questions and felt their questions were always answered adequately and in a way they could understand. Patients commented that they knew the names of their doctors and appreciated that they spoke to them and not just to their parents.

The children’s community nursing team worked closely with nurses in order to provide ongoing support for children with long term conditions in the community.

The trust performed about the same as other trusts for the 21 questions relating to understanding and involvement of patients and those close to them in the CQC Children and Young People’s Survey 2016.

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Is the service responsive?

Service delivery to meet the needs of local people

The children’s hospital provided a wide range of general and specialist services to children and young people in the east of London and further afield.

The hospital delivered a broad range of services for children and young people such as allergy, diabetes and endocrinology, respiratory, cystic fibrosis, neurology, gastroenterology, haematology, oncology, urology and surgery and highly specialist services such as a retinoblastoma (eye cancer in children) service which screened for, diagnosed and treated retinoblastoma.

The hospital neonatal intensive care unit (NICU) was a level three centre which meant it cared for very small or very sick new-born babies and had a wide variety of staff on site, including neonatologists, neonatal nurses, and respiratory therapists.
The paediatric critical care unit was a level three unit which meant that it provided care for children requiring intensive care and monitoring, including medically unstable patients requiring intubation or ventilation, single or multi-organ support, and continuous or intensive medical or nursing supervision.

The paediatric short stay unit was a 12-bedded unit designed for children referred from A&E or directly from oncology to be monitored for 24 to 48 hours; however, nurses reported that due to increasingly complex needs, children could stay for three to five days. This was similar to what we found at our last inspection.

The day care unit provided elective surgery, surgical and medical day care to children and young people. There was also a room for investigations and transfusions.

There were five outpatient clinic areas set across two floors of the children’s hospital providing clinics Monday to Friday from 8.30pm to 5:30pm. Clinics in outpatients included neurology, urology, epilepsy, nephrology, tuberculosis, genetics, allergy testing, sleep studies, ophthalmology and ear, nose and throat (ENT). The eye service provided a one stop shop for eye clinics where a child could see the optometrist, ophthalmologist and orthoptist all in one day to avoid having to come to hospital several times. Each outpatient clinic area had a child friendly waiting room which was decorated with colourful pictures, furnished with colourful chairs, had a range of toys and a water dispenser. There was a television and interactive game for children to play with as well as leaflets on conditions such as asthma and epilepsy. Waiting areas also had posters signposting patients and families about the option to have a chaperone in consultations.

The service provided a rapid access clinic which enabled general practitioners (GPs) to obtain specialist paediatric advice and rapid review of patients without an A&E attendance. GPs had access to a hotline throughout the day from Monday to Friday and consulted with a senior paediatrician for specialist opinions on individual cases to determine whether a child required hospital admission. The service operated three slots a day and children could be booked in to be seen by a consultant within 72 hours.

The children’s hospital had five inpatient wards and a dedicated children’s discharge lounge. The discharge lounge provided continuity of care off the wards while a child waited for their prescription or transport to take them home. The discharge lounge did not operate overnight, however two cubicles were used for sleep studies.

All areas of children’s services were spacious and child friendly and there were posters advertising free Wi-Fi for use by patients and their families, however patients and parents told us that this rarely worked. A young patient said this could sometimes be a problem when they needed internet access to complete schoolwork or access social media to keep in touch with their friends.

There was play therapy provision for both outpatients and inpatients and play specialists could be called to support children on the paediatric critical care unit. There were playrooms on every inpatient ward and a vast, colourful indoor space called the healing space which children could play in and where some entertainment for the children took place. There was also a child friendly garden with outdoor toys where children could play under supervision.

There were transition clinics which were clinics for young people who were in the process of moving their care from children’s services to adult services. Transition was coordinated by the relevant paediatric clinical nurse specialist who handed over the young person’s care to the adult specialist teams such as sickle cell, cystic fibrosis and diabetes. While transition was discussed with young people aged 12 to 13 and transition usually occurred at the age of 16, the service recognised the need for flexibility for the timing of transition as not every young person was ready to move to adult services at a specific age.
Young people aged 16 to 18 were nursed on adult wards but the service was flexible to the needs and preferences of the young person. There was now a clear protocol on the management of adolescents on adult wards and the service had also appointed a clinical nurse specialist for young people who focused on supporting young people transition from children to adult services. The trust also had planned to roll out a dedicated adolescent admissions booklet.

Parents were allowed to stay overnight with their child. The trust also had links with local charities and parents travelling from outside of London were able to utilise rooms in nearby children’s charity funded accommodation.

Similar to the last inspection, signage to various wards and clinics in the children’s hospital was not clear. The lifts to the children’s hospital did not signpost the neonatal unit clearly and we frequently saw patients and visitors struggling to find areas of children’s services particularly the outpatient clinics which were set across two floors.

We visited the hospital school which provided educational support for children of school age and enabled children and young people to continue their education while having treatment in hospital. We spoke to teachers who explained that they would attend morning handovers on the wards to identify children with educational support needs. They would also work closely with the speech and language therapy team and play team. There was a well-equipped schoolroom and tutoring could also take place by the bedside. Teachers liaised with a child’s school to make sure the child didn’t fall behind with schoolwork. We spoke to young learners who said they enjoyed attending school and that the teachers were very supportive in helping keep up with their school work. One young person told us they were supplied with a laptop to do their coursework as they could not leave their bed to attend the schoolroom.

The trust performed better than other trusts for one question, worse than other trusts for one question and about the same as other trusts for the remaining 15 questions relating to responsiveness in the CQC Children and Young People’s Survey 2016.

Q2: Did the hospital give you a choice of admission dates? 5.67 – Better than other trusts

Q57: Did you like the hospital food? 5.76 – Worse than other trusts

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Meeting people’s individual needs

The service took account of the individual needs of children and young people including vulnerable patients and those with specific needs. Children’s wards were bright, spacious and welcoming and had been designed with children and young people in mind.

Staff knew how to arrange translation services to support patients and their families whose first language was not English. Staff confirmed that it was easy to book translation services which could be arranged face to face, or by telephone using the trust’s bilingual health advocacy and interpreting service or interpreting service telephone line. Staff also knew how to access British sign language services for children and young people with hearing impairments. Information leaflets on the ward could also be requested in large print and in a range of languages such Bengali, Cantonese, Hindi, Somali, Urdu and Turkish.

There were different children’s food menus for young children and older children. Menus were bright and colourful and had options for specific cultures and preferences. For example, there were kosher and halal options as well as vegan, vegetarian and gluten free. Menus also carried a
detailed list of allergens. Patients said the food was okay and one patient particularly liked the breakfasts.

There were set protected mealtimes but the service was flexible around the needs of the patients. Snacks could be prepared in the parents’ kitchen and children were able to access snack boxes of sandwiches, fruit, juice and biscuits at any time of the day. Staff also told us they were able to order hot food out of hours. Parents were allowed to keep food in the parents' kitchen and staff had left label stickers so that parents could label their food which they stored in the fridge. Parents kitchens all had fridges, microwaves and kettles as well as some seating area. There was also a dining room on each ward which children could use instead of eating at their beds.

The neonatal unit had ‘rooming in’ rooms which allowed parents and carers the opportunity to stay overnight to gain confidence in caring for their baby before going home, but with nursing care nearby to provide reassurance and support.

There was a room on the neonatal unit which had a butterfly symbol to signify to visitors and staff that it was a bereavement room. The unit provided cooling cots and parents could stay in the room for as long as they needed. All wards had quiet rooms for sensitive conversations.

The hospital cared for children and young people with learning disabilities and now had a comprehensive learning disabilities pathway. We viewed the pathway which consisted of specific flowcharts to follow depending on whether the child was an inpatient or outpatient. Children with learning disabilities also had a hospital ‘passport’ which highlighted important information about the child and their likes and dislikes. Staff were able to describe how they would support children with learning disabilities and received additional support from the complex needs specialists and play specialists. The eye service in the outpatient department had a dedicated visual impairment support worker who supported children and families with their diagnoses. The eye service also conducted clinics in the community in schools for children with learning disabilities.

The team of 10 play specialists and four play workers provided extensive support from Monday to Friday and visited all children and young people on wards, however there was no play therapy provision at weekends. The team organised a comprehensive daily schedule which was tailored to the child’s age and needs. Play specialists and play workers provided art therapy, music therapy and distraction during procedures. Playrooms on each ward were accessible to wheelchair users and contained CDs, DVDs, CD players, toys and books for all ages, soft playmats and sensory equipment. There was no specific room for adolescents who chose to be cared for on the children’s wards but young people told us play specialists still visited them and brought DVDs and crafts activities which they appreciated. Play staff would also bring DVDs and toys into children’s cubicles if they were unable to come to the playroom. Play specialists were able to use British sign language, Makaton (a language tool which uses signs and symbols to help people communicate) and used communication aids to communicate with children. A play specialist showed us a photo book which showed the stages of a procedure to a child in order to ‘dispel the myths’ and relieve any anxiety. Comments from staff and patients about the play team were overwhelmingly positive and reflected that their input enhanced children’s hospital experience.

The trust now had a clear policy to ensure that mixed sex accommodation breaches did not occur. We saw that staff observed the policy and ensured that children over the age of 11 did not share bays with the opposite gender. However, an older child commented that they did not like sharing ward spaces with very young children.

Access to multi-faith chaplaincy was available and we saw leaflets directing patients and families to this. However, religious needs were not recorded on the patients’ records. There was a multi-faith prayer room based on the second floor of the hospital.
There were effective processes in place to support vulnerable children and young people and the service had strong links with community services. Children who required child and adolescent mental health services (CAMHS) were risk assessed and nursed on a one to one basis with a registered mental health nurse if required and were supported by the paediatric liaison team which consisted of a psychiatrist and psychologist and the children’s community nursing team.

The service had recognised the lack of sufficient provision and support in end of life care in children’s services and were in the process of securing a bereavement nurse post. There was a comprehensive action plan for end of life care provision which included workshops, speaking with families about their experiences, review of policies, pathways and National Institute for Health and Care Excellence (NICE) quality standards.

**Access and flow**

There was timely access for children and young people’s services. Most specialities were meeting referral to treatment (RTT) standards. Data provided by the trust showed that between February 2018 and August 2018 the average referral to treatment time compliance rate for incomplete pathways was 94%.

The flow within children and young people’s services from admission, through to theatres, wards and discharge was managed effectively. We followed the patient journey through paediatric theatres and found that children and young people were transferred from the dedicated paediatric recovery area to the ward appropriately and without delay. A consultant paediatrician was available at peak times of activity, seven days a week.

The service did not audit discharge lounge waiting times but staff commented that they recorded the time spent in the lounge manually. Staff said that children could stay in the discharge lounge for 15 minutes but also up to four hours depending on whether they were waiting for prescriptions, to talk to a consultant or for transport.

There were daily site management meetings which discussed bed capacity. Referral protocols were available on the trust intranet and included internal and external referral processes for different services including safeguarding, social services, mental health, general practitioner (GP) and community services. Staff found these easy to access and felt supported by the children’s community nursing team.

GPs assessing or treating children with unscheduled care needs had access to 24/7 immediate telephone advice from a consultant paediatrician through the trust’s rapid access clinic. The service provided a rapid access service so that a child could be referred to the paediatric assessment unit within 72 hours. Senior staff said they received positive feedback from GPs about the service and it had reduced admissions significantly.

Families of children with long-term conditions could call their clinical nurse specialist for advice at any time. Oncology patients could call the paediatric short stay assessment unit directly for advice and support at any time of the day. A cubicle would be left vacant on the ward so a child could be admitted at any time.

Similar to the last inspection staff on the paediatric short stay assessment unit commented that children still stayed on the unit longer than 48 hours due to the complexity of the patients and a backlog in the inpatient wards. The unit had put in a business case to expand the unit from 12 to 24 beds to accommodate more children but still needed to plan around how they would staff this.

Parents in the children’s outpatient unit commented that they were able to access appointments easily and staff were very flexible with appointment times. Appointments were confirmed in letters
and parents received text message reminders to ensure appointments were not missed. Parents appreciated the text messaging system. Parents in the outpatient clinics commented on long waiting times but that they were informed in their appointment letter that there would be a long wait time for some clinics. Parents also mentioned that it was hard to find the right outpatient clinic and signage in the children’s hospital could be quite confusing.

There were two public access lifts to the children’s hospital. On two days of our inspection we observed large queues to access the lifts to the children’s hospital. Parents commented that they could sometimes be late for their clinic appointments because of the queue for the lifts. This was a comment that was also made at the last inspection.

The service had introduced a text messaging appointment reminder system which had reduced ‘did not attend’ (DNA) rates. The DNA rate for appointments in children’s outpatients was 12.4% and the DNA rate for children for paediatric surgery was 11.5% which was an improvement from the previous inspection. If a child did not attend their appointment, consultants would follow this up with the patient’s GP. To further reduce DNA rates, the service had introduced reminder telephone calls for all appointments as well as a clinical review of all DNA cases.

**Learning from complaints and concerns**

From April 2017 to March 2018, there were six complaints about children’s services at the Royal London Hospital. The trust took an average of 35 days to investigate and close complaints. This was in line with their complaints policy, which stated complaints should be completed between 10 and 60 days.

All complaints related to A&E paediatrics. The general theme from the complaints was that the staff were unfriendly and the care provided was inadequate.

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

From April 2017 to March 2018, there were 217 compliments given to the Royal London Hospital. No core service breakdown was available.

Complaints were discussed at clinical governance meetings and we saw evidence of discussion of complaints within the clinical governance meeting documentation. However we did not see evidence that learning from complaints was shared with staff.

There were a number of ways patients and families could send feedback including filling in feedback forms. Comments boxes were placed at the reception on the wards and outpatient clinic areas. Feedback forms were child friendly and forms on children’s wards had cartoon monkey character’s, smiley face icons and questions for children to answer about their experience. There were posters explaining to young children how they could make a complaint and feedback forms had been developed with children and young people in mind, with space for children to write their comments.

Children and their families said they felt comfortable about speaking directly with staff if they wanted to complain. Nurses said they tried to address concerns as they arose by speaking to patients and families directly and explaining how they would address their concerns. Formal complaints could be made through the Patient Advice and Liaison Service (PALS) and there were leaflets and posters on walls of all of the children’s services areas. There was also a ‘young person’s guide to making a complaint’ poster displayed on the walls of the wards. Parents and carers said they felt confident that complaints they made would be taken seriously and acted upon; however, one parent commented that it took a week for a consultant to come to talk to them.
about a complaint they had made. Nurses also commented that the complaints process was too slow.

Is the service well-led?

Leadership

During the time of our inspection, the children and young people’s service was undergoing a change in divisional structure. Children’s services which used to be a part of the women and children’s service division was in the process of becoming its own standalone children’s hospital division by the 1st October 2018.

The new divisional management team which was still in its infancy, consisted of a divisional director, associate director of nursing and divisional manager. The team demonstrated an understanding of their priorities but were newly established and had not fully implemented local plans. For example, they were still in the process of recruiting a full cohort of clinical leads and ward managers to each area of the service. A matron was assigned to each area of paediatrics. Neonates, therapies and the community team had also just been brought under the leadership of the new children’s division.

Staff were able to identify the new divisional management team as well as the site based leadership team which had now fully embedded in the service. However, some staff were still unable to name the trust chief executive.

Staff commented positively on the new divisional structure and site management and said they regularly saw the associate director of nursing on the wards. Staff commented that managers were visible and approachable and found it was now easier to escalate issues.

Consultant paediatricians told us they felt listened to and encouraged by the leadership team. They told us that the leadership team focused on growth and development and felt the flow of information from the paediatric senior management team to the consultant body was effective.

There was a children’s board and a non-executive director who was a champion for children.

Vision and strategy

The service now had a formalised plan in place for the future strategy and vision for the division. There was a clear vision for the service which was to be the preferred emergency and tertiary care centre for children and young people across east London. Frontline staff we spoke with were aware of the vision of the service.

Divisional leaders told us that the vision for children’s services included improving the holistic aspects of care for children and young people including adolescent services and mental health. The vision also included integrating the service’s secondary and community services with primary care providers in line with national and regional priorities.

We saw evidence that the service had started to work on areas such as transition and adolescent services as well as working closely with primary care providers.

However, we found that staff awareness of the trust’s We Care values (Welcoming, Engaging, Collaborative, Accountable, Respectful, Equitable) was variable.
Culture

We observed a very positive, open and honest culture within the teams across paediatrics at the children’s hospital which valued staff and was based on shared values. Staff consistently commented on the supportive, child-focused and friendly teamworking environment.

Staff on the neonatal unit were passionate and focused on getting the best systems and service for babies and displayed good working relationships on the unit.

Within children’s services, staff reported that they were listened to and supported. There was respect for each member of the multidisciplinary team and the contribution they made.

Consultant paediatricians told us there was a supportive culture among clinicians and an approach to challenge and peer review.

Staff were knowledgeable about the duty of candour and knew about the trust’s processes and procedures and could give examples of how they applied the duty of candour and the learning that was shared from an incident.

At the last inspection, staff told us of instances of bullying and harassment on some wards. We did not find evidence of this from talking with staff, including clerical and housekeeping staff who consistently commented on the friendly atmosphere of the wards and clinics in children’s services.

Governance

There were effective governance arrangements and a focus on audit, review and oversight across the service which involved staff at all levels. Governance and performance information was shared with staff in a monthly newsletter.

The trust had a governance structure at board level and below to lead on quality performance. This ensured accountability for quality and the required performance standards. Information from governance meetings were shared in the form of minutes, emails and in team meetings.

The divisional leadership team attended monthly children’s hospital board meetings which discussed overarching governance, strategy and planning.

The service had weekly clinical governance meetings which were attended by matrons, the governance lead, general manager and head of therapy. These meetings discussed actions from incidents and undertook deep dives into incidents as necessary.

The weekly clinical governance meetings fed into monthly governance meetings chaired by the associate director of nursing where everyone was invited. Learning from incidents was discussed and there were specific sessions on areas such as responses to complaints.

Matrons attended monthly medications group meetings where medication incidents were discussed and themes identified. Managers investigated medication errors and fed back on incidents and actions at this meeting.

There was now a hospital wide meeting every week which discussed serious incidents across all services in the hospital. Matrons reported that this was a good opportunity to be informed about incidents outside of the division and share learning with their teams.

There were discharge planning meetings and psycho-social multidisciplinary team meetings that involved a range of staff including mental health teams, health visitors, safeguarding teams, specialist nurses, play specialists and consultants providing staff with a forum to escalate issues to ensure good care and treatment outcomes for patients.
Mortality and morbidity meetings were held monthly and learning points were discussed and shared by email.

**Management of risk, issues and performance**

The service had effective systems for identifying risks but as a newly formed division, we were yet to see the impact from planned divisional quality governance group meetings.

The divisional leadership team attended quality and improvement meetings where serious incidents, deteriorating children, patient experience, infection prevention and medicines management was discussed.

We received a plan that the new divisional management team had devised for upcoming divisional quality governance group meetings. The team intended to meet on a monthly basis to discuss risk and governance issues with reports from speciality meetings, mortality and morbidity meetings, the deteriorating patient lead, the medicines management group and safeguarding team. The divisional leadership team would then report back to the trust’s quality and safety committee. The divisional team intended to communicate five key quality messages per month to staff which would be disseminated during department meetings, posters, email and newsletters.

During our inspection staff told us they were encouraged to report incidents, always received feedback and shared learning to improve safety. Learning was shared effectively through a number of ways including email, learning sessions and team meetings.

Some areas of the service had implemented clinical practise meetings where consultants talked about how to improve practise and how guidance is developed to the team on the ward. While the meetings were open to all, this was mainly attended by consultants. On the neonatal unit a consultant was allocated a governance week where they would summarise incidents and learning points to distribute to the unit’s team in a weekly meeting.

The service had implemented daily safety huddles which occurred on the wards to deliver key safety messages to the team.

Divisional leaders were aware of the risks in the service and had put in mitigation for the risks and were monitoring these regularly. We viewed the risk register which reflected what we found on inspection. Divisional leaders were aware of risks such as the service challenges of the neonatal transfer service which featured on the risk register.

There was a dashboard to monitor key performance indicators and staff used the ‘perfect ward’ application to monitor audit compliance in real-time. Audits were undertaken on a regular basis to ensure guidelines were being followed.

Mortality and morbidity meetings were held every month within the division where serious incidents were presented. These meetings were a multidisciplinary forum attended by consultants, doctors, nurses, anaesthetists and therapists. Minutes were recorded and accessible by staff on the intranet or staff could request for the minutes to be sent by email. The divisional leadership team also hosted monthly ‘lunch and learn’ sessions which shared learning from incidents across the division and was open to all to attend.

Staff were knowledgeable about the trust’s major incident protocol and spoke about recent practise exercises they had taken part in. We also saw action cards and a quick reference sheet with a bleep number in the on-call room.
Information management

The service was in the process of transitioning from paper to electronic records and at the time of the inspection was still using a combination of paper and electronic notes. This sometimes made it difficult to find information in a timely manner as some information was recorded electronically and some were still on paper. Paper notes were kept securely in trolleys behind the nurses station. There were clearly labelled drawers behind the nurse’s station where staff could access forms and assessment tools.

There were computer stations and computers on wheels throughout children’s services but some staff commented that computers could be slow and sometimes did not work. We observed staff logging off after using computers. Staff commented that the new IT system which had been implemented was user friendly.

The trust had Wi-Fi for public use but patients and families we spoke with said that this rarely worked and children said they found it difficult to do schoolwork or access social media to keep in touch with friends and family.

The trust used a ‘perfect ward’ application which measured staffing numbers and audited areas of children’s services in real time. All nurses had access to the application and could download it onto their phones or access it via a computer. The application allowed staff to monitor their own wards and also see their progress against other wards.

There were quality information boards across all of the children and young people’s wards which provided current quality data such as staffing levels, environmental cleaning audit data and audit outcomes for hand hygiene.

There were information boards on how to access the Patient Advice and Liaison Service (PALS) and multi-faith chaplains.

The trust website for the children’s hospital was designed with children in mind which meant children could easily have access to information about their hospital stay or appointment. The website was split into three sections for under five-year olds, five to 11 year olds, 12 to 19 year olds and parents. There were also video guides for the hospital’s services from a child’s perspective.

Engagement

The service engaged well with patients and staff and collaborated with partner organisations effectively.

Staff told us they thought that paediatrics was well represented throughout the trust and there was good communication from managers. There was regular departmental communication through newsletters, staff emails and regular team meetings. Staff told us they felt clear about plans for the trust.

Patients and families on wards were encouraged to share their views on the quality of the service. We saw this demonstrated through child friendly feedback forms and comments that had been collected and put on the walls of the wards.

There were lots of examples of where staff had engaged with a number of different professionals to support the complex needs of their patients such as seeking mental health input for children with eating disorders and engaging with the local authority to support families.

The children’s services engaged with young people and their families in the design of services. The trust took part in the ‘15 Step Challenge’ which was a toolkit to help explore quality from the
patient’s perspective. There was an adolescent steering group which met monthly and fed into the pan trust adolescent steering group. A youth forum called the Youth Empowerment Squad (YES) met once a month to share views about their care and help influence decisions to make the hospital experience better for their peers.

There were examples where consultants provided teaching sessions in general practitioner (GP) practices in the community. Consultants working on this project described positive working relationships with the local Clinical Commissioning Group (CCG).

The play team promoted a ‘play in hospital week’ where parents and carers were invited to see the value of play and how it helps children express their feelings and worries, understand what is happening and cope with treatment.

The trust made use of ‘greatix’ for staff to report and share comments when their colleagues had gone above and beyond. Staff we spoke with were positive about this feature. There were 54 greatix reports in July 2018 with key themes being around taking the time to teach, being supportive, going the extra mile and showing compassion.

The service involved patients in designing posters for ‘the star of the month’ where doctors or nurses could be nominated by children for ‘going above and beyond’.

The service was supported by the trust’s own charity and other children’s charities which were involved in organising entertainers for children on the ward, volunteers supporting parents on the neonatal unit, new toys for playrooms and accommodation for parents.

Learning, continuous improvement and innovation

The service had started to work with primary care clinicians and had begun general practitioner (GP) in-reach sessions for education and reducing reliance on hospital services. Consultants commented that they received positive feedback from GPs about these sessions. The hospital, together with primary care practitioners also used a booklet which informed parents and carers about the appropriate places for treatment when their child is unwell. Staff commented that the booklet was received well by parents and had helped to reduce reliance on hospital services.

The paediatric critical care unit was a member of the regional paediatric critical care network and was involved in a project looking at patient and parent involvement to improve paediatric critical care services.

The service had also begun working on focusing on the wellbeing of staff and had trained 75 staff in dealing with conflict. There were also regular debriefs after difficult cases and there were plans to appoint a wellbeing lead.
Outpatient services at Barts Health NHS Trust are provided at all hospital sites: Royal London Hospital, Whipps Cross Hospital, St Bartholomew's Hospital, Mile End Hospital and Newham University Hospital. Barts Health saw around 1.48 million outpatient attendances in 2017/18 with the Royal London Hospital seeing 188,114 first outpatient attendances and 473,697 follow-up attendances of these.

The trust took the decision to devolve the management of outpatient departments from a centralised structure to each hospital. At the Royal London Hospital this had occurred three weeks before our inspection.

The outpatient services at the Royal London Hospital were contained within the specialist medicine division which was led by a divisional director, divisional manager and an associate director of nursing. The divisional leads reported to the hospital's managing director who in turn reported to the chief executive officer.

We inspected the service over three announced inspection days 01 to 03 October 2018.

During our inspection visit, we visited seven departments and we spoke with 13 members of staff including doctors, nurses, allied health professionals, administrative and other staff. We spoke with the 10 people who were part of the senior leadership team. We reviewed 10 patient records and spoke with 11 patients and relatives.

The trust had 1,358,950 first and follow up outpatient appointments from April 2017 to March 2018. The graph below represents how this compares to other trusts.

(Source: Hospital Episode Statistics - HES Outpatients)
Number of appointments by site

The following table shows the number of outpatient appointments by site, a total for the trust and the total for England, from April 2017 to March 2018.

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Number of Spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Royal London Hospital</td>
<td>765,685</td>
</tr>
<tr>
<td>Whipps Cross University Hospital</td>
<td>521,004</td>
</tr>
<tr>
<td>St Bartholomew’s Hospital</td>
<td>316,882</td>
</tr>
<tr>
<td>Newham University Hospital</td>
<td>274,495</td>
</tr>
<tr>
<td>Outreach Clinics</td>
<td>42,432</td>
</tr>
<tr>
<td>This Trust</td>
<td>2,099,264</td>
</tr>
<tr>
<td>England</td>
<td>105,566,870</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics)

Type of appointments

The chart below shows the percentage breakdown of the type of outpatient appointments from April 2017 to March 2018. The percentage of these appointments by type can be found in the chart below:

Number of appointments at Barts Health NHS Trust from April 2017 to March 2018 by site and type of appointment

(Source: Hospital Episode Statistics)
Is the service safe?

**Mandatory training**

Information provided following the inspection showed that trust set targets between 80-85% for completion training modules.

A breakdown of compliance for October 2018 for all staff in outpatients at Royal London Hospital is shown below.

<table>
<thead>
<tr>
<th>Training Module Name</th>
<th>Target = 85.00</th>
<th>Completion %</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Level 1</td>
<td>Target = 85.00</td>
<td>100.00</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>Target = 85.00</td>
<td>100.00</td>
<td>Yes</td>
</tr>
<tr>
<td>Harms - Slips, Trips and Falls (Patients)</td>
<td>Target = 85.00</td>
<td>100.00</td>
<td>Yes</td>
</tr>
<tr>
<td>Harms - VTE</td>
<td>Target = 85.00</td>
<td>100.00</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>Target = 85.00</td>
<td>100.00</td>
<td>Yes</td>
</tr>
<tr>
<td>Clinical Documentation</td>
<td>Target = 85.00</td>
<td>100.00</td>
<td>Yes</td>
</tr>
<tr>
<td>Complaints</td>
<td>Target = 85.00</td>
<td>100.00</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>Target = 85.00</td>
<td>100.00</td>
<td>Yes</td>
</tr>
<tr>
<td>Consent</td>
<td>Target = 85.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dementia Awareness</td>
<td>Target = 85.00</td>
<td>100.00</td>
<td>Yes</td>
</tr>
<tr>
<td>Early Warning Systems</td>
<td>Target = 85.00</td>
<td>100.00</td>
<td>Yes</td>
</tr>
<tr>
<td>Emergency Planning</td>
<td>Target = 85.00</td>
<td>92.19</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>Target = 85.00</td>
<td>97.66</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>Target = 85.00</td>
<td>83.59</td>
<td>Yes</td>
</tr>
<tr>
<td>Fraud Awareness</td>
<td>Target = 85.00</td>
<td>95.31</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety</td>
<td>Target = 85.00</td>
<td>93.75</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention and Control - Clinical</td>
<td>Target = 85.00</td>
<td>97.92</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention and Control - Non Clinical</td>
<td>Target = 85.00</td>
<td>77.50</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>Target = 85.00</td>
<td>87.50</td>
<td>Yes</td>
</tr>
<tr>
<td>Investigation of Incidents</td>
<td>Target = 85.00</td>
<td>100.00</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical Gas Safety</td>
<td>Target = 85.00</td>
<td>100.00</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>Target = 85.00</td>
<td>88.24</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling - Inanimate Loads</td>
<td>Target = 85.00</td>
<td>92.50</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling - Patient Handling Low Risk</td>
<td>Target = 85.00</td>
<td>100.00</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling - Patient Handling Practical</td>
<td>Target = 85.00</td>
<td>100.00</td>
<td>Yes</td>
</tr>
<tr>
<td>Nutritional Care</td>
<td>Target = 85.00</td>
<td>100.00</td>
<td>Yes</td>
</tr>
<tr>
<td>Privacy and Dignity</td>
<td>Target = 85.00</td>
<td>100.00</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation - Basic Life Support</td>
<td>Target = 85.00</td>
<td>100.00</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk Assessment for Managers</td>
<td>Target = 85.00</td>
<td>100.00</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>Target = 85.00</td>
<td>92.97</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>Target = 85.00</td>
<td>100.00</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 1</td>
<td>Target = 85.00</td>
<td>96.88</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>Target = 85.00</td>
<td>100.00</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 3</td>
<td>Target = 85.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Security</td>
<td>Target = 85.00</td>
<td>95.31</td>
<td>Yes</td>
</tr>
<tr>
<td>Working at Barts Health</td>
<td>Target = 85.00</td>
<td>97.66</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The data showed that the hospital was meeting its target in all but two modules, Fire safety and infection prevention and control for non-clinical staff. The trust did not include data concerning its performance in the area of consent.

We were told that newly qualified staff receive an 18-month preceptorship, and a clinical development programme. It was discussed that there will be new and upcoming development opportunities for nursing staff and junior management. The trust confirmed that it was currently looking at the Duty of Candour training to ensure all staff are aware of this process.
Band 8 qualified nurses undertook a senior nurse development leadership program, and the trust were currently looking at the Mary Seacole leadership qualification. (The Mary Seacole programme is a six-month leadership development programme which was designed by the NHS leadership academy to develop knowledge and skills in leadership and management)

The trust provided data showing its training compliance over the previous months which is displayed in the table below.

<table>
<thead>
<tr>
<th></th>
<th>OPD/RLH (Reception Team, Nursing Team &amp; Phlebotomy Team)</th>
<th>OPD/Management</th>
<th>Central Appointments Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>APRIL</td>
<td>96.11</td>
<td>98.5</td>
<td>98.77</td>
</tr>
<tr>
<td>MAY</td>
<td>95.53</td>
<td>99</td>
<td>97.86</td>
</tr>
<tr>
<td>JUNE</td>
<td>93.64</td>
<td>98.5</td>
<td>97.21</td>
</tr>
<tr>
<td>JULY</td>
<td>94.22</td>
<td>98.92</td>
<td>96.97</td>
</tr>
<tr>
<td>AUGUST</td>
<td>NO REPORT IN AUGUST</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SEPTEMBER</td>
<td>94.16</td>
<td>98.4</td>
<td>98.88</td>
</tr>
</tbody>
</table>

**Safeguarding**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data prior to the inspection.

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

<table>
<thead>
<tr>
<th>Department</th>
<th>Overall % by Department</th>
<th>Safeguarding Adults Level 1 %</th>
<th>Safeguarding Adults Level 2 %</th>
<th>Safeguarding Children Level 1 %</th>
<th>Safeguarding Children Level 2 %</th>
<th>Safeguarding Children Level 3 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Patient Appointments</td>
<td>98.88</td>
<td>Target = 85.00</td>
<td>Target = 85.00</td>
<td>Target = 85.00</td>
<td>Target = 85.00</td>
<td>Target = 85.00</td>
</tr>
<tr>
<td>OPD Management</td>
<td>98.26</td>
<td>100.00</td>
<td>100.00</td>
<td>100.00</td>
<td>100.00</td>
<td>50.00</td>
</tr>
<tr>
<td>RLH OPD</td>
<td>94.29</td>
<td>92.97</td>
<td>100.00</td>
<td>96.88</td>
<td>100.00</td>
<td></td>
</tr>
</tbody>
</table>

The trust did not meet one of its targets, safeguarding children Level 3; they have told us that there is only a requirement for two people in outpatients to have this training. One has completed the training whilst the other was booked to attend a course in October.

We were told that all staff received adult and children safeguarding training level 1 and 2. The trust had clear and comprehensive policies, processes and training related to safeguarding for adults and children. Staff told us they could find policies easily from the trust intranet and understood their responsibilities and said the safeguarding team were supportive and accessible. Although we did not see in some areas flowcharts on display for staff to follow.

The outpatient staff we spoke with demonstrated a good understanding of the trust safeguarding procedures. Nursing staff we spoke with could describe in detail how they would process a possible safeguarding incident. Staff described the action they would take when they became aware of a safeguarding need. For example, involving the trust’s safeguarding team, the patient’s GP and the police if necessary.

There were robust systems in place for recording and reporting suspected cases of female genital mutilation (FGM). Should FGM be identified or suspected then staff would inform the senior nurse or consultant in charge. This was followed up with referral to the the safeguarding team.

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Should staff suspect sexual exploitation, this would be discussed with trust safeguarding lead and the consultant and nurse on-call. This would be documented in patient notes, an incident report completed also communication with social services, police and school as required.

**Cleanliness, infection control and hygiene**

The trust had an infection prevention and control (IPC) policy and all staff received mandatory training in this area. The trust had submitted hand hygiene audit information which is displayed in the following table.

![Hand Hygiene Audit Graph](image)

This showed that hand hygiene compliance was between 93 and 100%. Staff we observed followed the WHO five steps to hand hygiene guidance and we noted that the process of handwashing and techniques used were of a good standard. Hand hygiene audit information was displayed in departments that showed high levels of compliance.

Hand gel was available in all outpatient waiting areas and we observed staff using hand gel regularly when both entering and leaving clinical areas. There were hand washing basins in rooms which were visibly clean and we saw guidance on “five steps to hand hygiene” posters present above single use soap dispensers. This was in line with World Health Organisation (WHO) advice.

Link nurses were available to provide advice to staff concerning infection prevention and control within the outpatient’s department and the infection prevention control teams contact number was visible.

We observed staff following local infection control policies, which included the removal and disposal of clinical waste. We saw that containers for the disposal of sharp objects (sharps bins), such as needles, were dated, accurate and correct in that sharps bins had signatures of staff, indicating the date of construction and by whom. (Adhering to the BS7320UN3291 standards) and were in line with health and safety regulation 2013 (The sharps regulations), 5 (1) d. This requires staff to place secure containers and instructions for the safe disposal of medical sharps bins. Containers were free from protruding needles/sharp objects and were stored safely above floor level.

In the outpatient departments we visited during the inspection, we observed floors to be clean, furnishings and fittings were clean and in a good state of repair, hand-free waste bins were clean with foot pedals, paper towels were available from enclosed dispensers, environments were free
from visible damage (flaking paint or damage services) and work surfaces were free of clutter and
visible cupboards were clean. Cleaning rotas were completed on departments and displayed
continuity and evidence of staff cleaning the department.

The management of clinical waste was safe using a colour coded systems for the disposal of
waste and clear segregation of clean and dirty equipment, whilst infectious healthcare risk waste,
was stored separately to domestic waste in a secure designated storage facility area. The waste
was managed, stored and disposed of in compliance to the EU waste regulations (The waste
framework directive 2008/98/EU).

‘Clean me’ stickers were visible on all equipment; trolleys were cleaned, labelled using green “I am
 clean” stickers on equipment and there was a cleaning schedule for all equipment; sterile
dressings were organised and clinical equipment was appropriately stored. We observed staff
clean reusable medical equipment and decontaminate flexible endoscopes available in some clinic
rooms in compliance with the Health Technical Memorandum and the safe management and
disposal of health care waste guidelines from the Department of Health.

We found that personal protective equipment (PPE) such as disposable gloves and single use
aprons were readily available for staff to use.

There were no visible flowcharts or pathways for staff to follow if patients attended the department
with symptoms of diarrhoea and vomiting. However, during interview, the matron confirmed that
the correct procedure would be followed and a deep clean within the clinical area would be
undertaken, and the matron was in the process of reviewing and introducing flowcharts/pathways
for different procedures within the department. Staff also told us that they would not assess any
patient who had sickness and diarrhoea; until these patients are isolated to a side room.

When we spoke with staff they could not explain how they would share information with other
departments regarding patients with alerts organisms such as MRSA, C diff or ESBL.

Environment and equipment

The majority of clinics were held in the main outpatient department, however some clinics could be
held in other areas of the hospital. For example, the hospital conducts pain care outpatient
community clinics, at secondary care partnership clinics based at Tower Hamlets - Mile End
(persistent pain service) and in Newham - Essex Lodge.

We found that toilets and baby changing areas were located within waiting areas and were clearly
marked. Areas were clean, calm and well lit. Toilets were clean, tidy with an appropriate gender
symbol on the door. There were parent and baby rooms available to use together with disabled
toilet facilities.

Visible whiteboards were used to inform patients of waiting times.

Queues at reception were no more than five at any one time, averaged three. However, we saw in
clinic 1 that patients attended the reception area with problems and complaints which inhibited the
smooth running of the clinic. We were told by staff that patients were sent letters for invitation to
appointments at the dressing clinic (for dressing only), the letter referred to clinic 3 from which the
consultant runs their clinic from, but in some cases patients were not required to see the
consultant. We were told that this meant patients waited incorrectly in clinic 3 before returning to
clinic 1.

We found signage to be mixed within the department with in some areas signage clearly indicated
different areas such as dermatology, neurophysiology, x-ray, fracture and cardiac. Whilst in other
areas this could be improved.
Resuscitation equipment was checked daily. These checks were found to be documented, with emergency medicines sealed and in date. Safety testing for portable appliances was carried out by the trust on an annual basis. All devices we checked during inspection were valid with the previous inspection date recorded on a sticker.

Waiting areas were clean with plenty of suitable chairs for patients waiting to be seen. We observed medics and nurses calling patients for their appointments in all clinics and led them down to clinic rooms.

**Assessing and responding to patient risk**

Outpatient staff identified patients who were potentially at risk before coming to the clinic during daily meetings. This enabled them to prioritise transport for patients so they were seen as early and as promptly as possible. Stretcher patients were reviewed at the start of each clinic and were allocated a room which could accommodate a stretcher and hoist should this be needed. We were told by nursing staff that patients living with learning difficulties, dementia or mental health conditions were prioritised and reviewed as soon as possible.

We were told during discussions with management that that the department did not often have acutely unwell patients and there was no formal monitoring tool in use. However, the service was working on a monitoring tool, to ensure that patients will be monitored in the future, should any patients deteriorate in the outpatient departments, although it was not clear when this would be implemented. This monitoring tool included observations, what time the clinician had seen the patient, Waterlow score, nutritional and fluid status.

We requested further information from the trust concerning the monitoring of unwell patients, they stated that all vital signs are recorded on their internal system, and a NEWS (National Early Warning Score) score will be calculated when a full set of obs and conscious level was entered. However, at present, only patients who have been identified as 'unwell' and those requiring admission will have a full set of observations done (temperature, pulse, respiration rate, O2 saturation, BP and BM if appropriate).

They stated that With regards to the escalation process, once a trained nurse has assessed the patient, it will be decided if a repeat observation is required after a period of time (i.e. patient fainting during blood test due to a vasovagal response), if a clinician is needed to re-assess the patient for possible admission (i.e. pyrexial patient coming for a dressing change whose wound appears infected) or if an emergency call is required immediately (i.e. patient found unresponsive in the waiting area).

They further stated that NEWS is not currently used in outpatients. However, staff knew how to obtain the score for the unwell patients.

Staff we spoke with demonstrated knowledge and understanding of patient risk, particularly for people living with dementia, a learning disability, elderly or frail patients and those with one or more medical conditions.

Each patient had an admissions form and any risks were identified or documented. The admission documentation was used if a patient become unwell or required hospital admittance and the status of the patient was clearly evidenced.

Evidence of risks were documented on admissions forms. Waterlow scores were also was documented on an admissions forms if there was an indication that the patient’s pressure areas were at risk. We saw that clinics were flexed, this meant that patients were prioritised and those at higher risk were to be seen more urgently.
Nurse staffing

There were no nationally recommended methodologies for determining nurse staffing levels or skill mix within outpatient settings. The outpatient clinics were staffed by registered nurses and health care assistants supported by a senior sister. The trust told us that staffing was reviewed on a daily basis to assess the capacity of staff to manage the workload in the department. Nursing staff were trained to work in multiple areas of the department so that they could support if there was unplanned absence.

Managerial staff told us that they had a combined 26.6 whole time equivalent (WTE) staffing establishment which included nursing staff and HCSWs, with a current vacancy rate of one WTE band six nurse.

The workforce performance review pack was reported on monthly and reviewed in the CSS directorate’s outpatients performance review meetings. This would be a joint presentation by the HR manager and the operational leads. Key exceptions would be noted, discussed and understood. Actions would be agreed to address any areas of concern. Operational teams would also feed in any concerns from their teams with regards to causes of staffing issues, such as recruitment delays or high sickness.

Because responsibility for managing staffing had recently been transferred from the CSS directorate to the site based team, the performance review process described above, was in future due to take place in the RLH specialist medicine directorate’s outpatient performance review meetings. The first meeting was scheduled for 18 October 2018, meaning that from this date specific data will be able to be produced.

Because the CSS directorate is a trust wide team, the trust provided us with trust wide outpatients data reporting overall data on actual whole time equivalent (WTE) and headcount staffing figures for nursing and midwifery staff working in outpatients for July 2018. These figures were not provided at site level. The WTE was 401.41 with 348.6 (86%) filled by substantive staff.

Managerial staff explained to us that the outpatient services did not use agency staff and only used regular bank staff. All bank staff were provided with local departmental inductions and training was monitored the same way as for permanent staff.

We were told that the nursing shift rota which was available electronically was completed every two weeks upto six weeks in advance and was flexed to meet the needs of the service, the matron explained that changes could be made following at the 9 AM “huddle board” meeting or as a result of demand and capacity discussions with the service director.

Trust wide data showed that during 2018 the trust filled between 86 – 88% of its 401.41 WTE.

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

Turnover data for nursing and midwifery staff within outpatient’s services was provided as additional information following the inspection. Data provided was trust wide and showed that during 2018 the trust had an annualised turnover rate between 12 -15%

Sickness data for nursing and midwifery staff within outpatient’s services was provided as additional information following the inspection. Data was trust wide and showed that during 2018 the trust had an annualised sickness absence between 5 – 6%.
Medical staffing

Outpatient department medical staffing was provided by doctors working in the specialty relevant to the clinic. Medical staffing was managed by the medical departments rather than overseen by the outpatient department as a whole. For instance, the surgery division provided surgical medical staff to provide clinic services. Medical staff working within outpatients were of mixed grades, ranging from consultants to junior doctors. All clinics which we observed had a consultant to oversee them. Further data on medical staffing was not provided.

Therefore the trust provided us with trust wide outpatients data reporting overall actual whole time equivalent (WTE) and headcount staffing figures for nursing and midwifery staff working in outpatients for July 2018. These figures were not provided at site level. The WTE was 401.41 with 348.6 (86%) filled by substantive staff.

The Royal London Hospital did not provide planned vs actual staffing data for medical and dental staff within outpatient services.

From January to December 2017, the Royal London Hospital did not report on outpatients shifts filled by locum and agency staff.

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

Records

The trust used mainly paper records, with some electronic access to documents. We were told by managerial staff that the trust was working towards moving to a paper light system.

The department computer system fed into the main hospital system which meant staff on medical assessment units could view the patient notes. We were told with permission community services could also access the patient records.

At our previous inspection we found that records were not kept securely within the department. This had improved during this inspection and we saw that patient notes were now kept in lockable trolleys. However, we observed one instance where a note trolley was left unlocked and open in an empty corridor.

We reviewed a sample of patient notes during the inspection and found that they were completed appropriately using the notes to identify patients with pre-existing mental health conditions, learning disability or dementia.

Patients we spoke with told us that their notes followed them when they moved between different departments or saw different doctors. Patients told us that their notes were available for their appointments.

Medicines

We saw that medicines were stored appropriately and recorded on patient notes. Controlled drugs (CDs) are medications requiring additional security. Staff we spoke with were aware of the appropriate safety measures required and knew how to access medication policies on the trust intranet. There were no drugs that were out of date in the clinical area and we found prescription sheets were stored securely when we checked.

We looked at the recording and storage of FP10 forms (prescription). Prescriptions were counted and checked daily and the key to the cupboard was kept by the person in charge. Back up stock was also checked. There was a pharmacy policy.
Medicines were stored in dedicated medication fridges which had daily temperature checks. Temperature logs we looked at showed that the fridges had not exceeded the acceptable temperature limits. Fridges were locked and team leaders had control of the keys. Ambient room temperatures were also checked and logged and we saw that they did not exceed recommended levels.

We found emergency drugs for anaphylactic shock and emergency oxygen which had been checked daily by staff and signed.

However, when we asked staff they were unaware of when pharmacy technicians visited the department to check the drugs and to replenish the stock level.

**Incidents**

Staff we spoke with understood the process for reporting an incident and we heard that incidents were discussed at departmental meetings. They were also discussed at safety huddles although not all staff were aware these meetings were minuted. The matron confirmed that she had developed an outpatient’s email group, in which they communicated continually to staff of any risks, learning from incidents and the trust bulletins.

Incidents were reported electronically and investigated within the appropriate area, or escalated if necessary.

The incident log submitted by the trust showed that 170 incidents specific to the outpatient department had been reported between April to October 2018. Of these, six were categorised as ‘low harm’ (minor injury) and 164 were ‘no harm’. The majority of incidents were associated with patient waiting times, in that patients had experienced longer than usual waits. There were no other significant patterns or trends in terms of type of incident.

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

From April to October 2018, the trust reported no incidents classified as never events for outpatients.

*(Source: Strategic Executive Information System (STEIS))*

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in outpatients which met the reporting criteria set by NHS England from April 2018 to October 2018.

*(Source: Strategic Executive Information System (STEIS))*

The Duty of Candour is a regulatory duty that relates to openness and transparency. It requires providers of health and social care services to notify patients (or other relevant persons) of certain “notifiable safety incidents” and provide reasonable support to that person. Staff we spoke with during the inspection demonstrated a good understanding of the duty of candour and could describe instances where it would be applied.

**Safety thermometer**

The NHS Patient Safety Thermometer is a national tool to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering ‘harm free’ care. This information is intended to help staff focus their attention on reducing patient harm and improve the safety of the care they provide.
We requested this information from the trust following our inspection, in response the trust stated
The Safety Thermometer tool is not used in outpatients at RLH as it is not suitable for an
outpatient setting.

Is the service effective?

**Evidence-based care and treatment**

Auditing of clinical activity and the identification and implementation of relevant National Institute
for Health and Care Excellence (NICE) guidance was predominantly managed by individual
specialties rather than overseen by the outpatient department as a whole. We were told that NICE
guidance was disseminated by the trust governance team to the senior managers who distribute to
matrons who would disseminate to staff via the meeting structure or via email. NICE guidelines
were discussed at staff meetings and implemented if relevant and we observed staff adhering to
NICE guidelines

Staff we spoke with confirmed that they could access trust policies and local work protocols via the
intranet or shared drive.

**Nutrition and hydration**

The department had vending machines available which patients could use in waiting areas. The
machines contained drinks and snacks.

We were told that the departments could provide sugary drinks for those patients who felt faint
during the consultations or whilst waiting.

Patients assessed as requiring hydration and nutrition received food boxes that were prepared by
the hospital. This was documented on the admissions form.

**Pain relief**

Nursing staff told us that any patients experiencing chronic pain would be referred to the pain
management team. Doctors seeing patients would usually prescribe any pain relief they required.

Patients with sudden pain that may be in a deteriorating state were assessed using a scoring
system and asked to rate their pain on a scale from 0 to 10.

We observed nursing and medical staff enquire about pain and comfort of patients during clinics.
We also saw evidence of pain relief prescriptions in clinic notes.

**Patient outcomes**

From April 2017 to March 2018, the follow-up to new rate for The Royal London Hospital was the
same as the England average:
Responsibility for measuring patient outcomes in outpatients sat with the clinical services providing that care, and was measured through a programme of audit. The trust had a dedicated clinical effectiveness unit that coordinated this work.

We did not see evidence of the monitoring of patient outcomes.

They told us that they were responsible for ensuring that relevant NICE guidance was reviewed and services provided benchmarked against that guidance, through a process of clinical audit. The Royal London Hospital also contributed to a number of national audits, including the National Diabetes Outpatient Audit, the National Neurosurgery Audit programme, the Renal Registry, the National Parkinson’s Disease Audit, and the National Inflammatory Bowel Disease Audit.

Competent staff

We found that staff were trained in areas outside of those considered mandatory, in such things as dementia awareness, blood transfusion and investigation of incidents. Newly qualified staff receive an 18 month preceptorship, and a clinical development programme and the trust was considering implementing the Mary Seacole programme.

Staff were encouraged to complete continuous professional development (CPD) There were good opportunities for staff development including training courses and leadership schemes. For example, band 8 qualified nurses undertook a senior nurse development leadership program.

Staff we spoke with felt that they could approach senior leadership if they had concerns and managers felt there was a supportive culture and good collaborative working. We saw that staff had received formal training in conflict resolution to enable them to sensitively manage any difficult behaviours that patients may display

We were told that clinical nurse specialists ran clinics in the outpatient’s centre these were not under the management structure of the outpatient’s department, but were managed by their respective divisions.

The Royal London Hospital did not provide any

Appraisal data for staff within outpatient’s services was provided following the inspection. The appraisal rate for the outpatients department was 94%.
Multidisciplinary working

Multidisciplinary team (MDT) working was evident throughout the outpatient department. We observed positive working relationships between nursing, medical and allied health professional staff. Nursing, medical and healthcare assistant staff we spoke with all told us that the department had a positive MDT approach to patient care. We were told by managers that nursing staff, allied health professionals and managers were encouraged to attend the meetings.

Within the pre-assessment clinic we saw that MDT meetings took place weekly and that all of the team looked at the high risk pre-assessment history of a patient before their appointments in the clinic.

Staff we spoke with felt that different teams worked well together and there was good multidisciplinary team working which enhanced patient care, both within the outpatient department and throughout the hospital as a whole. Nurses and junior doctors we spoke with found consultants available and approachable.

Seven-day services

Most clinics were run between Monday and Friday, 9am to 5pm. However, extra clinical capacity could be generated to meet demand. We heard that some clinics, such as fracture clinic, could run additional clinics at the weekend in order to meet the 72-hour appointment target for new fractures. Out of hours fracture clinics were run during the week as standard and the plastics clinic was run seven days per week.

Health promotion

Patients requiring extra support were identified by outpatient services and people were assisted to manage and monitor their own health. There was a smoking cessation service which the outpatient department could refer into.

There were a variety of pieces of patient information available in the waiting areas. In x-ray there were stop smoking posters (‘are you ready to stop?’), along with smoking clinic details.

In the cardiac area there was a poster for the stop smoking clinic, this time it stated the date/time/location of the next clinic and stated no appointment necessary.

There was educational literature available for patients around the department which included advice and signposting to further support around issues relating to cancer, dementia, comorbidities and long term health conditions.

Educational posters and leaflets around the department providing extra information for patients on self-care and various chronic conditions.

At the fracture clinic a poster gave activity and exercise tips to get started. Another stated ‘over 50? Broken a bone? Stop at one’ was a poster encouraging action on osteoporosis.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Outpatient staff showed an understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff we spoke with were aware of their duties and responsibilities in relation to patients who lacked capacity. The trust provided training on the Mental Capacity Act and Deprivation of Liberty Safeguards as part of their wider safeguarding training.

We observed patient consultations and witnessed patients giving verbal consent after comprehensive explanations of tests and examinations had been given by staff. Evidence of patients giving consent was present in all clinical records we reviewed during the inspection. We
did not see any evidence of Deprivation of Liberty Safeguards in any of the clinical records we reviewed as the records we reviewed did not relate to the need for DoLS.

Staff had access to a policy for consent and mental capacity. In most cases verbal consent was obtained. We were told that written consent would be obtained for any invasive procedures.

Is the service caring?

Compassionate care

Patients we spoke with consistently gave positive feedback about the care provided by nursing staff, who they described as kind and caring. Patients told us that the nursing staff were ‘excellent’ and many patients commented that staff in general had ‘good communication skills’.

All patients we spoke with praised them highly. All patients we spoke with told us they felt the care provided was good...

We observed nursing, medical, healthcare assistant and allied health staff provide compassionate and considerate care to patients. All staff we observed introduced themselves and attempted to build a good rapport with patients.

The environment and the consulting rooms in the outpatients department allowed for confidential conversations.

The Friends and Family test (FFT) is a single-question survey that asks patients whether they would recommend the NHS service they have received to friends and family. We requested information concerning the friends and family test from the trust. They stated that FFT data collection was not mandated in outpatient department areas and was not tendered for in the first phase of the trust’s FFT contract, but outpatient departments obtained FFT information for service improvement. It went on to say that the collection of FFT data had proved challenging but was set up in RLH areas in June 2018. It added that during July and August 2018, attempts had been made to map Short Messaging Service responses (SMS) into a format from which analysis could be made, but this had been technologically challenging. In the meantime, they had used paper surveys in outpatient areas since early July.

We reviewed the data provided which showed that from 1164 responses it had received in July and August that 59% of people when asked ‘How likely are you to recommend our service to friends and family if they needed similar care or treatment?’ stated they were likely or extremely likely to recommend the service.

The trust chaperone policy set out the right of all patients to have a chaperone present, irrespective of gender. All patients had the right, if they wished, to have a chaperone present during an examination, procedure, treatment or any care irrespective of organisational constraints or settings in which they were carried out. A chaperone is an impartial observer who is not a family member and wherever possible, should be the same gender as the patient.

We saw that chaperone posters were displayed in prominent places within the outpatient department. The poster stated that if patients would like a chaperone to let a member of nursing staff know. It stated that if there was no suitable chaperone available the appointment could be moved ‘slightly’ to facilitate this. Reception staff told us that some patients may arrive and there are no available details on the system. The technician will go through questions and assessments to check on patient needs and support they may require.
Emotional support

We observed that staff were sensitive and respectful of patients. Staff were aware of the emotional impact treatments could have on patients and took steps to support their patients. Patients we spoke with told us that they received emotional support from staff when this was required.

Though there was no dedicated ‘quiet room’ for patients, staff told us that they could usually find a side room for patients who were upset. There were various information leaflets available for patients to explain their condition, for instance about cancer support services provided by Macmillan.

We observed an ambulatory patient in the fracture clinic waiting area. When their appointment was called the patient was unable to get in to the wheelchair to their side. We saw two healthcare assistants assist the person unsuccessfully. We saw the patient become upset; however, a member of the nursing staff assisted and transferred the patient to the wheelchair. We saw that the person was emotionally supported during this.

Patients reported that if they had any concerns, they were given the time to ask questions. Staff made sure that patients understood any information given to them before they left the clinic.

Understanding and involvement of patients and those close to them

Patients told us they received appointment letters in time and understood that information was shared with their GP; they were copied into this correspondence. We saw information displayed in outpatient clinics which gave advice about how to report any safeguarding concerns.

There was a trust patient information poster that covered four things in one. Hand hygiene, chaperone, your property your responsibility and how did we do? By reception there was a poster authorised jointly by NPSA (national patient safety agency) and the Royal College of Radiologists. It set out expectations from an x-ray service and encouraged patients to ask: when will I be told about results? When will I get results? What are details of who I need to contact if I don’t hear anything? Are my NoK details correct?

Patients we spoke with told us that they felt staff included them in their care and that consultants explained things clearly. We observed a patient’s appointment with a consultant and saw that the doctor took time to explain things to the patient and answer their question. One patient we spoke with told us ‘my consultant explains things to me, is patient and answers any of my questions’.

Most patients we spoke with understood when they would receive results or further communication from the hospital and who to contact if they were concerned.

Most patients we spoke with told us that staff listened to them and communicated well to explain what was happening with their care. Patients told us they felt able to ask questions about their care and treatment and that their concerns would be heard. One patient felt that the doctor had not explained themselves well and they had been dismissive, they were intending to make a complaint to the trust.

Is the service responsive?

Service delivery to meet the needs of local people

From April 2017 to March 2018, the Royal London Hospital's did not attend rate was higher than the England average.
We observed that outpatient environments were appropriate and patient centred, with seating available in sufficient numbers for patients, there were toilet and babychange facilities. We observed vending machines for patients to be available.

The service offers a patient transport service managed by the trust this enables the most vulnerable patients to be prioritised for transport services.

The trust provided information for those people observing Ramadan by means of their Ramadan Health factsheet. Their website explains how the hospital can provide support for its Muslim patients and directs patients to its Muslim Chaplaincy Service.

The chart below shows the ‘did not attend’ rate over time.

(Source: Hospital Episode Statistics)

The trust provided further information concerning those people who ‘did not attend’. A patient was recorded as a DNA when they failed to attend a booked outpatient appointment (including telephone & Skype) and did not inform the trust in advance that they would be unable to attend.

The following table shows outpatient did not attend % rates by site.

<table>
<thead>
<tr>
<th></th>
<th>New</th>
<th>FUp</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>NUH</td>
<td>15.8</td>
<td>14.2</td>
<td>14.7</td>
</tr>
<tr>
<td>RLH</td>
<td>13.5</td>
<td>12.2</td>
<td>12.6</td>
</tr>
<tr>
<td>WX</td>
<td>12.2</td>
<td>12.6</td>
<td>12.5</td>
</tr>
<tr>
<td>Barts</td>
<td>11.9</td>
<td>9.7</td>
<td>10.1</td>
</tr>
</tbody>
</table>

From this information we can see that 12.6% of all patients did not attend for either new or follow up appointments at outpatients in The Royal London Hospital.

The hospital currently uses text message reminders. These we were told, had been in place for a number of years and were typically sent five days prior to the appointment. The message contained basic appointment information only. It was considered that text reminders had proved to be effective in reducing and maintaining DNA rates at current levels.

A small number of specialties (Cardiology, Dental, Neurosciences and Paediatrics) commissioned the central appointments team to perform a call and remind service. The trust found this process to be labour intensive and had helped maintain lower DNA rates by a small margin.
The hospital widely accepted that when patients were involved in negotiating and agreeing appointments, they were more likely to attend and it was considered that with the devolution of the outpatients department and the central bookings team to the Royal London Hospital that this may have a positive impact on the DNA rates. We were informed that most reception areas rebooked follow up appointments with the patient present, and the central appointments team endeavoured to contact newly referred patients to arrange an appointment over the telephone.

**Meeting people’s individual needs**

The service identified people’s individual needs through alerts on the administrative system. This included alerts for learning disabilities, dementia, and interpretation. There was a learning disability lead nurse and staff we spoke with knew how to contact them in advance of a patient with a learning disability attending the department.

Some measures had been taken to make the environment dementia-friendly such as picture signs for toilets and doors and furniture in contrasting colours to the floor and walls. Such as special clocks for dementia patients had recently been introduced. People faced with Alzheimer’s memory loss and Dementia benefit from structure, routine and focus. They lose the ability to recognise the time. Placing large numbered clocks throughout an environment help reduce anxiety about the time and ease the worry of missing an appointment.

Posters in the fracture clinic reception area stated access to PALS. They also stated ‘our bilingual advocacy and interpreting service (BHAIS) provides a dedicated service to patient’s relatives and carers who do not speak English as a first language, who use sign language or who have learning disabilities’. The Bilingual Health Advocacy and Interpreting Service (BHAIS), provided language services to patients, relatives and carers who either do not have English as a first language or are users of British Sign Language (BSL). The poster stated this in nine languages. There was a Text Relay service for patients with hearing impairments and a hearing loop.

We found information leaflets in languages commonly spoken locally such as Urdu, Punjabi and Arabic. The service was also able to provide a face to face and telephone interpreting service for patients during their consultation.

In the pre-assessment clinic we saw that once a referral and appointment had been confirmed, the clinical coordinator requested medical notes three weeks ahead of the patient’s appointment. We were told that the clinical coordinator scrutinised the history of the patient’s conditions, and prepared pre-assessment case notes. The patient’s acute or chronic conditions were discussed between the team before the patient attends.

On attendance if necessary a lung function test was undertaken before the patient was examined by an anaesthetist. This was in place and considered good practice as it saved the need for a further appointment at a later date, and prevented the need for a further appointment to be reassessed.

There were whiteboards in all waiting areas informing patients of the delay in each clinic and we observed nurses verbally informing patients of the length and reason for delays. Most clinics on the day of inspection were running on time with a few clinics running delays of between 15 and 45 minutes. We heard from staff we spoke with that the most common cause of delayed clinics was clinicians arriving late at the start.

We were told that the trust offered a service for adults with learning difficulties clinic. The clinic at RLH which had been running for 9 years was orthoptic and optometric led and delivered specialist assessment for patients with moderate to severe learning difficulties. It allowed patients to access eye health who are unable to attend their local opticians. It linked in with the dental team to
coordinate assessments when a general anaesthetic was required to ensure the patients gets the most out of their visit. The clinic had won a national award and was considered the gold standard in eye care for patients with learning disability.

**Access and flow**

The trust had recommenced reporting on its referral to treatment (RTT) performance in recent months following a four year absence. The trust provided RTT information for the week of 27 September 2018. It showed it had attained 89.2% which was below its target of 92%. Figures showed that for the months of June, July and August 2018 performance was 83.66%, 84.29% and 84.97% respectively against the trust’s target of 92%. We saw in some areas such as diabetic medicine (100%) that the trust was consistently achieving above its target whilst in others, such as ENT it was achieving below its target (82.2%). The below table illustrates the hospitals RTT performance in August 2018.

<table>
<thead>
<tr>
<th>Responsible Site</th>
<th>Speciality</th>
<th>Breaches</th>
<th>Non-Breaches</th>
<th>Total Volume</th>
<th>52+ Weeks</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal London</td>
<td>Allergy</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>100.00%</td>
</tr>
<tr>
<td></td>
<td>Anaesthetics</td>
<td>0</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>100.00%</td>
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<tr>
<td></td>
<td>Breast Surgery</td>
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<td>1</td>
<td>0</td>
<td>0.00%</td>
</tr>
<tr>
<td></td>
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<td>45</td>
<td>1</td>
<td>100.00%</td>
</tr>
<tr>
<td></td>
<td>Clinical Oncology</td>
<td>4</td>
<td>16</td>
<td>20</td>
<td>0</td>
<td>80.00%</td>
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<tr>
<td></td>
<td>Colorectal Surgery</td>
<td>216</td>
<td>1,252</td>
<td>1,468</td>
<td>1</td>
<td>85.29%</td>
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<td></td>
<td>Dental Medicine Specialties</td>
<td>79</td>
<td>548</td>
<td>627</td>
<td>1</td>
<td>87.40%</td>
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<tr>
<td></td>
<td>Dermatology</td>
<td>73</td>
<td>1,933</td>
<td>2,006</td>
<td>1</td>
<td>96.36%</td>
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<td></td>
<td>Diabetic Medicine</td>
<td>0</td>
<td>204</td>
<td>204</td>
<td>0</td>
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</tr>
<tr>
<td></td>
<td>Dialysis</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0.00%</td>
</tr>
<tr>
<td></td>
<td>Endocrinology</td>
<td>0</td>
<td>26</td>
<td>26</td>
<td>0</td>
<td>100.00%</td>
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<tr>
<td></td>
<td>ENT</td>
<td>403</td>
<td>1,861</td>
<td>2,264</td>
<td>1</td>
<td>82.20%</td>
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<td>Gastroenterology</td>
<td>227</td>
<td>1,816</td>
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<td>37</td>
<td>0</td>
<td>100.00%</td>
</tr>
<tr>
<td></td>
<td>Gynaecological Oncology</td>
<td>1</td>
<td>351</td>
<td>352</td>
<td>0</td>
<td>99.72%</td>
</tr>
<tr>
<td></td>
<td>Gynaecology</td>
<td>240</td>
<td>1,216</td>
<td>1,456</td>
<td>0</td>
<td>83.52%</td>
</tr>
<tr>
<td></td>
<td>Haem Oncology</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>100.00%</td>
</tr>
<tr>
<td></td>
<td>Hepatobiliary &amp; Pancreatic Surgery</td>
<td>21</td>
<td>339</td>
<td>360</td>
<td>0</td>
<td>94.17%</td>
</tr>
<tr>
<td></td>
<td>Hepatology</td>
<td>16</td>
<td>287</td>
<td>303</td>
<td>0</td>
<td>94.72%</td>
</tr>
<tr>
<td></td>
<td>Maxillo-Facial Surgery</td>
<td>6</td>
<td>65</td>
<td>71</td>
<td>0</td>
<td>91.55%</td>
</tr>
<tr>
<td></td>
<td>Medical Oncology</td>
<td>2</td>
<td>9</td>
<td>11</td>
<td>0</td>
<td>81.82%</td>
</tr>
<tr>
<td></td>
<td>Nephrology</td>
<td>9</td>
<td>750</td>
<td>759</td>
<td>0</td>
<td>98.81%</td>
</tr>
<tr>
<td></td>
<td>Neurology</td>
<td>343</td>
<td>1,827</td>
<td>2,170</td>
<td>0</td>
<td>84.19%</td>
</tr>
<tr>
<td></td>
<td>Neuro-ophthalmology</td>
<td>1</td>
<td>8</td>
<td>9</td>
<td>0</td>
<td>88.89%</td>
</tr>
<tr>
<td></td>
<td>Neurosurgery</td>
<td>138</td>
<td>802</td>
<td>940</td>
<td>0</td>
<td>85.32%</td>
</tr>
<tr>
<td></td>
<td>NULL</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>0</td>
<td>50.00%</td>
</tr>
<tr>
<td></td>
<td>Oncology (Chemotherapy)</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0.00%</td>
</tr>
<tr>
<td></td>
<td>Ophthalmology</td>
<td>40</td>
<td>1,293</td>
<td>1,333</td>
<td>0</td>
<td>97.00%</td>
</tr>
<tr>
<td></td>
<td>Oral Surgery</td>
<td>1,478</td>
<td>4,517</td>
<td>5,995</td>
<td>12</td>
<td>75.35%</td>
</tr>
<tr>
<td></td>
<td>Orthodontics</td>
<td>245</td>
<td>773</td>
<td>1,018</td>
<td>2</td>
<td>75.93%</td>
</tr>
<tr>
<td></td>
<td>Pain Management</td>
<td>22</td>
<td>389</td>
<td>411</td>
<td>0</td>
<td>94.65%</td>
</tr>
<tr>
<td></td>
<td>Plastic Surgery</td>
<td>214</td>
<td>578</td>
<td>792</td>
<td>6</td>
<td>72.98%</td>
</tr>
<tr>
<td></td>
<td>Radiotherapy</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>100.00%</td>
</tr>
<tr>
<td></td>
<td>Restorative Dentistry</td>
<td>139</td>
<td>756</td>
<td>895</td>
<td>1</td>
<td>84.47%</td>
</tr>
<tr>
<td></td>
<td>Retinoblastoma</td>
<td>4</td>
<td>10</td>
<td>14</td>
<td>0</td>
<td>71.43%</td>
</tr>
<tr>
<td></td>
<td>Rheumatology</td>
<td>37</td>
<td>963</td>
<td>1,000</td>
<td>0</td>
<td>96.30%</td>
</tr>
<tr>
<td></td>
<td>Trauma &amp; Orthopaedics</td>
<td>405</td>
<td>1,474</td>
<td>1,879</td>
<td>2</td>
<td>78.45%</td>
</tr>
<tr>
<td></td>
<td>Trauma &amp; Orthopaedics - Lower Limb</td>
<td>22</td>
<td>191</td>
<td>213</td>
<td>0</td>
<td>89.67%</td>
</tr>
<tr>
<td></td>
<td>Trauma &amp; Orthopaedics - Spinal</td>
<td>50</td>
<td>169</td>
<td>219</td>
<td>1</td>
<td>77.17%</td>
</tr>
<tr>
<td></td>
<td>Trauma &amp; Orthopaedics - Upper Limb</td>
<td>30</td>
<td>85</td>
<td>115</td>
<td>0</td>
<td>73.91%</td>
</tr>
<tr>
<td></td>
<td>Unknown</td>
<td>7</td>
<td>9</td>
<td>16</td>
<td>0</td>
<td>56.25%</td>
</tr>
<tr>
<td></td>
<td>Upper Gastrointestinal Surgery</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>100.00%</td>
</tr>
<tr>
<td></td>
<td>Urology</td>
<td>60</td>
<td>1,253</td>
<td>1,313</td>
<td>0</td>
<td>95.43%</td>
</tr>
<tr>
<td></td>
<td>Vascular Surgery</td>
<td>183</td>
<td>875</td>
<td>1,058</td>
<td>1</td>
<td>82.70%</td>
</tr>
</tbody>
</table>

Regarding cancer waiting times and the percentage of people seen by a specialist within two weeks of an urgent GP referral (all cancers), the trust was performing better than the 93%
operational standard, for people being seen within two weeks of an urgent GP referral. The performance over time is shown in the graph below.

Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers), Bart’s Health NHS Trust.

![Graph showing percentage of people seen within 2 weeks of urgent GP referral](source)

(Source: NHS England – Cancer Waits)

Regarding the percentage of people waiting less than 31 days from diagnosis to first definitive treatment (all cancers), the percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers), Bart’s Health NHS Trust.

The trust was performing better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat). The performance over time is shown in the graph below.

![Graph showing percentage of people waiting less than 31 days from diagnosis](source)

(Source: NHS England – Cancer Waits)

 Regarding the percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment, the trust was performing better than the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral. The performance over time is shown in the graph below.

Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment, Bart’s Health NHS Trust:
The NHS e-Referral Service (e-RS) combine electronic booking with a choice of place, date and time for first hospital or clinic appointments. Patients can choose their initial hospital or clinic appointment and book it in the GP surgery at the point of referral, or by phone or online.

We were told that the trust had recently moved to 100% e-RS booking in conjunction with local GPs. Appointments were managed by the central appointments team which was based off site and open on weekdays from 8:30am to 5pm. We requested that the trust provide information for the previous three months to review its performance.

We were told that there were no performance review packs available for July, August or September because the specialist medicine division’s performance review process was being aligned to incorporate outpatient services as a new directorate. The final implementation of electronic booking took place on 01 October 2018. This meant that the trust was managing the paper switch off through its ‘business improvement unit’. It added that the first outpatient’s performance review under the specialist medicine division was scheduled for 18th October 2018.

We reviewed the information it did provide for the month of June 2018, it showed that appointments team received 27002 calls during June 2018, of these 73% were answered within 60 seconds which was below the target of 90% and there was an average queue time of 47 seconds. The information showed that the appointments team had dealt with 2902 e-RS bookings.

We found that urgent, two-week referrals were prioritised and appointments would be given to these patients. However, patients considered to be non-urgent were allocated into a waiting list that the trust referred to as ‘Appointment Slot Issues’ (ASI) should capacity constraints exist. We were told that the ASI list was reviewed twice each day to determine its size for each speciality. This group of patients were found to be more difficult to allocate appointments to, due to availability. Patients could therefore remain on the ASI list awaiting an appointment for an unspecified time dependant on the capacity demands of the respective speciality.
The data provided by the trust showed that numbers of patients awaiting appointments on the ASI list were 3087 in September 2018; however, the data shows an overall decrease from 5320 patients awaiting appointments in April 2018. The speciality areas with the largest ASI lists were Colorectal Surgery (230 patients awaiting appointments) Respiratory Medicine (162) and Gastroenterology (150).

From the data above, it can be seen that in September 756 patients had been awaiting an appointment for four weeks.

The trust was not adhering to its policy concerning ASI lists in that the trust policy ‘Access and management’ stated that ASIs should be resolved within a maximum of five working days for urgent patients and 10 working days for routine patients.

We were told that access to the appointment booking system was not restricted; this meant that departments could book onto the list which caused overbooking. We were told that this could mean that people could be incorrectly classified as urgent in order to receive an earlier appointment; the central booking team had begun to identify GPs who may be incorrectly flagging patients as urgent. Staff told us that it was unclear who had oversight of this within the trust.

**Learning from complaints and concerns**

From April 2017 to March 2018, there were 182 complaints for outpatient services at Royal London Hospital. The trust took an average of 45 days to investigate and close complaints, this is in line with their complaints policy, which states complaints should be completed between 10-60 days.

The top three themes with the highest number of complaints were:

- Diagnosis/ treatment: 48 complaints
- Communication: 48 complaints
- Delays in care: 41 complaints
From April 2017 to March 2018, there were 39 compliments given to Bart’s Heath NHS Trust. No site or core service breakdown was available.

**Is the service well-led?**

**Leadership**

The outpatient services were contained within the specialist medicine division. It was led by a divisional director, divisional manager and an associate director of nursing. The divisional leads reported to the managing director who in turn reported to the chief executive officer.

It was led operationally by a general manager, service manager, reception manager, information and performance manager and a matron who line managed outpatients nursing staff.

In February 2018, the trust decided to devolve the management of outpatient departments to site management teams from a previous structure whereby all outpatient departments across the trust were centrally managed by the clinical support services division (CSS).

The trust anticipated improvements could be made in the outpatient departments by enabling clear accountability for sites for all outpatient services including referral to treatment, demand and capacity, clinic cancellations and implementing best practice outpatient’s model.

It considered that it would also enable the removal of the distinction between core and non-core services. Creating clearer lines of access for patients and improve patient experience.

Leaders of the service understood the challenges to quality and sustainability which faced the service and were able to describe how they intended to mitigate them, though there were limited audit and performance measurement processes in place in the department following the recent move to the devolution of the outpatient department.

Staff we spoke with told us they regularly saw the divisional director in the department and within the appointments team. A clinical coordinator told us they felt supported by the director of nursing and the majority of staff we spoke highly of the matron.

Staff confirmed that the leadership support within the non-clinical teams and clinical teams had improved and the structure was clear and confirmed that regular meeting were held and information is cascaded down to all the areas.

**Vision and strategy**

The trust vision was to be a high performing group of NHS hospitals, renowned for excellence and innovation and providing safe and compassionate care to their patients.

Underpinning this vision was the trust’s ‘WeCare’ values which the trust stated shaped everything they do every single day. The values were Welcoming, Engaging, Collaborative, Accountable, Respectful and Equitable.

Most staff we spoke with understood the WeCare values whilst some staff were not aware of the trust strategy, but could verbalise the strategic direction of their own service.
Culture

Most staff we spoke with felt valued by their managers. Some staff we spoke with felt that their manager did not support them but overall there appeared to be a supportive culture. Staff we spoke with told us they were committed and proud to work at the hospital.

Staff we spoke with felt supported by their managers and their colleagues which aided in delivering good care and treatment, who they described as visible and approachable. Nursing staff told us that here was a generally good relationship between consultants and nurses in the department and it did not feel hierarchical. They felt there was a good working culture at the hospital and that quality and safety were priorities, there was a no blame culture and staff felt they could challenge senior colleagues if necessary.

Staff told us they felt that it was good team working environment, highlighting they were aware of the raising concerns procedure for cultural change.

There were good opportunities for staff development including training courses and leadership schemes. For example, band 8 qualified nurses undertook a senior nurse development leadership program, and the trust was currently reviewing the Mary Seacole leadership qualification.

Staff we spoke with felt that they could approach senior leadership if they had concerns and managers felt there was a supportive culture and good collaborative working.

Governance

Outpatient services had transferred from a centralised management structure to site based leadership three weeks before our inspection.

Information that was submitted following the inspection was in many cases trust wide, for example vacancy rates, turnover rates and sickness information. We were told that there were no performance review data packs available for July, August or September because the specialist medicine performance review process was being aligned to incorporate outpatient services as a new directorate.

We requested referral to treatment data (RTT) during the inspection; we were told that the trust had only returned to reporting on its RTT performance in recent months and very little was available this meant that RTT information was not considered within its integrated governance processes to address performance which was below its target of 92%.

Patients remained on the appointment slot issues (ASI) list awaiting an appointment for an unspecified time dependant on the capacity demands of the respective speciality, in September 756 patients had been awaiting an appointment for four weeks. We were not assured that governance processes were in place to manage the ASI list challenges.

However, within departments staff we spoke with were clear about their role, how their work fits within the wider department and who they were accountable to. The matron explained that they had developed an outpatient's email group, in which she communicated continually to staff of any risks, incidents and the trust bulletins. Six weekly quality meetings took place and there was a 9 AM, safety huddle 'board' meeting where staff were clinically updated regarding patients, the demand and capacity of the department and any other information regarding the clinics.

We requested a local audit programme specific to outpatients. The information provided by the trust showed that audits were undertaken in hand hygiene, medicines management and fire safety.
The department held governance board meetings weekly where infection control, safeguarding, end of life and risks/incidents were discussed.

Management of risk, issues and performance

There were three main risks present on the outpatient’s divisional risk register. These were a risk that was associated with the Appointment Slot Issue (ASI) whereby patients were not receiving appointments in a timely manner, resulting in an increasing ASI list.

A risk associated with the storage facility of health records, where the environment was considered unfit for purpose.

The issues and risks which managers identified were in line with what we found on inspection and there was alignment between these and the risks outlined on the risk register.

We saw from reports provided that whilst under the clinical support services (CSS) division, risks and performance were reviewed on a monthly basis. However, information received following the inspection from the trust stated that there were no performance review packs available for July, August or September because the CSS review process was being aligned to incorporate outpatient services as a new directorate. It added that the first outpatient’s performance review under the specialist medicine division and site based management, was scheduled for 18th October 2018. This meant that for the months of July, August and September there was no formal oversight of risks and performance.

Information management

There were computer stations throughout the outpatient department with access to the trust intranet; we found there were a sufficient number of these computers for them to access information when they needed it. Staff had access to policies and standard operating procedures through the intranet. Staff we spoke with confirmed that this ensured that information was easily accessible and up to date.

The department used mainly paper patient records. We saw that notes throughout the department were stored in an organised fashion securely in dedicated trolleys. We observed one instance where a note trolley was left unlocked and open in an empty corridor.

Engagement

The 2017 NHS staff survey showed that 36% of staff felt there was good communication between senior management and staff which was better than the national 2017 average for combined acute and community trusts which was 33%. The survey also showed that the trust was performing better than compared with the national average in relation to its quality of appraisal at 3.25 / 5 compared to 3.11 / 5 and the effectiveness of the use of patient / service user feedback where the trust was rated 3.75 / 5 by its staff compared with the National average of 3.69 / 5.

Managers we spoke with confirmed an importance of good communication with staff and said they hoped staff had an understanding of where the department was heading as they felt this had been communicated with staff in meetings, newsletters and consultation events particularly following the devolution from the CSS division to local management.

Staff engagement was often informal and took place at the 9am safety huddle meetings, where minutes had not been taken or with managers walking around the department and talking to staff.

Most staff we spoke with felt their managers were visible, communicated well with them and involved them in development to the service.
Learning, continuous improvement and innovation

The trust informed us of their critical care follow up clinic in outpatients. It explained that in line with recommendations from NCG83 the Royal London Hospital had implemented an outpatient follow up clinic for patients who had been admitted. The clinic used a multidisciplinary approach, and was staffed by two critical care nurses, a consultant and a clinical psychologist.

The clinic was run monthly, offering 10 clinic spaces per month. This represented a very small capacity to see patients on a 1 to 1basis, compared to the numbers eligible to attend, and therefore patients were invited to express an interest in being involved in the follow up clinic. All eligible patients were sent a letter of invite. Patients highlighted during their stay as needing ongoing support were telephoned and screened by the clinic nurses specialists to identify areas of need, as are patients who live a long way from the hospital or who may have difficulties attending the clinic. We were informed that a patient who wanted to attend in person could book in, and those identified with particular physical or psychological issues were encouraged to attend for face to face meetings.

At the clinic, patients met one of the clinical team. Its purpose was to offer patients and their relatives/carers a chance to review their intensive care unit stay, ask any outstanding questions they may have, they were afforded the opportunity to review any of their scans, and be signposted to support services. For example, if they continued to be struggling low mood related to changes in health status, pain or mobility issues.

Consultant to consultant referrals were also made within the hospital if needed. These provided health promotion information, for instance on sleep or scar management. The service also offered some patients and relatives the opportunity to visit the unit, as part of closing their experience, saying thank you to staff who cared for them, or to help with missing memories, and those who wished could be taken on a tour of the unit.

Recently the service held a patient and relative experience feedback day, with patients and relatives who had expressed an interest in helping the team improve our care and who were keen to talk in more detail about their ideas for improvement and what was working well.
Dental Hospital

Facts and data about this service

The Royal London Dental Hospital provides clinical experience for undergraduates and dental care professionals and qualified dentists undertaking further training. It also provides specialist services in oral and maxillofacial surgery (OMF), oral medicine, orthodontics, paediatrics dentistry, restorative dentistry and an emergency dental service. In addition to these services there is a Behcets Centre of Excellence and a Specialist Sleep Apnoea Clinic.

The Dental Hospital is set out over five floors, including a dental school on the top floor. There are 111 dental treatment chairs. Various clinics run throughout the week which includes implants, prosthodontic and general restorative. The hospital sees approximately 110,000 patients every year.

Sedation and general anaesthetic are both provided at the hospital for patients who would benefit from these procedures.

We visited the hospital over three days during our announced inspection. We looked at all areas of the hospital visiting each department. We spoke with 27 members of staff including the divisional director, clinical director, consultants, lead nurses, general managers, general dental nurses and trainee dental staff. We also spoke with 10 patients and relatives of people who use the service.

We reviewed and used information provided by the hospital to come to our judgements about the service.

Is the service safe?

Mandatory training

The trust set a target of 85% for completion of mandatory training.

A breakdown of compliance for mandatory courses as of 7 September 2018 for all staff in dental services is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Transfusion %</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Complaints %</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention and Control - Non Clinical %</td>
<td>98.1%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness %</td>
<td>94.8%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling - Inanimate Loads %</td>
<td>94.5%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety %</td>
<td>93.8%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling - Patient Handling Low Risk %</td>
<td>93.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Security %</td>
<td>93.5%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution %</td>
<td>93.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity %</td>
<td>93.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
### Name of course

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fraud Awareness %</td>
<td>93.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Working at Barts Health %</td>
<td>91.7%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Emergency Planning %</td>
<td>91.5%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Investigation of Incidents %</td>
<td>90.3%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk Assessment for Managers %</td>
<td>90.3%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Privacy and Dignity %</td>
<td>88.5%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Early Warning Systems %</td>
<td>86.9%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Nutritional Care %</td>
<td>86.9%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Harms - VTE %</td>
<td>85.2%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Clinical Documentation %</td>
<td>83.9%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>4 Harms - Catheter Acquired Infections %</td>
<td>83.6%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>4 Harms - Pressure Ulcer Prevention %</td>
<td>83.6%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>4 Harms - Slips, Trips and Falls (Patients) %</td>
<td>83.6%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines Management %</td>
<td>83.3%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance %</td>
<td>82.1%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Consent %</td>
<td>81.3%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling - Patient Handling Practical %</td>
<td>81.3%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention and Control - Clinical %</td>
<td>78.4%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety %</td>
<td>77.7%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Medical Gas Safety %</td>
<td>76.6%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation - Basic Life Support %</td>
<td>72.7%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

*(Additional Document Requests)*

The service provided mandatory training in key skills to all staff and had systems in place to ensure all staff completed it. We reviewed mandatory training completion rates and they were in line with required levels. For example, blood transfusion and complaints completion rates were at 100%; dementia awareness was 94.8 and equality and diversity was at 93%.

Training was monitored by central services by the trust overall. Heads of departments were responsible for ensuring that staff attended mandatory training. Reminder emails were sent when training was due and this is followed up at 121’s. We spoke with two lead nurses who had responsibility for monitoring training for the dental hospital. They told us that the training matrix was discussed at clinical governance meetings. If staff were highlighted in red then the lead nurses would send them an email reminding them that training was outstanding. They would then follow-up until the training was completed.

Staff we spoke with confirmed that they felt they had the right level of access to training.

Reception staff were managed by the outpatients department, so training requirements differed for them. However, the reception manager told us that staff completed safeguarding training as part of their mandatory training.

**Safeguarding**

The trust set a target of 85% for completion of safeguarding training.
A breakdown of compliance for safeguarding courses as of 7 September 2018 for all staff in the dental service by department is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Level 1 %</td>
<td>94.8%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1 %</td>
<td>92.7%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 2 %</td>
<td>90.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2 %</td>
<td>88.2%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 3 %</td>
<td>81.0%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Additional Document Requests)

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

There was a Trust wide policy and procedures for safeguarding. The policies and procedures provided staff with information about identifying, reporting and dealing with suspected abuse. There was a trust wide lead for safeguarding. Within the dental hospital one of the consultants was identified as the ‘go to’ person if staff had queries. Staff we spoke with confirmed that they know who this person was.

We saw evidence that staff had completed safeguarding training and had 94.8% and 92.7% respectively completion rates for level one Children and adults training and 90.6% and 88.2% compliant with level 2 against the Trust target of 85%.

Staff we spoke with during the inspection had comprehensive knowledge of abuse and neglect and how to report concerns, including notification to the CQC. They understood their responsibilities and discussed safeguarding policies and procedures at various meetings and between teams. For example, we were given example of where reception staff and dental nurses had made referrals following concerns that they had identified. These concerns were escalated and acted upon appropriately.

We saw that the paediatric department discussed safeguarding and open cases at their governance meetings, which were documented comprehensively. Other examples included a referral being made to safeguarding for multiple missed appointments. Information was communicated to staff across all levels appropriately, as was necessary to safeguard children.

Information was available on noticeboards throughout the departments

**Cleanliness, infection control and hygiene**

All areas of the hospital were visibly clean. This included clinical areas, theatres, surgeries, patient toilets and the reception area. Cleaning schedules were in place and signed and dated.

Handwashing facilities and alcohol had gel were available throughout all clinical areas of the hospital. Appropriate stocks of personal protective equipment were available. We observed staff following the “bare below the elbow” national hygiene guidance. We reviewed the results of hand hygiene audits for each dental department covering September 2017 to August 2018. The results were consistently between 95-100%
The dental hospital had suitable arrangements for transporting, cleaning, checking, sterilising and storing instruments in line with HTM01-05. This process was carried out by the main hospital’s sterilisation department. The dental hospital had access to records which showed that equipment used for cleaning and sterilising instruments were validated, maintained and used in line with the manufacturers’ guidance.

Two of the lead nurses were the infection control leads. Both had received role specific training and demonstrated good knowledge of their lead areas. The leads carried out daily and weekly walk around checks to all departments in the hospital. The infection control lead for the main hospital carried out monthly audits with the lead nurses. Results of the monthly audits were discussed at the monthly audit meetings. Any actions identified were followed up and the lead nurses reported back on progress.

There were suitable arrangements for handling, storage and disposal of clinical waste including needles (sharps). Clinical waste was stored correctly. Sharps boxes were assembled and labelled correctly in the surgeries that we entered. Staff told us there was an up to date sharps risk assessment. We saw a copy and it was completed accurately and up to date.

The hospital had procedures to reduce the possibility of Legionella or other bacteria developing in the water systems, in line with a risk assessment. The risk assessment was commissioned by the main hospital which covered the dental hospital. The risk assessment was carried out in August 2018. Low risk actions had been identified and actions had been planned to rectify. Waters lines were maintained correctly. The hospital had records of water sampling, dip slide testing and water temperature testing.

Infection control audits were completed every six months. The results of the most recent audit demonstrated that they were complaint.

Staff completed infection control training annually. All staff were up to date with training.

Environment and equipment

We saw that fire equipment was available and well maintained. For example, equipment such as fire extinguishers, emergency lighting and smoke detectors were available throughout the hospital on all floors and in each department. Staff told us that they carried out weekly checks and tests to the equipment. We saw records of these checks. Checks were also carried out by the Trust maintenance team. Fire drills were carried out weekly.

Fire awareness training completion rates were at 80% which was within the Trusts completion targets.

Health and safety risk assessments were completed periodically. No health and safety risks were identified during the last risk assessment.

The hospital had a named Radiation Protection Adviser (based at the main hospital) and Radiation Protection Supervisor ensuring that the service complied with legal obligations under IRR17 and IR(ME)R 2018 radiation regulations. We reviewed the radiation protection file and it was fully up to date. All X-ray machines had had their three-yearly service in line with manufacturers recommended guidelines for servicing. Daily visual checks were completed and weekly tests and monthly quality assurance audits were also completed on X-ray machines. We saw evidence of HSE notification and local rules were displayed appropriately.

There was a comprehensive programme of quality assurance of radiographs and X-ray equipment. This include daily and weekly visual checks, monthly quality assurance audits and six-monthly checks to equipment.
Radiograph audits were completed every three months.

Staff were up to date with their Continuing Professional Development (CPD) requirements for radiography. Completion rates at the time of our visit showed 90% of dentists and 100% of nurses had completed recent training.

The maintenance and use of equipment kept people safe. Regular checks were carried out to machines that were used for cleaning and sterilising equipment such as autoclaves, washer disinfectors and pressure vessel. We saw documentation to confirm servicing of the equipment.

There were systems in place for the maintenance of equipment. Portable appliance Testing (PAT) was arranged and carried out by the maintenance team at the main hospital. Portable appliances had been tested in January 2018 and were due for re-testing in January 2022.

**Assessing and responding to patient risk**

Comprehensive assessments were carried out by all departments of the potential risks to patients and these were planned for. For example, in the orthodontic department although patients were referred from a referring dentist they still completed a full assessment of the patient's oral health which included assessment of caries, periodontal problems and suspected cancer. All issues identified were referred to the referring general dental practice for follow up.

We found that dentists managed risks to patients in relation to conscious sedation in accordance with the guidelines published by the Royal College of Surgeons (RCS) and Royal College of Anaesthetists (RCA) 2015.

Patients were appropriately checked and assessed for sedation procedures by staff. The dental care records we checked confirmed that patients were checked by dentists prior to sedation. They carried out detailed medical and drug history and an assessment of health using the American Society of Anaesthesiologists (ASA) classification system in accordance with current guidelines. The ASA is a system used for assessing the fitness of a patient before surgery and is based on six levels with one being the lowest risk. The service carried out conscious sedation on level one and two patients.

There were appropriate arrangements in place for the treatment of medical emergencies. Resuscitation equipment and oxygen was available and checked regularly. There were two resuscitation stations on each of the three clinical floors of the hospital. Each station had resuscitation equipment, oxygen and medical emergency drugs in line with the Resuscitation Council guidance. All drugs we checked were in date and all equipment we saw was in working order. Staff told us they carried out checks daily to equipment and drugs. The lead nurses also carried out monthly checks along with the general hospital’s resuscitation team.

Staff were aware of the policy for dealing with and disposing of out of date drugs. Expired drugs were disposed of via the pharmacy. They told us that all expired drugs were replenished the same day.

Training for basic life support completion rate was on target for 100% completion rate. In addition, staff in the oral and maxillofacial service worked closely with trainees to ensure they knew how to respond to medical emergencies including managing patients who were having seizures. Staff told us that they had seen great improvements in responding to medical emergencies because of this additional training that was given.

The hospital had scenario based emergency training annually. They set up a surgery setting and got staff involved in practical hands on role play to practice how they would respond.
Medicines were managed in a safe way. Medicines were stored securely and logs were in place that recorded details such as expiry, checks, and use. No medicines were dispensed from the hospital. All medicines were prescribed by prescription.

**Nurse staffing**

Royal London Hospital reported the following nurse staffing numbers for dental services as of July 2018:

<table>
<thead>
<tr>
<th>Team/department</th>
<th>Staff group</th>
<th>Number of staff (WTE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthodontic Services</td>
<td>Nurses - Band 6</td>
<td>1</td>
</tr>
<tr>
<td>Orthodontic Services</td>
<td>Healthcare Assistant - Band 2</td>
<td>0.52</td>
</tr>
<tr>
<td>Orthodontic Services</td>
<td>Healthcare Assistant - Band 4</td>
<td>3.8</td>
</tr>
<tr>
<td>Dental Training</td>
<td>Nurses - Band 7</td>
<td>1</td>
</tr>
<tr>
<td>Guttman Dental Outreach Centre</td>
<td>Nurses - Band 6</td>
<td>1</td>
</tr>
<tr>
<td>Guttman Dental Outreach Centre</td>
<td>Healthcare Assistant - Band 4</td>
<td>6.84</td>
</tr>
<tr>
<td>Paediatric Dentistry</td>
<td>Nurses - Band 7</td>
<td>0.60</td>
</tr>
<tr>
<td>Paediatric Dentistry</td>
<td>Nurses - Band 6</td>
<td>1.40</td>
</tr>
<tr>
<td>Paediatric Dentistry</td>
<td>Nurses - Band 5</td>
<td>1.00</td>
</tr>
<tr>
<td>Paediatric Dentistry</td>
<td>Healthcare Assistant - Band 4</td>
<td>8.93</td>
</tr>
<tr>
<td>Bechet’s</td>
<td>Nurses - Band 7</td>
<td>1</td>
</tr>
<tr>
<td>Dental Management Team</td>
<td>Nurses - Band 7</td>
<td>2</td>
</tr>
</tbody>
</table>

(Additional Document Requests)

From May 2017 to April 2018, Royal London Hospital reported a vacancy rate of 5.4% for nursing staff in dental services. This was lower than the trust target of 6.3%.

We discussed the current vacancies with the various managers in each department. Most of the vacancies had been recruited to and they were awaiting recruitment checks to be completed before staff began working in the service. The other vacancies were in the process of being advertised. Managers were confident they would be recruited to successfully.

(Additional Document Requests)

Staffing levels were planned and reviewed so that people received safe care and treatment. We reviewed staffing rotas for week commencing 24 September 2018 and 1 October 2018 and saw that there were enough staff to deal with the demands of the service being provided. There were two current vacancies in nursing.

Staff told us that the nurse managers were responsible for preparing the rotas in advance to identify any shortages. All nurses were trained to work in all areas so they could move around each department and provide cover if there were shortages. All shortages due to annual leave or sickness were covered in-house or put out to the hospital bank staff. There was a regular pool of bank workers. However, if a bank member of staff had not worked in the hospital for a while they had to undertake an induction to familiarise themselves with systems and processes. We reviewed copies of staff induction records. They covered appropriate areas including safeguarding, fire safety and emergency procedures.
Nursing staff were trained in all areas so they could work across the services as demand and capacity required. Staffing ratios varied across the services. For example, nurses worked one to one with specialists in paediatrics and orthodontics. In restorative dentistry staffing ratios were reviewed daily in line with the needs of the service.

The dental hospital was a teaching hospital and undergraduates and students worked throughout all departments.

Medical staffing

Dental services at the Royal London Hospital reported the following medical staffing numbers:

<table>
<thead>
<tr>
<th>Service</th>
<th>Staff group</th>
<th>Number of staff</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Restorative Dentistry</strong></td>
<td>NHS Restorative Consultants (part time)</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Honorary Consultants (full time)</td>
<td>8 (3 Restorative, 1 Prosthodontics, 1 Endodontics &amp; 3 Periodontology)</td>
</tr>
<tr>
<td></td>
<td>Specialty Doctors (part time)</td>
<td>5 (2 Prosthodontics, 2 Endodontics and 1 Periodontology)</td>
</tr>
<tr>
<td><strong>Special Care Dentistry</strong></td>
<td>NHS Consultants (full time)</td>
<td>2 (one of which is a locum)</td>
</tr>
<tr>
<td><strong>Paediatric Dentistry</strong></td>
<td>NHS Consultants (part time)</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Honorary Consultants (1 part time and 1 Professor)</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Specialty Doctors (part time)</td>
<td>2</td>
</tr>
<tr>
<td><strong>Orthodontics</strong></td>
<td>NHS Consultants (part time)</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Honorary Consultants (part time)</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Specialty Doctors (part time)</td>
<td>6</td>
</tr>
<tr>
<td><strong>Oral Surgery</strong></td>
<td>NHS Consultants (full time)</td>
<td>2 (one of which is a locum)</td>
</tr>
<tr>
<td></td>
<td>Honorary Consultants (full time)</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Associate Specialists (part time)</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Specialty Doctors (part time)</td>
<td>1</td>
</tr>
<tr>
<td><strong>Oral Pathology</strong></td>
<td>NHS / QMUL Consultant (full time 50:50)</td>
<td>1</td>
</tr>
<tr>
<td><strong>Oral Maxillofacial Radiology</strong></td>
<td>Honorary Consultant (part time)</td>
<td>1</td>
</tr>
<tr>
<td><strong>Oral Medicine</strong></td>
<td>NHS Consultant (full time)</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Honorary Consultants (full time)</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Specialty Doctors (1 full time)</td>
<td>2</td>
</tr>
<tr>
<td><strong>OMFS</strong></td>
<td>NHS Consultants (part time)</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Locum Consultant (part time)</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Specialty Doctors (full time)</td>
<td>2</td>
</tr>
<tr>
<td><strong>Dental Public Health</strong></td>
<td>Honorary Consultants (1-part time, 1 Professor)</td>
<td>2</td>
</tr>
</tbody>
</table>
At the time of our inspection the hospital was not using agency staff. We were told that all
vacancies or staff absences were covered by the nursing staff. This included holidays and
sickness. Managers said they could do this because many staff worked part-time so were
available to do additional shifts if required

**Records**

People's individual care records were written and managed in a way that kept people safe. We
checked nine sets of dental care records which covered the various specialities including
restorative, orthodontics, out patients and oral surgery. We saw that the records had a
comprehensive assessment of the patients presenting condition, results of blood tests and X-rays,
a comprehensive account of the patient's medical history, clinical diagnosis, treatment plan,
consent and detailed description of the treatment carried out.

Dental care records of patients undergoing procedures under conscious sedation showed that
checks were undertaken and suitably recorded by staff during the sedation procedure. This
included pulse, blood pressure, breathing rate and oxygen saturation of the blood.

The Barts surgical safety checklist for dental extraction was used to minimise the risk of wrong site
surgery. This was recorded in dental notes.

All test results were available on the electronic recording system

Record keeping audits were completed regularly by the various dental departments. They had
clear records of the results of these audits and the resulting action plans and improvements.

**Medicines**

There were reliable systems for appropriate and safe handling of medicines. All medicines were
stored securely and logs were in place to monitor use and expiry. We checked records relating to
the prescribing, administration and supply of medicines. The records we checked showed
compliance with relevant legislation.

Medicines were not dispensed by the hospital. All medicines were prescribed by prescription only.

There had not been any incidents relating to medication.

Antimicrobial prescribing audits were completed on a regular basis. We reviewed the results of a
national antibiotic audit conducted in February 2018. The results demonstrated that the trust was a
low prescriber of Antimicrobials which is in line with the National Guidance for Dentistry and
appropriate antimicrobial guidance. Number of prescriptions issued for the period between 01
February to 28 February 2018 was 17 compared to the national average of 37. The trust planned
to discuss the outcomes of the audit at the next scheduled audit meeting.

The hospital had undertaken and contributed to an audit looking at reducing antibiotic use
nationally. An audit was undertaken in February 2018 to establish overall use of antibiotics in
dentistry and OMFS. All dental hospitals in the UK and Ireland were invited to take part. The
conclusions and recommendations from this audit were used to inform national and local antibiotic
prescribing practice in dentistry.

Other contributions made towards medicines safety included, one of the consultants being part of
a team developing an e-learning module for antibiotic management
Incidents
The dental hospital had various processes in place to monitor safety. This included standard operating procedures, regular audit meetings and protocols for staff to follow. All incidents were discussed at the monthly clinical governance meetings. We saw minutes of these meetings which confirmed this.

The dental hospital had daily staff safety huddles. The purpose of these meetings was to ensure staff had information they needed to deliver the service. Managers told us it was important to have these meetings daily because the nature of their roles differed daily. Topics covered include staffing and resourcing, practical information relating to the building and any other issues that could impact on patient, staff or visitor’s safety and wellbeing.

There were protocols for staff to follow in relation to safety. Information was displayed in each bay in the emergency clinic about how to respond to safety events. White boards were also used to record information.

In the past 12 months there had been one never events which was a wrong site surgery. In response to the incident they had written new standard operating procedures to reduce the risk of it occurring again.

Lessons were learnt, analysed and investigated when things went wrong. The hospital took part in and lead on local and national safety programmes to share learning. They took the opportunity to learn and share their experiences of safety events with other dental hospitals and the wider dental community. For example, the clinical director had shared their experiences from the wrong site surgery nationally and presented at various national patient safety meetings and was also a representative on a Patient Safety Group. One of the consultants’ was part of the National guidance on safety. Contributions towards national standard operating procedures for safety in endodontology had also been made by staff at the hospital.

Staff and leaders were aware of the duty of candour principle. The clinical director and divisional director described the hospital culture as a ‘no blame’ culture. They gave an example of a wrong site extraction and explained the steps that they took as an organisation to learn from the mistake and not try and cover up. The clinical directors said, “we took responsibility at all levels, everyone involved accepted their involvement and was eager to learn from it”. They said they used the incident as an example to improve processes in other departments and share learning. Candour was displayed and they demonstrated transparency and openness with the family involved.

Incidents were logged on their datix system and if appropriate recorded as ‘never events’. The medical director was responsible for attending meetings with other senior leaders in the trust and sharing wider learning around never events throughout the entire hospital.

One of the consultants had a broad experience of patient safety in dentistry. They had completed funded research projects. They had produced several publications in peer-reviewed journals relating to patient safety in dentistry. This included the development of a comprehensive training video for correct site surgery. This video was widely used and referred to in dentistry.

Is the service effective?

Evidence-based care and treatment
The Royal London Dental Hospital had an international reputation in both research and training. The hospital had a national profile for the work they conducted with Behcet’s disease and sleep apnoea. They had a dedicated sleep apnoea clinic which is a nationally recognised centre.
The hospital was leading many research projects looking at oral involvement of Behcets disease. They were part of a team developing a national standardised clinical data set for the disease.

The service provided care and treatment based on national guidance. They had systems to keep dental practitioners up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

The hospital used the Peer Assessment Rating (PAR) for the orthodontic service. The PAR is an assessment of orthodontic outcomes. A PAR score of 70% or more represents a very high standard of treatment. The last assessment the hospital scored 84% which was considered an outstanding result.

Clinical staff we spoke with demonstrated knowledge and understanding of national guidance. This included for example standards for Conscious sedation from the Royal College of Anaesthetists, National Institute for Health and Care Excellence (NICE) and the Department of Health Delivering Better Oral Health Toolkit. This work was monitored by carrying out audits and peer reviews. Each speciality had a comprehensive set of audits that met with the requirements of NICE and other guidance.

Dentists used rubber dams in line with guidance from the British Endodontic Society when providing root canal treatment.

Each department had their own set of working guidance. For example, in the paediatric department information leaflets were available which included instructions for parents and guardians attending for dental treatment under general anaesthetic and inhalation sedation procedures. All patients were provided with a copy of their treatment plan which was signed by the parent/guardian.

**Nutrition and hydration**

People were given information about nutrition and hydration. Information about healthy eating and how it related to good oral health was available to patients.

Patients undergoing dental procedures were given appropriate information to ensure they stayed hydrated during procedures such as when they were having a procedure which required fasting (e.g. information relating to drinking enough fluids to sustain them). Patients undergoing conscious sedation were also given appropriate advice prior to the procedure.

**Pain relief**

Dentists assessed patients appropriately for pain and other symptoms. For example, in cases of very young children where local anaesthesia was not appropriate for tooth extraction, general anaesthesia under the care of a hospital anaesthetist was used as an alternative.

Patients were appropriately prescribed local anaesthesia by dentists for the relief of pain during dental procedures such as dental filings and extractions.

**Patient outcomes**

There was a clear approach toward monitoring, auditing and benchmarking the quality of the service. Staff were proactively involved in peer review research. They took opportunities to participate in benchmarking research. Several audits and projects had been published and peer-reviewed in journals and the work staff completed was nationally and internationally recognised.

The European Reference Network (ERN) Andalusian Quality Assurance agency had recently completed a quality assurance audit on the Behcets service. They scored 97.2%
Each department had systems in place for regular auditing of their area of the service which include a specific audits lead. Annual auditing meetings were held within the dental hospital where all departments came together to discuss auditing and the results.

We saw multiple examples of changes and recommendations from audits. For example, changes to time slots being allocated for specific orthodontic treatment. As a result of this change the orthodontic department saw a reduction from 9% to 3% of patients stating waiting times during appointments were long. Another area of improvement was the implementation of a quality improvement project to improve patient and parent understanding of inhalation sedation. Clinicians also carried out a pre-operative assessment and treatment outcomes in conscious sedation research. The aim of the evaluation was to review the effect of preoperative assessments and the subsequent impact on the success of conscious sedation. The evaluation found that the preoperative assessment was valuable in detecting high blood pressure and giving risk factor advice for patients with a high body mass index (BMI).

One of the consultants explained that they had achieved positive results in the haemophilia service. They explained that staff in the department worked closely with nurses and consultants to reduce the need for admission to hospital. They used laser treatments for some patients and this had significantly reduced the cost and need of further treatment. The lead consultant presented findings from case studies of 12 patients that demonstrated the excellent patient outcomes achieved in the service. Historically patients with haemophilia or inherited blood disorders experienced significant intra oral bleeding (sometimes requiring blood transfusions), social embarrassment linked to constant bleeding and an inability to taste food. They explained the benefits of the laser treatment. Patients attended for six 10-minute sessions of laser treatment. Outcomes achieved included improved quality of life for patients, reduction in hospital admissions, no further haematological intervention, patients no longer requiring blood transfusions and the ability for these patients to access routine dental treatment without hospital admission.

The dental hospital achieved outcomes above the national averages for certain areas. For example, the oral maxillofacial department was achieving above national average for outcomes with patients.

The hospital was also consistently achieving above average results with patient outcomes in the Behcet’s service. For example, in areas such as patients seen by neurology, follow up appointments and expediated appointments the hospital were performing better than other comparable services. There were also areas they were performing above national averages in relation to clinical outcomes. The clinical lead for Behcets showed us statistics for outcomes relating to time to diagnosis. Nationally in 2014 time to diagnosis was between 12-14 years. Over the past four years the hospital had reduced this to approximately 6.5 years. Their outcomes in this area had consistently been better than the other Behcets centres. They also told us that 10-20% of patients with ocular disease go blind. The clinical lead told said that “over the past four years no patient has become blind who is being seen in this clinic. They explained that the ocular patients are difficult to manage but they have tight control and operate an “open patient access” as well as a programme of education of doctors and dentists which has raised awareness of the disease resulting in prompt treatment for these patients.

The hospital demonstrated improved outcomes in the utilisation of general anaesthetic (GA) slots for paediatric dental extractions. Over a 16-week period there were 88 same day cancellations. This included children who were not brought, not following starvation rules and child unwell. To reduce the amount of non-utilised slots they implemented a “sit and wait” system. Suitable emergency clinic patients were invited to attend the day unit and the opportunity of being treated. During this period a total of 13 children were seen and treated and utilise the GA slots.
Competent staff

Staff working in the hospital had international profiles for their work and achievements. They were encouraged to use and develop their skills further in the service. The lead for the Trauma department was a leading professor in facial trauma surgery. They had contributed to several key publications in the field of facial trauma surgery. Another consultant in oral surgery had also published widely on pain management and patient safety. We saw examples of how these and other staff used their skills and experience to share best practice and ensure positive patient outcomes.

Clinical staff were appropriately qualified and maintained their skill through regular training. We reviewed the training matrix and saw that staff were up to date with their continuing professional development. Staff we spoke with confirmed that they had regular appraisals, were well supported and had regular supervision.

Staff had received training in specialist areas such as sedation, special care, orthodontics. One of the consultants was a member of the National Dental Sedation Group. Staff told us that their involvement in the group meant that they were very up to date with sedation guidance. The hospital was accredited to teach sedation for dental procedures.

Staff completed regular training in cardio-pulmonary resuscitation (CPR) appropriate to their clinical grade. For example, staff involved in providing intravenous sedation, inhalation sedation or general anaesthetic services undertook immediate life support training in addition to basic life support.

Multidisciplinary working

There was excellent multidisciplinary working at all levels within the dental hospital, the wider trust and external organisations. They had developed innovative and efficient ways to deliver joined up care.

We saw that departments within the dental hospital and the main hospital worked together in a co-ordinated way. We saw examples of working with other departments such as oncology, maxillo-facial. This included arranging joint appointments with other departments and meetings between doctors to discuss individual cares to ensure the approach to the persons care was considered holistically. This also included planning discharges and transferring to other departments.

The Behcets team worked with eight clinical teams to plan and co-ordinate patient care. Meetings took place before and after each clinic session with representation from each clinical team. The clinical lead for Behcets said “this is a multidisciplinary one stop shop to make the service patient centred, we deal with all their issues at one appointment”. The clinical lead referred to the disease as being “multi systemic disease which is poorly understood and hard to diagnose”. Multidisciplinary working was key to overcoming these obstacles.

We saw examples of multidisciplinary (MDT) working with services outside of the hospital. Referrals were received from general dental practitioners (GDPs). There was a speciality specific vetting team which dealt with the vetting process daily. Staff told us the system of splitting referrals by speciality was a more efficient way for handling referrals. They told us that they had seen a reduced number of inappropriate referrals because of this process which meant that patients were seen and received treatment in shorter timescales. The Behcets department work closely with GPs and other allied professionals. This included having an annual ‘Behcets in a day’ education day. They invited other professionals to attend to raise the profile of Behcets.

The restorative service had worked with another hospital in relation to cleft pallet and helped to impact patient’s treatment and experiences with their MDT working.
Senior clinicians worked closely with dentists in local dental networks (LDN). The clinical director explained their involvement in the LDN and commented on the work they contributed to including some recent work around referrals. The group had used the royal London’s Dental hospital referral guidelines as a template for some work they were doing. The hospital was also an active member of the Association of Dental Hospitals and contributed to this group in various ways. For example, nurses had recently presented on wrong site tooth extraction.

**Seven-day services**

The service operated clinics between the hours of 8:30am and 5:00pm Monday to Fridays, with ad-hoc clinics taking place in the evenings, and at the weekend.

We were told that these additional clinics were part of a drive to give patients increased flexibility, as well as ensuring that clinics were made available to those patients who needed to have a follow up appointment within a certain timescale and reduce waiting times.

**Health promotion**

People were given information relating to health promotion. This included information about healthy diets and smoking cessation. Information included resources such as a brushing and diet guide for children and other health promotion leaflets.

Staff told us they discussed oral health with patients during consultations. This detail was recorded in the dental care records we checked.

There were oral health education nurses and trainee hygienists working in the hospital. They were available to give people advice about good oral health. The advice given and information we checked in the dental care records was in line with the Department of Health’s Delivering Better Oral Health Toolkit 2013. This is an evidence based tool kit used for the prevention of common dental diseases.

Staff were involved in promoting national priorities to improve the populations health and implemented initiatives to support this. For example, for three days over the Christmas period (annually) dental nurses and health care assistants worked at the main hospital teaching patients in the dementia unit oral health and denture care. They also distributed toothpaste and toothbrushes for free. Staff told us that since they implemented this initiative they had seen improved links between the main hospital and the dental hospital and improvements in patient’s oral health.

The hospital identified and worked with people who may need extra support or information. The hospital was in an area where there was a high Bengali population and within the population group some were identified as chewing beetle nut and using pan leaves. There was an oral medicine department who worked with patients. Staff told us that there was a correlation between chewing of beetle nuts and an increased risk of developing oral cancer. To educate patients the dental hospital had set up an advice and counselling service specifically to tackle this. They told us that the service was well utilised and they saw patients across all age spectrums, including children.

The dental hospital provided oral health packs for patients who were admitted to the general hospital site.

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

There was an effective system for obtaining consent for patients undergoing general anaesthesia and conscious sedation. We checked four dental care records in relation to consent and they demonstrated that valid and informed consent was obtained and recorded.
There were various consent forms which covered the range of treatments and circumstances. For example, the dental hospital was a teaching hospital where patients received treatment from students. There were consent forms for undergraduates where additional information was given to the patients and consent obtained from them. There were also consent forms for complex procedures such as when a patient was having a biopsy.

The documentation for conscious sedation and general anaesthesia included the referral form, clinical assessment with a full medical, social and drug history and NHS consent forms.

Staff we spoke with demonstrated that they understood the legal requirements of the Mental Capacity Act 2005. Staff had access to colleagues such as social workers and safeguarding officers who were familiar with working with vulnerable patients. The dentists we spoke with explained how they carried out assessments of capacity and how best interest decisions were made in cases where patients lacked capacity to consent for treatment.

Dentists we spoke with were familiar with the concept of Gillick competence in respect to the care and treatment of children under 16.

Completion rates for Dementia and Mental Capacity training were 100% for all staff.

Is the service caring?

Compassionate care

We saw that staff took the time to interact with patients who used the services and treated them in a respectful way. We visited the paediatric department and saw that the environment was very “child friendly”. There were toys and interactive displays to make the environment less clinical and a fun environment.

Services were organised in a way that demonstrated compassionate care. For example, patients attending the Behcets clinic received a one stop shop service. The consultant we spoke with told us that patients attending this clinic often had chronic illnesses and were required to attend many different services (i.e. heart conditions, ophthalmology). In response to this the service set up a system that tried to ensure that patients care was co-ordinated in a way so that they only needed to attend the clinic on one occasion and all their appointments were covered in one visit. They told us that patients appreciated this as it meant less visits and less stress.

Emotional support

Patients and carers across all the dental services we spoke with told us that they had positive care and treatment experiences. They told us they felt well supported and were given emotional support.

We observed that there were signs and posters throughout the hospital sign-posting patients, family members and carers to services which could help them.

The service had processes in place to support the emotional wellbeing of people who used the service. For example, there was a sensory room for children and people with disabilities and behavioural problems. The room had various aids and equipment to provide support to patients pre- and post-treatment in a calming atmosphere to support them emotionally. Staff told us that the room was used by patients and they saw the positive benefits it had on patients.

Staff were aware of the importance of providing emotional support when delivering care. There were systems in place to provide support for anxious patients or those undergoing surgery or sedation procedures.
We saw comments and feedback on the various success trees in each department with comments from patients relating to staff who had provided emotional support to them and enhanced their patient journey, often quoting that the staff had gone “above” expectations. Feedback we received from patients we spoke with confirmed this. They described staff as “superb” and “wonderful”. One patient commented that although the hospital may be under strain, this is never reflected in the quality of care they receive.

The services worked well with other departments in the hospital for the emotional well-being of patients. We saw examples of multi-disciplinary working with departments such as psychology and psychiatry services to ensure patients emotional needs were catered to. For example, staff who worked in the Trauma department gave examples of patients who had undergone cancer treatment and as a result required extensive oral and facial reconstruction. Staff explained how they worked with these patients and implemented processes to make their patient journey more streamlined to reduce number of appointments and repeated visits which could impact on their emotional well-being.

Understanding and involvement of patients and those close to them

People we spoke with and patient feedback we reviewed demonstrated that information was given to people in a way in which they understood and felt involved in their care or the care of their relative. They confirmed that they were given appropriate information about their treatment and felt involved in their care.

Each service had information leaflets and guides for the various procedures so that people could take information away with them about the procedures they were about to have. Staff told us that they always went through information with people to ensure they were clear about what their treatment was and the options they had. For example, there was a comprehensive information pack for children undergoing sedation treatment. It outlined what to expect, including the effects and intended outcome.

We spoke with clinicians and they told us that they always had consultations with patients and explained to them the procedures in simple terms to ensure they understood. The consultant who was the lead for Behcets told us that when a patient attended they went through a comprehensive proforma which included a full assessment of health, mental state and wellbeing. They explained that part of the assessment included ensuring that the patient was involved in their treatment planning and understood the procedure. This was because treatment was complex and it was therefore important that they knew and fully understood.

Staff were highly motivated and inspired to offer care to patients in a caring and dignified manner. For example, in the trauma and OMFS department staff explained that patients who had suffered severe trauma including severe disfigurement, required additional emotional support and this was viewed by staff as equally as important as their actual treatment. They delivered the service in a way that reflected they were considering emotional well-being. They explained how patient and their family’s lives were severely disrupted however by involving them in every step of their treatment was crucial to the success of treatment.

We saw numerous examples of staff taking people’s personal, cultural and social needs into account when providing care and treatment

We saw that people were involved in the co-ordinating of their care, their feelings were considered and time was taken to ensure they were comfortable with procedures. Staff in the various departments gave examples of patients who were undergoing extensive or complex treatment. In such circumstances they often planned appointments that were just consultations where they
talked then through the procedure, showed them to equipment that would be used or just discussed their general wellbeing and feelings about the treatment. This was done to ensure the patient felt involved and understood their treatment. Staff said that this approach was particularly important especially for young children. It was a way to engage them and make them feel cared for assure them that their care was individualised for them.

Patients with Behcets disease were heavily involved in there care and treatment. There were comprehensive processes for communicating information and decisions about their care and treatment. Discussions and recommendations from pre- and post-clinic MDT meetings were feedback specifically to each patient discussed as well as to the patients GP. They also had a patient listening day every year where they give patients the opportunity to provide feedback as well as educating them about their disease. Patients had also recently been empowered to make a signposting video for parents bringing their children to the clinic. The clinical lead told us this had improved patient’s experiences and feelings of being involved.

Is the service responsive?

Service delivery to meet the needs of local people

The services provided reflected the needs of the local population. The hospital was in a multicultural area and had patients from differing backgrounds. To meet the needs of people the hospital had information available in different languages that reflected the local communities. For example, there was a leaflet called “Delivering High Quality language services”. This leaflet had details of bi-lingual health advocacy services and interpreting services for patients.

The service ensured that children were treated in an appropriate environment. The paediatric department was child friendly. The walls were painted in vibrant colours and there were pictures and images on the walls. One of the nurses said, “we like to make the environment fun so that the children feel relaxed”. The paediatric department was in an open plan rooms with dividers between chairs to maintain privacy. Staff told us that if a child was having sedation they also used a screen to further ensure privacy.

The services met the needs of people with learning disabilities and those with significant anxiety. There was a sensory room for patients where they could relax before treatment. The service also information available in easy read formats.

The hospital did experience some issues with technology as a result of having a multi-cultural patient population. The explained that their text messaging service sent messages to all patients who had an appointment. However, the messages were in English so patients who did not speak English received messages that they may not be able to read. Rectifying this was a work in progress.

The dental hospital responded to the needs of patients by providing flexibility with appointments and joint clinic appointments. We saw examples of how the service acted to minimise the time people had to wait for treatment and care and prioritise care to those with the most urgent needs.

The hospital was fully accessible. The entrance to the building was step-free and there were lifts to access each floor. The main entrance door was automatic and opened on approach. There was a lowered reception desk for patients in wheelchairs. Patient toilets were wheel chair accessible and had baby changing facilities. Consultation and treatment rooms were accessible and accommodated patients in wheel chairs or those with pushchairs. Staff told us that if patients had mobility issues and could not walk they could hoist them in and out of their chair. Staff had
received appropriate training for this. A hearing loop was available throughout the hospital for patients with hearing aids. Disabled parking was available on the hospital grounds.

Staff had undertaken training in special care to accommodate patients with physical and learning disabilities and procedures were in place to support these patients.

The service worked well with other health and social care services to meet the needs of patients. For example, the hospital had templates of letters to general practitioners (GP's). Details of how to get the letter in other languages was printed on the reverse of the letter.

Meeting people’s individual needs

We saw example of how the service was delivered and coordinated to consider people with complex needs. For example, staff in the restorative team told us they provided patient focussed care for special care. Steps they took to do this included liaising with ophthalmology to arrange eye tests for patients, the lead nurse assisted with arranging care for patients with complex needs, referral pathways were streamlined.

Staff in the Head and Neck cancer service attended multidisciplinary meetings before a patient had treatment. This was for example to co-ordinate their dental treatment at the same time as their cancer treatment to reduce multiple attendances at the hospital.

Access and flow

At the time of our inspection the hospital acknowledged that they had experienced issues around waiting times for appointments. For example, in response they had implemented measures to try and reduce the waiting times and lessen the impact on patients. Methods included adding additional clinics at the weekends and in the evenings.

We looked at referral to treatment times (RTT). Paediatrics were at 89.3%, oral surgery was 73.1% and maxillofacial were at 97.1%. Staff told us that improvements had been made with the RTT over the past few months. For example, radiography RTT had reduced from four months to six weeks over the past six months. The hospital acknowledged that improvements were required in some departments with RTT rates, however they were responding by implementing processes to reduce the impact to patients. For example, in the orthodontics department they aimed to see new patients within five weeks, but this was taking longer. One of the causes of long waiting times was due to inappropriate referrals being received and the varied and often poor-quality X-rays provided by some patient’s general practitioners. To reduce the backlog and waiting times for patients the hospital had added in additional appointments on the weekends and evenings. They accepted patients with paper referrals and took new X-rays if required and provided treatment. Staff told us this initiative was having a positive impact on reducing the number of referrals that had to be returned and reduced waiting times.

People had access to emergency care. There was a dedicated chair for ‘trauma’ patients in the paediatrics department. In the restorative service they ran a trauma service. The clinics for this ran in parallel with the general clinics so that if a patient attending for a routine appointment required urgent assistance they could see them straight away. Staff told us this also reduced delays for people accessing the service and treatment because they did not need to be booked in to come back later.

The hospital had an emergency dental clinic which ran every day. There were four chairs available for emergency cases. Patients could call in and were triaged accordingly. Where patients could not be seen they would be referred to the NHS 111 or to the Accident and Emergency department within the main hospital.
People could access care and treatment in a timely way. The hospital had introduced a preferential booking system to assist patients to access appointments at times that suited them. This included making appointments available on the weekends and in the evenings. Staff told us that since the introduction of the preferential booking system the number of failure to attends (FTAs) had reduced throughout the departments that were using the new system.

Staff commented that there were some challenges with services that were not directly managed by the dental hospital. The appointments system, reception staffing and records were central services. They said that these arrangements could present some challenges at times with access to appointment booking and flow of the service. The Clinical Director told us that they were actively working with other departments to address the challenges, particularly those in relation to accessing centrally held records.

**Learning from complaints and concerns**

There had been 20 complaints within dental services at Royal London Hospital in the time between April 2017 to March 2018. The trust took an average of 35 days to investigate and close complaints - this is in line with their complaints policy, which states complaints should be completed between 10 and 60 days.

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

At the time of the inspection there were two open complaints. We reviewed both complaints and two complaints which had been closed. We saw that all complaints had been handled in line with the trusts policy. The responses we reviewed were of a high quality. We saw there was a real sense of taking patients complains seriously and involving staff who were involved in the complaint by encouraging them to share their thought, reflections and learning. We also saw that candour was displayed as patients were actively involved. We saw example of where the hospital liaised with the person or family affected by phone and confirming things by letter. A new complaints manager had been appointed in the past six months. Staff told us that since their appointment complaints outcomes and learning had been more widely shared.

We saw that the hospital monitored complaints and had processes to learn from them. Complaints were monitored monthly at the clinical governance meetings. The issues arising, investigation into these issues and the stage at which the complaint was at were discussed. Timeframes were reviewed and where complaints were complex the patient was advised that if necessary an extension to normal timescales may be required to investigate it appropriately.

We sat in on a clinical governance meeting and heard discussions around complaints and the lessons learnt. We also reviewed minutes of previous meetings and saw that information was routinely shared and lessons learnt from complaints. For example, one complaint related to a delay in diagnosis. Because of this complaint a report had been written with a proposal to change their standard operating procedures to prevent or lessen the chances of this happening again. Learning and outcomes from complaints and actions were delegated to the appropriate member of staff and dates agreed for actions.

People who used the service had access to information to make a complaint if they needed to. Information was on display in patient waiting areas and on department notice boards. Information relating to PALS was readily available to patients.
Is the service well-led?

**Leadership**

There was a leadership structure that supported the smooth running and delivery of the service. There was a divisional director who covered surgery and the dental hospital. The clinical director reported to the divisional director the clinical director was responsible for the day to day running of the hospital. Assisting the clinical director were lead consultants who had responsibility for each speciality. Each service speciality (i.e. paediatric, restorative, maxilla facial) had clinical leads and managers and head nurses to provide leadership to staff.

Staff we spoke with were clear about the leadership structures. They spoke about managers and leaders being approachable, supportive and visible.

The leaders who we spoke with demonstrated that they understood the challenges the hospital was facing as well as being aware of and able to celebrate the successes. For example, one director explained the challenges with the maxilla-facial referrals. They explained the systems they were trying to put in place to educate and feed back to general dental practices to reduce the number of unnecessary or inappropriate referrals. They all referred to wanting to achieve a centre of Excellence and being one of the leading dental hospitals in the country.

The Trust leadership team met every Friday and one of the clinical leads from the dental hospital attended the meeting to present on all the dental outcomes. The clinical lead told us that this meeting was useful because it gave them the opportunity to not only provide feedback on performance but also report on and seek assistance or find solutions to obstacles or issues they were facing.

Other meetings included bi-weekly meetings between the clinical director and the Dean of the Dental school, clinical governance meetings, performance review meetings, service meetings and audit meetings. Leaders told us that some of these meetings were inclusive and staff at all levels were involved to attend and participate.

We saw examples of the culture of the service being centred around the needs and experiences of people who use the service. For example, they had produced an easy read guide for sedation for patients.

**Vision and strategy**

The hospital had a robust, realistic strategy for achieving the priorities and delivering good quality care. Staff gave us an overview of the strategy of the Dental Hospital and how their priorities aligned with the main Trust vision. They told us that the strategy outlined areas of improvement, service development and strengths and set out how they would address and improve in these areas. We sat in on one of the governance meeting and reviewed minutes of previous meetings. We saw that the vision and strategy was strongly reflected and planned for in these meetings.

There were folders in each department with copies of the hospital vision and strategies, which staff had access to. Managers told us that outlining the vision and strategy was also a part of the staff induction process. We saw induction templates and confirmed which confirmed that this was the case. Promoting the vision and strategy was also a module taught to the undergraduates as part of their training.

Staff we spoke with told us that the internal intranet was very user friendly and if they wanted to get information about the hospitals vision, strategy or governance procedure they were easily accessible.
Staff at all levels who we spoke with understood their role and responsibilities in achieving the vision and strategy. They had a clear understanding of the strategy and their role in implementing it.

**Culture**

Staff across all staffing levels spoke positively about the service. They were passionate about the work they carried out and there was a mutual respect for roles irrespective of what level. Staff referred to managers, including the clinical director having an ‘open door’ policy and they felt confident not only speaking with them about issues, but feeling that they would be listened to. One of the consultants described the culture as ‘clinically led’.

Roles and responsibilities were clearly defined and there was a sufficient mix of skills and abilities across the staffing levels.

The culture of candour, openness and honesty was evident at all levels. Staff we spoke with were open with issues relating to never event and incidents and embraced the opportunity to learn from these experiences, irrespective of whether they had occurred within the department they worked in or not. For example, staff explained situations where they liaised with families to discuss with them when things went wrong. This included speaking with the family/patient face to face, writing to them and letting them know if actions taken and changes implemented because of the incident that affected them.

The clinical director told us that the leadership style of the hospital was to let staff lead in their area of expertise. Weekly meetings were held with the lead consultants for each service and they discussed as a group issues that affected the dental hospital. Decisions were made as a group of leaders even if the decision did not affect a leader’s department. We were told about a matter that affected the orthodontic service. The clinical director explained that all the service leads were involved in the decision-making process because the culture of the service was that of a ‘team’. This was also demonstrated on a trust level and issues relating to the dental hospital were discussed at the trust weekly divisional meetings.

The hospital valued staff and their contributions. Barts Health Hero Awards was a trust initiative and services had been nominated in previous and the current year, for their contributions. For example, one of the service managers had won the award and the paediatric department in the dental hospital had been nominated.

**Governance**

The dental hospital had effective governance procedures in place to underpin the provision of services. For example, for the provision of conscious sedation governance procedures included policies and protocols for pre- and post-treatment checks, emergency equipment requirements and medicines management. Dentists and dental nurses carried out other checks for reasons of safety. These include sedation equipment checks, staff present during procedure, patient checks including consent, discharge and post treatment instructions.

There were clinical governance leads in each department. Each department had a head nurse who was responsible for risk management. Anything that flagged up in relation to risk was addressed by them. For example, if there were issues or risks related to performance they were fed back to and discussed at the monthly governance meetings.

Clinical governance meetings were held monthly. Topics such as never events, complaints, audits, mandatory training and staffing were discussed. We reviewed meeting minutes and saw that topics were discussed in detail and comprehensive notes were taken. Actions that were set at meetings were always followed up at the next meeting.
Management of risk, issues and performance

The service maintained a risk register. At the time of our inspection there were 13 entries on the register. The risk register was reviewed at the monthly clinical governance meetings. New risks were added and existing risks were re-graded up or down. Staff explained that the highest risk was within the orthodontics service where it was difficult to control delays. The hospital had processes in place to manage all the risks well.

Managers told us that the hospital took a serious approach to risk and considered all things that could pose actual or potential risks. For example, a consultant was leaving the service and they had rated this as a risk. This was because they planned staffing with the inclusion of this post and their forecasting of service deliver was based on 120 new referrals which they received on an annual basis. If no one was recruited to the vacancy then waiting times could go up and this could have an impact on service delivery and patient care.

Information management

The hospital has processes in place to manage people’s information in a safe way. Computers were password protected and paper records were stored securely. We observed staff logging into computers with passwords and locking their screens when they left their computer.

We saw that the hospital responded and lessons were learnt when there were breaches of data security. The hospital had responded to the recent cyber-attack appropriately, taken action and considered lessons learnt.

We saw there was a holistic understanding of performance, which sufficiently covered and integrates people’s views with information on quality. We spoke with the clinical director and they had a very good understanding of their performance. They were aware of the areas the hospital was performing above national averages, for example the maxillofacial and Behcets. They told us that whilst departments were separate, they worked holistically and interpreted performance in this way because working between departments was integral to their service.

Engagement

We saw that people’s views and experiences were gathered and acted on to shape and improve the service and culture. The hospital used ‘Success trees’ for patients to record their satisfaction levels with the service. They were positioned in every department in the hospital and patients and staff had the freedom to leave comment to which the hospital responded. Both positive and negative comments could be left. Comments we saw ranged from appreciation from trainee dental nurses and students to comments from patients about staff being friendly, kind and helpful. The hospital posted responses to the comments monthly. For example, they thanked people for compliments relating to specific staff and they also explained why, at times people were not seen at their appointment time or kept waiting longer than expected.

The service sought out and acted on feedback from people who used the service. Patients were encouraged to complete the Friends and Family Test (FFT) and ‘I want great care’ surveys. These surveys were analysed and any themes or trends, both positive and negative were shared and discussed at the monthly governance meetings. Any specific trends were also shared with individual departments so that learning and improvements could occur. The hospital supplied us the results of the FFT. The most recent results related to November 2017. We saw that the overall results were very good. Results for whether people would recommend the service were 100% for oral medicines; 88% for oral surgery; 93% for restorative and 90.5% for paediatrics. The paediatric team ranked 13th and oral medicine 32nd out of 302 reviewed services in responses related to
whether people would recommend the service to friends and family. Undergraduates scored 100% for the same question.

Patient satisfaction collected from each speciality indicated high levels of satisfactions from patients. Results for the restorative patients (haemophilia and inherited blood disorder) demonstrated that 100% of patients stated that they were fully satisfied with the service and 96% said that the dental hospital had improved the main problem or reason for their referral.

Staff felt engaged and as if their views were reflected in planning. Managers had regular one to one meetings which covered wellbeing, governance, and anything else they needed to discuss.

The dental hospital had audit meetings and staff at all levels were invited to attend. The clinical director told us that the last meeting was attended by over 200 staff from all departments and levels. This reflected that staff felt included and were engaged.

Other ways staff were engaged included; a quarterly newsletter with updates relating to services, daily safety huddles and information being shared on the staff intranet.

**Learning, continuous improvement and innovation**

The hospital had innovative ways to engage with patients. They had recently devised Success trees. There were areas throughout the hospital where patients and staff could make any comments they wanted relating to the service. Staff told us that they found this initiative very useful and they had seen a rise in patient feedback about the service. We saw that it was well utilised by patients and their families and saw many positive comments and feedback.

Staff were focussed on continually improving the quality of care. Staff told us they were given ‘autonomy’ to be innovative and they were always fully supported by senior managers. We were given examples of the contributions staff had given to not only the hospital but the wider dental community to support innovation and continuous improvements. For example, one of the consultants in oral surgery had produced videos relating to teeth extraction and never events. The video was widely used within dentistry in the country. Staff told us that the work the consultant had completed had not only made positive impacts on procedures in the hospital but also dentistry in general. Several articles and journals had been produced which evidenced this and the impact the work had had.