

Barts Health NHS Trust

Whipps Cross University Hospital

Quality Report

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

Ratings

Surgery

Requires improvement



Summary of findings

Letter from the Chief Inspector of Hospitals

Whipps Cross University Hospital in Waltham Forest is part of Barts Health NHS Trust, the largest NHS trust in the country, serving 2.5 million people across Tower Hamlets and surrounding areas of the City of London and East London.

Whipps Cross University Hospital provides a range of general inpatient services with 586 beds, outpatient and day-case services, as well as maternity services and a 24-hour emergency department and urgent care centre. The hospital has various specialist services, including urology, ENT, audiology, cardiology, colorectal surgery, cancer care and acute stroke care.

This was a focused unannounced inspection to follow up on our previous inspection of Whipps Cross University Hospital in May 2017, where we found a number of concerns around patient safety and the quality of care. At that time we rated the surgery service as inadequate and the hospital overall was rated as requires improvement.

We carried out an unannounced inspection between 10 and 12 April 2018 and inspected the surgery core service only to ensure that improvements had been made.

We found that there had been some improvements to the surgical service to make services safer and more responsive to patients' needs and this has been reflected in the overall change in the rating from inadequate to requires improvement. However, we also found that some of the concerns highlighted during the last inspection still needed to be addressed by the trust.

Our key findings were as follows:

Safe

- Medicines were not always being safely managed. Access to medicines, including controlled drugs was not appropriately restricted on the surgical wards and the trust's medicines management policy was not being followed in relation to medicines storage. We found expired medicines were in stock on all of the surgical wards we visited.
- Staff knowledge about the incident reporting system had improved since our previous inspection, however, incidents, including medicines errors, were still not always being reported by staff.
- Most concerns relating to infection control in the theatre environment had been addressed since our last inspection, however; the environment on some wards and treatment areas was poor and did not meet the required safety standards.
- Nursing vacancy rates remained high and most surgical wards remained heavily dependent on temporary staff.
- Patient records were not always stored securely in line with information governance standards.
- Many items of equipment were old and in need of replacement. Some equipment was not fit for purpose and did not comply with the required safety standards.
- Staff compliance with mandatory training including safeguarding training had improved.
- There was improved compliance with venous thromboembolism (VTE) assessments.
- Surgical site infection (SSI) monitoring and follow up post-discharge was now taking place.

Effective

Summary of findings

- The service continued to contribute to national surgical audits however, data submission remained poor, results were mixed and there was limited evidence that results were used to drive local improvements in patient outcomes.
- As we found on our last inspection not all patients were screened for malnutrition as required by NICE guidelines. MUST compliance rates for surgical wards were still consistently below the trust target of 95%.
- Consent was taken on the day of surgery, which was not in line with the trust's policy.
- Staff appraisal rates had improved and now exceeded the trust's 90% target.

Caring

- Most patients we spoke with told us their experiences of care were positive. We saw that staff treated patients with compassion and demonstrated a genuinely kind and caring attitude.

Responsive

- Theatre cancellations were still happening on the day of surgery due to lack of available beds and over-running and late starting theatre lists. Theatre utilisation rates had shown improvement but were still below the trust's target.
- The hospital's referral to treatment time performance had shown improvement but was still below the expected standard.
- Recovery areas were no longer being regularly used to nurse patients overnight.
- There were not always sufficient staff to provide appropriate care to patients requiring additional support, for example those living with dementia.

Well Led

- Oversight of medicines management was poor and service leads were unaware of the extent of the risk to patient safety.
- The leadership team had developed a comprehensive action plan to address the concerns highlighted at the last inspection. We saw evidence of some improvements to the surgical service to make it safer for patients and more responsive to their needs.
- The service performed significantly worse than the trust average in a number of areas in the NHS staff survey.

Importantly, the trust must:

- Ensure that there are appropriate systems of medicines management at ward level and that staff are aware of their responsibilities in relation to this.

In addition, the trust should:

- Ensure that patients' care records are accurate, complete, legible, up to date and stored securely.
- Ensure that consent to procedures is taken in line with trust policies and best practice.
- Ensure staff have access to reliable equipment, which does not represent a risk to patient safety or delays treatment.
- Ensure there is an agreed replacement programme for theatre equipment.
- Ensure the facilities used by the pain service are fit for purpose.
- Ensure all ward and theatre environments are maintained in a good state of repair.

Summary of findings

- Ensure equipment is stored safely and securely.
- Improve referral to treatment time performance and reporting.
- Ensure there are adequate numbers of qualified, skilled and experienced staff employed and used to meet the needs of patients.
- Improve the flow of patients across the hospital to reduce late and cancelled operations.

Following serious concerns raised as a result of our inspection we issued the trust with a Warning Notice to make immediate improvements. The full details of this notice can be found at the end of the report.

Professor Edward Baker
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Surgery

Rating

Requires improvement



Why have we given this rating?

We saw evidence of improvements to the surgical service to make it safer for patients and more responsive to their needs. However, some of the areas of concern highlighted during our last inspection still needed to be addressed by the service.

Whipps Cross University Hospital

Detailed findings

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Detailed findings

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Our ratings for this hospital

Our ratings for this hospital are:

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

Notes

Surgery

Safe	Inadequate 
Effective	Requires improvement 
Caring	Good 
Responsive	Requires improvement 
Well-led	Requires improvement 
Overall	Requires improvement 

Information about the service

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, trauma, ear, nose and throat (ENT) and ophthalmic surgery.

Whipps Cross hospital is part of Barts Health NHS Trust which is currently in special measures.

Between April 2017 and March 2018, the hospital carried out 14,464 adult surgical procedures. The surgical specialities carrying out the most procedures were ophthalmology (3,502), trauma and orthopaedics (2,461), and urology (1,483).

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.

At the time of our inspection, there were 140 surgical beds in the designated surgical wards. There are 15 short stay surgery beds on Poplar ward, 28 male surgical beds on Primrose ward, 29 female surgical beds on Rowan ward, 12 elective orthopaedic beds on Sage ward, 27 emergency orthopaedic beds on Sycamore ward, and 28 day surgery beds on Plane Ward.

Since January 2018, and at the time of our inspection, Poplar and Sage wards, were being used as 'surge' beds. These are beds re-designated to accept patients from a range of specialties, admitted as emergencies over the 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 functions as an elective orthopaedic ward. However, elective orthopaedic surgery was suspended over the winter months. During our inspection, the ward was being used for emergency orthopaedic surgery. Patients from other surgical specialties and medicine were also on the ward. The trust planned to re-open Sage ward as an elective orthopaedic ward but were unable to do so because of the volume of emergency work.

We visited Hope ward, the elective admissions unit, Poplar, Primrose and Rowan wards. We also visited Sage, Sycamore and Plane Tree wards, theatres, anaesthetic rooms, pre-operative assessment unit and recovery areas. We visited the pain treatment room.

During our inspection spoke with 19 patients and looked at 12 care records.

We also spoke with a number of staff including allied healthcare professionals (AHPs), nurses, health care assistants (HCAs), doctors, consultants, ward managers, matrons and members of the senior management team. In addition, we reviewed a number of documents such as meeting minutes, audits, and performance and quality data.

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During our last inspection in May 2017, we rated the service overall as inadequate. We rated safe, responsive and well-led as inadequate, the effective domain as requires improvement and caring was rated as good.

Summary of findings

At our previous inspection, we rated the service as inadequate. At this inspection, we rated this service as requires improvement because:

- The trust had taken action to address many of the concerns we highlighted during the last inspection however, there were also several issues that still required improvement. We were not assured that there was sufficient management oversight of all the safety risks we identified during the inspection.
- We found that medicines were not being managed safely. Problems with the management of medicines were being identified in audits but the scale and extent of the issues had not been identified by the leadership team. Access to medicines was not appropriately restricted and the trust's medicines management policy was not being followed in relation to medicines storage. We found unlocked or broken medicines cupboards on the wards. Audits carried out by pharmacy staff found medicines trolleys unlocked on several occasions. The security of controlled drugs was not being maintained and expired medicines were in stock on all the wards we visited.
- Staff knowledge about the incident reporting system had improved since our previous inspection but we found that incidents, for example of medicines errors, were not always reported by staff. Staff on the wards told us they were often too busy to read incident reports.
- Nursing vacancy rates remained high and most surgical wards remained heavily dependent on temporary staff. Patients and ward staff told us staff were under pressure and permanent staff had an additional workload because agency staff were not able to carry out all the tasks the permanent staff were required to undertake.
- As during our last inspection, we found that patient records were not always stored securely in line with information governance standards. A significant number of incidents (117) had been reported

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involving patient information being stored in the wrong records or information or inconsistencies between the clinical information system and paper records.

- Although we saw evidence that the theatre environment had been improved there were on-going issues with infection control and cleanliness on the wards.
- The pain treatment room was not fit for purpose, as it did not meet current safety standards.
- Many items of equipment in theatres were old and in need of replacement. Replacement of old and obsolete equipment was included on the division's risk register, which described the potential risk to patient safety if the items stopped working or were not functioning correctly. Staff on the wards told us lack of equipment on the ward was one of their biggest challenges.
- The service continued to contribute to national surgical audit results however, data submission remained poor and results were mixed.
- As we found on our last inspection not all patients were screened for malnutrition as required by NICE guidelines. MUST compliance rates for surgical wards were still consistently below the trust target of 95%.
- Consent was taken on the day of surgery, which was not in line with the trust's policy.
- Theatre cancellations were still happening on the day of surgery due to lack of available beds and over-running and late starting theatre lists. Cancelled operations as a percentage of elective cases booked was 1.8%, which was slightly worse than the cancellation rate for the previous 12 month period (1.6%).
- The overall 18-week referral to treatment time (RTT) performance for patients waiting for surgical specialties at the hospital had improved from 69% to 79%, but still fell below the national indicator.
- There was no facility for confidential discussions with patients. Patients with special needs such as dementia or a learning disability waited for their

procedure in the recovery alongside patients who had undergone surgery. There were not always sufficient staff to provide one to one care for patients requiring additional support.

- The response rates for the friends and family test were low for some wards; in some cases less than 10%.

However:

- Staff compliance with mandatory training including safeguarding training had improved.
- There was improved compliance with venous thromboembolism (VTE) assessments.
- Surgical site infection (SSI) monitoring and follow up post-discharge was now taking place.
- The environment in theatres had improved since our last inspection. A refurbishment programme had been undertaken although work on theatres 3 and 4 was still to be carried out.
- Mortality and morbidity meetings were held where each surgical team presented cases for discussion. These showed lessons learned and changes in clinical practice were discussed. We also saw audits carried out in trauma and orthopaedics and urology cases were reviewed in a half-day clinical audit event.
- Complaints response time performance had improved from 14% to 79% of complaints dealt with within the trust target of 25 working days.
- We observed staff were professional and compassionate and worked as a team to support patients. Staff in theatres and on the wards ensured patients' dignity was maintained.
- The patient discharge process was being managed more effectively. Recovery areas were no longer being used inappropriately overnight. There were daily meetings where staff discussed all aspects of a patient's discharge. Staff ensured patients' relatives were involved in discussions and decisions about care and treatment.
- Staff could access support from a mental health team specialising in dementia.

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- Staff appraisal rates had improved.
- The results of the NHS staff survey showed the response rate for surgical and cancer services at Whipps Cross Hospital improved from 29.4% to 34.7%, although this remained lower than the overall trust response rate of 47.8%.
- The leadership team had developed an action plan in response to the staff survey incorporating approaches which had worked successfully in theatres.
- A strategy and quality improvement plan had been developed outlining the key objectives and improvements planned for surgical services. Individual specialties had reviewed their strategic objectives.

Are surgery services safe?

Inadequate 

We rated safe as inadequate which was the same as our previous inspection because:

- 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. Medicines were stored in treatment rooms which could be accessed by all clinical staff and housekeeping staff and in drawers and cupboards without locks.
- We found unlocked or broken medicines cupboards in clinic rooms on three wards. These clinic rooms were accessed using a pin code. The codes were known to all staff on the wards including house-keeping staff and had never been changed.
- The security of controlled drugs was not being maintained. On one ward the controlled drugs cupboard was too small resulting in various controlled drugs being stored inappropriately. Access to controlled drugs was not appropriately restricted.
- Expired medicines were in stock on each of the surgical wards. Some medicines had expired in August 2017. This was against the trust's medicines management policy.
- We observed a medicines trolley left open, not secured to the wall. We saw unlocked medicines trolleys had been reported as incidents on three occasions. We saw pharmacy checks on the wards had found medicines trolleys unlocked on several occasions but the appropriate actions were not being taken despite ward managers reminding staff.
- Staff knowledge about the incident reporting system had improved since our previous inspection but there was recognition that incidents, for example medicines errors, were still not always being reported. Staff on the wards told us they were often too busy to read incident reports.
- The environment on some of the wards was in poor condition. On Plane Tree ward, there was cracked plaster, chipped paintwork and wall casing coming away from the wall around the scrub sink exposing the

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wood behind. The environment on Sage ward was poor with cracked flooring and poor standards of décor. The pain treatment room was not fit for purpose. We advised the trust that the room did not meet current standards.

- Equipment in theatres was in need of replacement. Many items of equipment were included on the theatre risk register. Nursing and therapy staff on the wards told us lack of equipment on the ward was one of their biggest challenges.
- A significant number of incidents (117) had been reported involving patient information being stored in the wrong records or inconsistencies between the clinical information system and paper records. As at our previous inspection, we found records were not always stored securely.
- Nursing vacancy rates remained high and most surgical wards remained heavily dependent on temporary staff.
- Only four groups of staff had achieved 90% compliance with basic life support training. All other groups of staff had not met the trust's 90% target with rates as low as 50% for some medical staff.

However:

- Staff compliance with mandatory training including safeguarding training had improved.
- There was improved compliance with venous thromboembolism (VTE) assessments.
- Surgical site infection (SSI) monitoring and follow up post-discharge was now taking place.
- The environment in theatres had improved since our last inspection. A refurbishment programme had been undertaken although work on theatres 3 and 4 was still to be carried out.
- Mortality and morbidity meetings were held where each surgical team presented cases for discussion. These showed the lessons learned and changes in clinical practice were discussed. We also saw audits carried out in trauma and orthopaedics and urology cases were reviewed in a half-day clinical audit event.

Incidents

The service reported incidents using the trust's electronic incident reporting system. Between April 2017 and March 2018, surgical staff reported 2,050 incidents. The majority of incidents (1,763) were classified as 'no harm'. Three incidents resulted in serious long-term harm or death.

There was one never event in the previous 12 months. The wrong lens was inserted into a patient's eye during cataract surgery. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. We saw evidence that the trust had taken action to reduce the risk of this error happening in future.

The service reported 14 serious incidents (SIs) between April 2017 and March 2018. These included not assessing a patient's pain appropriately, the development and deterioration of pressure sores on Sycamore ward. Two incidents related to delays in treatment and sub-optimal treatment. Staff told us the care quality co-ordinator discussed incidents and any investigations with staff.

The largest reported numbers of incidents related to pressure ulcers (280), medication errors or omissions (185), equipment (172), records or communication (117), delays in care (83) and patient falls (82). Problems with staffing and the acuity of patients were reported as incidents on 19 occasions.

Of these incidents, 51 incidents were reported for patients being cared for in recovery following surgery because there was no suitable bed available in a ward area. We discussed this with managers who assured us this practice no longer happened. Data provided by the trust corroborated what they told us and showed that this practice had reduced.

At our previous inspection, we found that of the 1,249 incidents which had been reviewed and approved by managers, almost half (530) did not have any lessons learned recorded. At this inspection we found that 2,004 incidents were reviewed by managers. Only 46 had no further actions or the outcome of investigations. Incidents resulting in moderate or severe harm were investigated with 'Root Cause Analysis', or some other form of investigation completed. Whilst the vast majority of incidents highlighted the subsequent action taken, few identified subsequent learning disseminated within surgery or shared with other specialties.

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We saw examples of investigations into serious incidents which highlighted the lessons learned, how these would be communicated to staff and who was responsible for ensuring and changes in practice were implemented.

Agency staff told us the trust informed their agency about incidents as their employer kept them informed. Nursing staff were able to describe recent medicines related errors. However, they informed us they did not always report these on the incident reporting system. The site pharmacy lead told us that the culture around medicines incident reporting needed to improve.

Staff we spoke with understood the process for reporting incidents. They told us they mainly reported falls and pressure sores. However, two members of staff said they did not always have time to report incidents. The minutes of ward meetings we reviewed showed incidents were being discussed by staff on the wards.

Incidents in theatre were discussed by staff at a daily theatre meeting. Staff told us about a recent incident which had been discussed at the meeting and at a monthly audit meeting. Staff noted a pressure ulcer during a two-hour operation. It was unclear when this had developed. The incident prompted an education session for staff on preventing pressure sores.

The pre-assessment unit waiting areas had alarms installed in case of emergencies. This was as a result of learning from an incident involving a patient who collapsed. Staff had difficulty in raising the alarm to obtain the necessary assistance. The trust had acted to address the lessons learned.

Staff told us they were encouraged to report staffing shortages as an incident. However, data provided by the trust showed that staffing issues were only reported 19 times over 12 months, which did not reflect the scale of the staffing issues we were told about.

Investigation of incidents was included in the trust's mandatory training programme. 100% of eligible staff in most groups had completed this training module in the last 12 months. However, only 60% of eligible staff in theatres had completed this training module.

At our previous inspection, we were told that all patient deaths were reviewed at a monthly mortality and morbidity meeting but the trust did not provide us with the minutes of any meetings. It was unclear which staff attended these

meetings or how lessons learnt were recorded and shared. At this inspection, we saw minutes of mortality and morbidity meetings where each surgical team presented cases for discussion. These showed the lessons learned and changes in clinical practice were discussed. We also saw audits carried out in trauma and orthopaedics and urology cases reviewed in a half-day clinical audit event.

We saw the minutes of monthly ENT, general surgery, urology, critical care, trauma and orthopaedics mortality and morbidity meetings dating back to April 2017 where complications of surgery and deaths were reviewed.

We also saw the minutes of monthly ophthalmology clinical governance meetings dating back to April 2017 where incidents, complaints, patient experience, risks, mortality and morbidity, infection control, new clinical guidelines and alerts were discussed.

The surgical division's quality improvement plan included a project for improving learning from incidents at ward level. Feedback from ward staff indicated that they were too busy to spend time learning from incidents. The division were working on a robust feedback process to be established and implemented. The work was due to take place in March 2018 but had been delayed.

We saw the minutes of a ward quality and safety meeting where staff provided an apology under the duty of candour requirement for a grade 3 pressure sore. 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.

Safety thermometer

The NHS Safety Thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to patients, such as new pressure ulcers, catheter and urinary tract infections, falls with harm to patients and Venous Thromboembolism (VTE) incidents. Safety Thermometer data was available on safety cross boards located at the entrance to each ward. Staff updated these daily to demonstrate the number of days of harm-free care. The results of environmental and hand hygiene audits were also displayed on these boards, along with key metrics such as the numbers of cardiac arrests.

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The trust's venous thromboembolism (VTE) screening target was 95%. At our previous inspection, we found monthly VTE screening rates on surgical wards varied between 75% and 86%. At the time, the trust provided us with the VTE improvement document outlining how they plan to achieve the target. At this inspection, we found compliance had significantly improved during the 12 months between April 2017 and March 2018. The majority of wards achieved the target for the last three months January to March 2018, with many wards achieving 100%. The lowest level of compliance was on Primrose ward, which achieved 92.7% in January, 94.3% in February and 94.7% in March. The records of ward quality and safety meetings showed ward managers were auditing compliance and reminding staff of the importance of completing the assessments.

The safety thermometer information showed there were 62 pressure ulcers on all five wards between April 2017 and March 2018. There were nine falls in the same period and 10 urinary tract infections. Two wards had not collected safety-monitoring information in February and March 2018.

Cleanliness, infection control and hygiene

During our previous inspection, we identified serious concerns with regards to infection control and cleanliness within theatres. During this inspection, we found there had been significant improvement in this area. A major refurbishment programme had been completed within theatres however; work on theatres 3 and 4 was still to be carried out. The refurbishment programme included replacing the flooring in theatre 7 and the scrub area.

During the previous inspection, staff in theatres told us about problems with the instrument decontamination service, which had recently been outsourced to an external company used by the rest of the trust. During this inspection, staff told us that the problem was ongoing and instrument trays still arrived with missing instruments or set out incorrectly. Incident data provided by the trust for between April 2017 and March 2018 recorded that staff had reported 140 incidents where incomplete instrument packs were delivered to theatres. Since our last inspection, the trust had appointed a member of staff to a newly created instrument liaison post, to help address the impact of this issue on theatre productivity. Staff described how this was still work in progress but that the number of incidents reduced. Staff gave us examples of where the liaison coordinator had helped to quickly resolve issues and

ensure procedures were able to go ahead. Data provided by the trust showed that eight patients had been cancelled during the period June 2017 to March 2018 because of problems with instruments not being available. This issue was recorded on the services risk register and senior staff told us that daily, weekly and monthly reviews took place to monitor the issue.

At our previous inspection, Sage and Sycamore wards, which were both orthopaedic wards, were caring for both general surgery and medical patients. We commented on the potential for increasing the risk of infection by mixing patients from different specialties. At this inspection, we found medical, surgical and orthopaedic patients were still being cared for on these wards. Managers told us the pressures of emergency admissions meant they had no choice but to mix patients from different specialties. They told us they tried to ensure patients that might represent an infection risk were nursed in side rooms. During our last inspection, we reviewed the trust's isolation and management of infectious diseases policy and found that it was out of date. At this inspection, we found that the policy had been reviewed and updated in September 2017.

Hand washbasins and alcohol hand sanitising gel were available at ward and theatre entrances and the hand gel was widely available on the wards. Instructions for their use were clearly displayed next to, and on, the soap/alcohol dispensers. We saw there were posters at the entrance to each ward reminding staff and visitors to clean their hands before entering the ward. We observed nursing staff cleaned their hands before and after patient contact.

We saw the results of monthly hand hygiene audits between April 2017 and March 2018. These showed 100% compliance in theatres, and for the majority of the wards, except Poplar and Primrose. On these wards compliance rates were below 90% for the months between November 2017 and February 2018 and in December where compliance was 93% on Primrose ward.

Infection control training was included in the trust's mandatory training programme. Staff training completion varied between wards with Primrose and Sage achieving 93%, Poplar ward at 88%, Rowan ward at 85%, Sycamore ward at 81% and Plane Tree at 74%. Theatres was at 75%. The results of the hand hygiene audits indicated that staff compliance with infection control processes had improved

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since our last inspection. However, we observed hand hygiene practices on Primrose ward and saw that only two out of 14 opportunities, for example following contact with a patient, were taken.

We found the wards were mostly clean but there were areas that had not been dusted, for example the overhead lamps in patient bays. During our inspection, we became aware that there was a lack of clarity between nursing and domestic staff about the responsibility for cleaning a soiled toilet. The cleaning schedule for the sluice room was out of date and spillage kits had exceeded their use by date.

We saw that staff wore appropriate personal protective equipment (PPE), including gloves and aprons, when required. Waste bags were clearly identified with all relevant information including date, theatre, and case number in line with association for perioperative practice (AfPP) recommendations for safe practice.

A senior infection prevention and control (IPC) nurse said that the level of involvement of the IPC team on the wards had improved and there were daily visits to each ward to review any patients with infections. We were told each ward had an IPC link nurse who supported ward staff with IPC. However, not all nursing staff on the wards could tell us who the IPC lead or link nurse was.

The IPC team carried out bi-annual IPC audits on the wards. Audits reviewed the general condition and cleanliness of the environment and equipment as well as testing staff knowledge. The team carried out monthly hand hygiene (Saving Lives) audits to corroborate the checks carried out by the wards.

At our previous inspection, we observed some staff did not adhere to the infection prevention standards and protocols. Nursing staff were not challenging medical staff about adhering to the trust's bare below the elbow policy. During this inspection, we found doctors were adhering to the policy and the minutes of ward meetings showed nursing staff were reminded to challenge medical staff if required. We saw that theatre staff complied with trust policies for protective clothing.

We saw a report with information about the number of reported cases of MRSA and other acquired infections for the 12 months between April 2017 and March 2018. The report showed there had been three cases apportioned to

the trust, two were believed to have originated in the community or at another location. The three cases had been reviewed to identify where any changes in practice were needed.

There were five cases of Clostridium Difficile. These were reviewed and no breaches in care were identified.

There were six MSSA cases. These were investigated and likely sources identified and discussed with the trusts microbiology team.

There were 16 E.coli cases which were identified as being associated with procedures patients underwent.

There was one carbapenem-resistant enterobacteriaceae (CPC). This was investigated and the infection control team found staff had followed the trust's infection control policy. The patient concerned was isolated and contacts identified and screened. No further cases were identified amongst people the patient had been in contact with.

Two cases of ophthalmitis were reported in the last 12 months. The rate was 0.056% based on 3,500 cataract procedures in 12 months.

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. Service leads told us that SSI data was being collected and submitted to the national database for elective hip and knee procedures as required by Public Health England (PHE). The trust provided us with information about 180 hip and knee patients who were contacted after discharge. There were four cases of post-operative infection identified between March and December 2017. The volume of hip and knee surgery patients followed up was limited due to the suspension of elective surgery over the winter months.

Environment and equipment

At our previous inspection, we found a range of environmental issues. Some theatres were non-compliant with the department of health standards set out within HBN 26 'Facilities for surgical procedures in acute general hospitals.' Previously, the flooring in theatre 7 was cracked and stained and theatre 5 had holes and gaps in the ceiling outside the anaesthetic room. The hospital had completed a programme of remedial work. At this inspection, we

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found the environment in theatres was considerably improved. The trust had been carrying out a programme of repairs in theatres. The surgical division's quality improvement planned further work on theatres 3 and 4.

However, we found that there were still concerns with the environment on some surgical wards. For example, when we visited Plane Tree we found cracked plaster, chipped paintwork and wall casing coming away from the wall around the scrub sink exposing the wood behind.

The ophthalmic unit was a separate standalone unit, including outpatients and theatres. Space was limited and the unit was isolated from emergency support. There was an emergency 'help' call button on the wall in theatre which staff could use to obtain help. There was no facility for confidential discussions with patients and patients with special needs such as dementia or a learning disability waited for their procedure in the recovery alongside patients who had already undergone surgery.

One anaesthetic room was also shared between two theatres, which was not good practice because of the risk of potential patient identity errors.

At our previous inspection, staff told us that many items of theatre equipment were old and needed to be replaced. Replacement of old and obsolete equipment was included on the division's risk register, which described the potential risk to patient safety if the items stopped working or were not functioning correctly. Nursing and therapy staff on the wards told us lack of equipment on the ward was one of their biggest challenges.

The anaesthetic machines were approaching the end of their useful life and required replacement. Discussions were underway about a replacement plan for anaesthetic equipment at several sites across the trust. Replacing anaesthetic equipment was included on the risk register. The three highest risks were for items of equipment within ophthalmology.

The trust provided us with information about the theatre equipment servicing and maintenance schedule which showed there was a log of equipment which had been serviced or was due for review.

The trust also provided us with information about the annual maintenance and checks for operating theatres ventilation that showed these were up to date and had been carried out in February and March 2018.

We saw that 15 of the 34 risks recorded on the surgery and cancer risk register related to equipment, which was old or could no longer be repaired. The risk register also referred to a change in responsibility for maintaining medical equipment. The trust's medical engineering department had taken responsibility for servicing and maintaining of all theatre equipment. Staff in theatres were concerned that service plans were not fully developed which may lead to equipment failure whilst in use, patient harm and or cancelled procedures. However, the trust provided us with an equipment plan, which showed the dates for servicing equipment.

The risk register also contained risks for the chronic pain specialist table which was obsolete and parts unavailable for repair. The quality of the images provided by the flexi cystoscopes was also a concern and there was a risk this could result in missed diagnosis and patient harm.

When we visited the pain treatment room, we found there was no anaesthetic machine and the theatre table 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 standards of HBN 26.

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 which included syringes and other items was stored in units which were not secured. We also found a room on Primrose ward where ENT procedures were carried out. Equipment trolleys contained syringes and needles. The room was unlocked and access to the content of the trolleys was unrestricted. We brought this to the attention of the ward manager who told us the room belonged to ENT. They told us they would ensure the room was locked in future.

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 and 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.

Medicines

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Medicines were not being managed safely. 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.

Medicines were stored in treatment rooms which could be accessed by all clinical staff and housekeeping staff. In the treatment room on Rowan ward medicines were being stored in drawers and cupboards without locks. Locks were broken on medicines cupboards on Poplar ward and on the fridge in Sycamore ward. On Sage ward we found a cupboard containing oral medicines unlocked and unattended.

The issue of medicines security was listed on the pharmacy risk register. The pharmacy department conducted a quarterly "Safe and Secure Handling of Medicines Audit". Results from 2017-2018 showed that some but not all of these issues had been identified during the audit. Our findings during inspection show that action plans were not being adequately implemented following these audits.

We found unlocked or broken medicines cupboards in clinic rooms on three wards. These clinic rooms were accessed using a pin code. The codes were known to all staff on the wards including housekeeping staff and had never been changed.

The security of controlled drugs was not being maintained. Controlled drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse. On Sycamore ward the controlled drugs cupboard was too small resulting in various controlled drugs, including oxycodone 5mg/5ml, morphine PCA and Targinact, being stored in an outer cupboard where injectable medicines were also stored. This meant that access to controlled drugs was not appropriately restricted. This issue had not been identified during the quarterly controlled drugs audits undertaken by pharmacy.

Expired medicines were in stock on each of the surgical wards. During our inspection, we brought this to the attention of staff who disposed of the expired medicines. Some medicines had expired in August 2017. This meant regular checks of stock were not taking place on the wards. This was against the trust's medicines management policy, which stated, "Pharmacy staff should carry out inspections of the security and storage of stock medicines, with reconciliation where necessary. All supplies of medicines in clinical areas must be checked, those that are 'stock' are

within expiry and are stored correctly". Staff told us this requirement was difficult to fulfil as there was no pharmacy top up service to the surgical wards, an issue which had been on the pharmacy risk register since 2015. Some of the expired medicines, such as adrenaline, amiodarone and heparin, were on the trust's critical medicines list, this is a list of medicines that should not be omitted and should be given within two hours of prescribing.

Of the 25 charts we reviewed we found six contained missed doses, 11 medicines were involved, which equated to 19 doses in total. Twelve of the 25 charts had antibiotics prescribed. The medicines chart contained a specific section for prescribing antibiotics. This section prompted prescribers to complete all the required details for an antibiotic prescription. We saw evidence of appropriate monitoring of antibiotics, for example blood level monitoring. However, three of the prescription charts were missing the indication and/or duration of treatment, this was against the Trusts Antimicrobial Guide and NICE Guidance.

The pharmacy service monitored the effectiveness of the department against seven performance indicators. The figures for the period April 2017-March 2018 showed performance had improved for dispensing medicines (TTAs) patients needed when they were being discharged. Performance improved from 54% to 92% for urgent TTAs dispensed within one hour and from 62% to 94% for non-urgent TTA's dispensed within three hours. Performance for dispensing urgent in-patient medicines within 60 minutes had also improved from 48% to 96%.

Regular checks of medicines required by the trust's medicines management policy were not being undertaken on the surgical wards. On Rowan and Sycamore ward we found that fridge temperature checks were not always completed. On Primrose ward records showed that the fridge temperature had been above the recommended range every day for the last three months. Staff could not tell us about any action they had taken in relation to this. This meant we could not be assured that medicines kept in the fridge were suitable for use. During our inspection, we reported this to the ward pharmacist who had not been aware of the issue. Most staff we spoke with were unaware of the need to contact the pharmacy department although a ward manager told us an air conditioning unit was located in the treatment during the hot summer months.

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On Poplar ward we also found other medicines checks were not being undertaken. The hypobox (containing medicines to treat hypoglycaemia) had not been checked since December 2017. We found expired fluids in the sepsis trolley and informed the ward sepsis champion. Staff on Poplar ward told us that these checks were not being completed because they did not have time to do them.

Resources to support the administration of medicines were out of date on the surgical wards. We saw nurses using a drugs formulary BNF 66 (published in 2013) and referring to printed copies of the trust's formulary. Nurses told us that the most up to date Medusa guide was available on the trust's intranet but that it was often difficult to get access to a computer. This meant staff were not accessing the correct, current information about medicines.

We reviewed 25 prescription charts and saw that allergies were documented and medicines reconciliation had been completed by the pharmacist for all patients. We observed pharmacists providing ward staff with verbal and written advice about medicines.

We saw the results of medicines safety and security checks carried out monthly in theatres. Most theatres scored highly but there were frequent examples of loose ampoules stored incorrectly.

Pharmacists were present at ward level Monday to Friday. The service included medicines reconciliation, provision of medications not kept as stock on the ward and medicines optimisation.

Pharmacy and nursing staff were able to describe recent medicines related incidents that had occurred on the surgical wards. However, staff told us these incidents had not been reported on the incident reporting system. Staff told us this was because the incidents were near misses and had not directly affected patients. Staff recognised that the medicines incident reporting culture at the hospital was poor and needed to improve.

Access to controlled drugs was not restricted. On Sycamore ward we found controlled drugs which were stored in the intravenous (IV) medicines cupboard and in one theatre we found controlled drugs unattended.

We observed a medicines trolley on a ward left open, not secured to the wall. We saw unlocked medicines trolleys had been reported as incidents on three occasions. We saw

pharmacy checks on the wards had found medicines trolleys unlocked on several occasions but the appropriate actions were not being taken despite ward managers reminding staff.

We found stock in the treatment room which had exceeded the use by date by six months. The glucose solution was used for intravenous injections. We checked four spillage kits in the sluice and found three had expired in 2016, one had expired in 2011. We checked two spillage kits for cytotoxic medicines and found these had expired in April 2017.

The pharmacy service carried out quarterly audits for all wards and departments. The audit included 17 checks on controlled drugs including stock levels and signatures. The results were completed up to the end of December 2017. The errors were highest on Sycamore ward with an average of 125 over the last 12 months compared with 147 the year before. The second highest was Primrose ward where there was an average of 61 errors over the last 12 months. Sage ward had the lowest number of errors related to controlled medicines with only 17 errors in the last 12 months.

Action plans were developed for improving medicines management and ward managers were responsible for ensuring the actions were implemented. A pharmacist who specialised in governance monitored results which were reviewed at the Whipps Cross hospital peer review meeting with the Director of Nursing (DON) to discuss findings and arrange spot checks.

Quarterly Safe and Secure Handling of Medicines Audit – Pharmacy Report identified a number of common themes across wards which included not recording fridge temperatures daily, no signature lists for nurses who administer or order medication, medication storage cupboards not locked and allergy posters not displayed.

We saw the results of a safe and secure handling of medicines audit. These audits were carried out every three months with an emphasis on the storage of medicines. The most recent results showed three areas were identified as requiring improvement including the recovery areas in theatres 3, 4, 5 and 8 as well as Poplar, Sycamore and Rowan wards.

We saw the pharmacy department had an establishment of 14 staff but the actual number of staff varied from 5 in July 2017 to 10 in February 2018. The current team consisted of a senior pharmacist who managed the team, two full time

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band 7 pharmacists (one permanently based at WCUH and the other rotational across all sites), two rotational band 6 pharmacists, one permanent band 5 medicines management pharmacy technician.

Records

During our last inspection, we found that patient records were not always stored securely in line with information governance standards. During this inspection, we found the situation had not improved.

Information about patients was recorded on the trust's electronic clinical information system and on paper records. The majority of nursing information was included in the paper records.

The trust had introduced a new electronic clinical information system and told us they were moving away from paper records to electronic records. Several staff told us there were discrepancies between patient details on the paper and the electronic records. We also saw 117 reported incidents between April 2017 and March 2018 about records, many of which were concerned with incorrect patient information.

The risk register for surgery 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 staff might not be accessing the correct patient information. The surgical division's quality improvement plan included a project for carrying out a risk assessment of information inconsistencies between paper and electronic records. The plan showed the work was due to be carried out in March 2018.

In 2017, the trust introduced an electronic audit system called 'Perfect Ward' for monitoring the quality of care provided on the wards. New nursing assessment bundles were also introduced in October 2017.

Ward documentation reviews were undertaken in February and March 2018. The results of the reviews showed Poplar and Sage wards scored 100% for 9 out of 12 areas which included checking records contained the correct patient details, patient observations were completed to the set parameters and whether early warning scores were

calculated correctly. Sage ward scored 80% for completion of the Waterlow assessment and 80% for completion of a skin damage body map and 0% for the completion of the skin-monitoring bundle (SSKIN).

During our previous inspection, we saw that some wards performed poorly in the documentation audit. At this inspection, we saw that action had been taken by the trust to try and improve document completion. However, when we reviewed care records we saw examples of the new nursing assessment bundles but very few had been fully completed.

We reviewed 12 paper records and found six included the name and grade of the doctor responsible for the patient's care. Five contained clear information about patients' diagnosis and a plan for managing their treatment. Three of the records were not signed and dated. Patients' observations were recorded and completed at appropriate intervals. We found one message about a patient's care was written on a hand towel and filed in the patient's records.

We checked six sets of records in theatres and recovery and found these were fully completed.

We found records stored on two wards in unlocked filing cabinets and on the shelves of unlocked cupboards. In another ward, records were stored in a room with access via a key pad. However, whilst we were on the unit the room was open and unlocked.

On two occasions, we observed rooms in the pre-assessment unit where computers were left unlocked and we could see patients' details displayed. Staff used smart cards to access computers which the trust's information governance policy stated should be removed when staff move away from their computer. The surgical division's quality improvement plan identified this issue as one the division wanted to address. Work was planned for ensuring all ward staff had information governance training and quarterly audits for compliance to be undertaken. Communications and posters were to be developed. The plan showed the work would be undertaken in March 2018.

The most recent documentation audits carried out by the hospital in February 2018 showed nursing assessment completion was variable. On Sycamore ward, 25% of patients had no weight recorded and only 66% of patients who required monitoring had food charts completed. In addition, 20% of patients had not had a continence assessment and 50% of patients on Poplar ward did not

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have an individualised patient continence care plan in place. It was also highlighted that there was no record of any patient having had received a dementia assessment on Poplar ward. On Primrose ward, 40% had not had a dementia assessment and 20% of patients had not had a falls assessment. All the wards scored 100% for completeness of other assessments. Overall, Sycamore ward scored 90% on all measures, 88% for Sage ward, 93% for Poplar and 93% for Primrose ward.

Safeguarding

Safeguarding adults level 1 and 2 training was completed online and repeated every three years. All nursing and medical staff were required to complete level 2 safeguarding children training, while senior staff were required to complete safeguarding children level 3 training. The trust's target was 90% completion for all staff.

Compliance with level 1 safeguarding training exceeded the trust's 90% target for all staff groups within surgery apart from ancillary support staff in theatres, which fell just short at 89%. Compliance with level 2 training had improved since our last inspection from 75% overall. The majority of staff groups exceeded the trust's 90% target apart from Rowan ward. Medical staff in ENT, ophthalmology, orthopaedics and general surgery achieved 77%, 86%, 86% and 84% respectively.

All staff groups in surgery achieved the trust's 90% target for level 1 safeguarding children.

The majority of staff eligible to complete level 2 safeguarding children had completed the training with the exception of medical staff in general surgery 77% and ophthalmology 89%. Most staff required to complete level 3 training for safeguarding children had done so apart from a small number of staff in optical services.

All surgical nursing staff completion rates achieved the 90% target apart from Rowan ward, which achieved 88%.

All theatre staff achieved or exceeded the target for safeguarding training.

Compliance for medical staff did not meet the trust target in general surgery, ENT, ophthalmology, general surgery and orthopaedics. However, the level of compliance had noticeably improved since our last inspection.

Staff we spoke with were familiar with the safeguarding arrangements and were aware of the different forms of

potential abuse and how to report them. They told us they discussed safeguarding risks and concerns at the ward quality and safety meetings. We observed safeguarding concerns about one patient being communicated to other members of staff, during a safety huddle meeting on one of the wards.

Mandatory training

The trust's target for mandatory training was 90% compliance. The trust provided data for mandatory training compliance broken down by 26 staff groups across the surgery division. The majority of staff groups (22) had achieved or exceeded the trust's target. Only four groups of staff had not achieved this level of compliance: ENT medical staff, ophthalmology medical staff, general surgery medical staff, and urology medical staff.

The trust's training programme included nutritional care, information governance, consent, privacy and dignity, moving and handling.

Compliance rates were over 90% for conflict resolution (apart from general surgical medical staff at 84%).

The number of staff who had completed equality and diversity training exceeded 90% for all staff groups.

Most wards had completed medicines training (Poplar 93%, Primrose 93%, Rowan 94% and Sage 92%) apart from Sycamore ward at 71%, Plane tree ward at 75% and theatre staff at 72%.

Mandatory training also included training on VTE, falls, pressure ulcer prevention and catheter acquired infections known as '4 Harms' training. At our last inspection, compliance varied between wards with 71% of nurses on Primrose ward and 80% on Poplar ward who had completed the training. At this inspection, we found all three wards were 100% compliant with all four modules of the harms '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. Staff on all the wards exceeded the 90% training target for early warning training with scores ranging from 93% to 100%. During our inspection we saw posters advertising 'sepsis awareness week' involving talks and presentations on identification and treatment.

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At our last inspection we found infection prevention and control training had only been completed by 75% of clinical staff with compliance on some wards as low as 40%. At this inspection we found only one group of staff had not achieved the target, with 15 groups of staff achieving 100%.

Nutritional care training had been completed by 91% of nursing staff with 96% on Primrose ward and 93% on Poplar ward, 93% on Rowan ward, 100% on both Sage and Sycamore wards. This was another area where compliance with training had shown improvement since our last inspection.

All ward staff exceeded the target for training on the early warning system used by staff to identify deteriorating patients. The only staff groups which did not achieve the target were medical staff in ENT, urology, general surgery and ophthalmology. This was a further improvement since our last inspection.

Training with the poorest completion rates included medical gas safety, basic life support and fire training.

Only six of the 24 staff groups required to complete basic life support training, had achieved 90% compliance. The groups included staff on Plane Tree ward, pre-assessment staff, medical staff in anaesthetics and anaesthetic support staff. All other groups of staff had not met the 90% target with rates as low as 50% for orthopaedic medical staff, 65% of urology medical staff and 57% for ophthalmology medical staff and 65% of general surgery medical staff.

Assessing and responding to patient risk

Patients' records contained completed risk assessments for venous thromboembolism (VTE) nutrition and pressure ulcers.

Theatre staff met daily 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. Theatre staff completed appropriate checks before, during, and after surgery. They used the five- step approach to safer surgery (briefing, three stages of the WHO Surgical Safety Checklist and debriefing). This checklist approach was used to reduce errors and adverse events, improve teamwork and effective communication. We observed these checks being carried out. The checks involved fully interactive discussion involving all staff present in theatre. Patient details were checked, equipment requirements discussed and any special needs highlighted.

The trust carried out monthly audits of the five steps to safer surgery checklist in all operating theatre sites (main theatres, eye theatres, obstetric theatres and the pain procedure room). The audit reviewed all stages of the process including the team brief, sign in, time out, sign out, documentation and de-brief. Staff were observed carrying out the checklist for five cases per month. An audit of 10 cases per theatre using data from the computer records or sample of written health care records was also undertaken. Audit results were discussed at the Peri-Operative Clinical Governance Group meeting. Actions from the audit results were followed up by the surgery service management team. Over the past 15 months, compliance was 99% across all operating theatres. De-brief in the operating theatres ranged from 97%-100%.

A record of training was kept of all staff in the department who took part in the safe application of the safe surgery checklist. We saw that each member of staff had been assessed as competent in the use of the checklist or was working toward that competency and had read the latest policy.

The service used the national early warning score (NEWS) to identify deteriorating patients. This is a set of observations which monitor patient's vital signs. The results of these observations were recorded and measured over time to assess if patient's condition deteriorated. The charts contained information about the action staff should take if the NEWS) score increased. NEWS assessments were audited monthly to check they were being completed correctly.

The hospital carried out a monthly audit of NEWS to measure staff compliance with the trust's policy for identifying and escalating a deteriorating patient. The trust's target for compliance was 80%. We saw the audit results from January 2017 to January 2018 which showed compliance ranged from 56% to 97% across five surgical wards. The audits also showed 0% compliance on Rowan and Sage in January 2018 and for Primrose ward in November 2017.

All 12 records we reviewed contained NEWS scores. We checked and found the NEWS scores were all calculated correctly and patients were monitored at appropriate intervals. We were made aware of a serious incident where a patient had deteriorated following surgery and died.

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Despite the NEWS system, the patient had not been appropriately escalated and had developed irretrievable septic problems. The case had been fully investigated by the trust and was the subject of an inquest.

We saw examples of assessments for patients at risk of sepsis. All the records we reviewed contained sepsis risk assessments. Each ward had a sepsis trolley which contained the medicines and equipment staff required if a patient developed sepsis and they needed to respond quickly. We saw audit results for sepsis assessment for the surgical wards (Primrose, Poplar, Rowan, Sage and Sycamore). The trust carried out a monthly audit of patients who should have been screened for sepsis (NEWS >5 and signs of infection). The audit included patients screened for sepsis, those identified as having sepsis and how many received antibiotics within an hour. The trust commenced collection of the data in September 2017. Between October 2017 and March 2018, 155 patients were audited and the results showed that 67 were screened (43%). Of those screened 53% received antibiotics within one hour of the problem being identified. Sage ward started collecting data in January 2018.

The trust provided us with figures for the proportion of patients having perioperative medical assessment between April 2017 and 31 March 2018. The figures showed that 11,963 patients (104.7%) were assessed. The percentage was greater than the number of procedures because some patients required follow up assessment.

A NatSSIPS (National safety standards for invasive procedures) cross-site meeting group had developed new safety checks for major procedures. The new NatSSIP's checklist was launched in March 2018. The trust was working with ophthalmic, obstetrics, interventional radiology to introduce the updated checklist. The trust then planned to roll the updated checklist out to areas carrying out minor procedures. We saw the trust's project plan that showed how they would implement the new checklists in all areas by April 2018.

Patients requiring general anaesthetic, sedation or who were high risk were pre-assessed for surgery. Medical staff recorded any risk factors on the clinical information system. Pre-assessment clinics were nurse led. There was a drop in facility available for patients who were attending outpatients. Patients were given a card with relevant information about who to contact if they had any concerns

following the pre-op assessment. This included patients' details, the name of nurse they saw, contact numbers to call the unit and scheduling team to enquire about their operation time and date.

The majority of surgical patients were pre-assessed by nursing staff on the Plane Tree and in pre-assessment unit. Assessments were completed in person. The pre-assessment process followed national guidelines published by the National Institute for care excellence (NICE). The notes of the pre-assessment were available to theatre and ward staff. We observed the forms nurses used to conduct a pre-assessment and found them to comply with the National Institute for Health and Care Excellence (NICE) guidelines.

Every Tuesday morning an anaesthetist carried out cardiopulmonary exercise testing (CPET) for high risk patients. They saw up to three patients per session. We were told that recently a nurse from pre-operative assessment was allocated to assist the doctor. This way the service was now more integrated into the unit and ran more efficiently.

Nursing staffing

During our previous inspection, we found the use of agency staff on some of the wards was high. High vacancy levels and difficulty recruiting meant that some wards were still relying heavily on temporary staff. One ward manager told us that agency staff made up over 50% of their staffing rota on regular basis. At this inspection, we found that although there were still very high nursing vacancy rates the service had reduced their reliance on agency staff and were using more bank staff to fill shifts.

As at 31 March 2018, there were 50.18 whole time equivalent (WTE) nursing vacancies within the surgical services, this equated to a 17% vacancy rate. This showed a small improvement on the vacancy rates as at 31 March 2017 (19%) but was still significantly worse than the trust's target vacancy rate of 5%.

Nursing vacancy rates varied between clinical areas. On the surgical wards, the highest vacancy rates were on Primrose ward (34%) and Sycamore ward (26%), with the lowest rates on Plane tree (1%) and Poplar (8%). General theatres had a vacancy rate of 23% with ophthalmic theatres at 19%. Vacancy rates were higher than the surgical department average in pre-assessment (26%) but better in recovery (9%).

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Between April 2017 and March 2018, a total of 3,539 shifts on surgical wards were covered 75% by bank staff and 25% by agency staff. The highest agency staff use was on Primrose ward and the lowest on Plane Tree. On Primrose Ward, 2,154 shifts were covered 69% by bank staff and 31% by agency staff. The increased use of bank staff meant the service had improved the use of staff employed by the trust to fill rotas rather than relying on agency staff who might not be familiar with the hospital.

At our last inspection, the use of temporary staff in theatres was lower than on the ward, ranging from 13.9% to 19.6%. This was achieved following a recruitment drive. Staff told us the staffing situation in theatre had improved. Data provided by the trust showed that 1,763 shifts were filled 69% by bank staff and 31% by agency staff.

The service's vacancy rate for healthcare assistants was in line with the trust's target at 5% (8.83 WTE).

At our previous inspection, staff told us the high use of agency staff resulted in additional pressures on permanent staff because agency staff were not always familiar with the trusts policies and procedures. Staff we spoke with told us this was still an issue. They said it was more difficult for them to provide continuity of care for patients because of frequently changing staff. They said it was more difficult for them to complete all their nursing observations, which resulted in delays in providing personal care and checking patients at risk of developing pressure ulcers.

During our inspection, there were 15 medical patients being cared for on one surgical ward, 10 on another and six on another. Staff told us that providing care for a mix of surgical and medically ill patients added complexity to their role and made it more challenging to provide effective care for these patients.

Managers told us they were working to improve their staff recruitment process. They said they were placing recruitment adverts for individual wards replacing their previous recruitment to generic posts across surgery. Enhanced rates of pay had been introduced for health care assistants, which we were told had boosted recruitment. The trust was also encouraging unqualified staff to train and develop their skills. Theatres were establishing apprentice technician roles.

When we met the senior leadership team for surgery they told us they had developed a nursing strategy and links to a local university which they hoped would result in more

trainee nurses being attracted to work at the hospital. They told us they had recruited additional nurses internationally with three band six nurses due to come into post in a few weeks. They told us staffing was their highest priority on the risk register and they regularly reviewed staffing to ensure services were safe for patients.

The matron for surgery told us they reviewed staffing several times a day and tried to ensure there were two trained nurses on each ward as far as possible. They said permanent staff were sometimes moved to other wards to provide cover.

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.

Two wards were without ward clerks. Staff told us this resulted in nursing staff carrying out clerical tasks, for example updating patient information on the patient information system.

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 had initially been scored 8 which represented a medium risk but the risk rating at the time of our inspection had increased to 12.

The hospital had introduced an acuity tool four weeks prior to our inspection. The computer-based tool calculated required staffing levels based on patients' dependency levels. The system used a red, amber, green (RAG) system 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. 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.

We observed two handover meetings and found that staff knew their patients well. All staff involved in the handover had a list of patients for checking their details including risks highlighted as a result of clinical assessments, for example pressure sores. There was a handover in each bay

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with the needs of each patient discussed in turn. Updates on test results, visits from specialist nurses or therapists planned for that day were all discussed. The estimated date of discharge was discussed to check nothing had changed and information updates provided medical staff was shared.

Surgical staffing

Consultants provided on site medical cover Monday to Friday, five days a week. Consultant cover at the weekends was provided as an on-call service. 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 the on-call period to ensure consultants had the capacity to deal with emergencies.

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 meant the trust was unable to provide acute patient review by a consultant within 12 hours. Consultants or other senior medical staff were available to review patients whose early warning score (NEWS) showed deterioration. Consultant led ward rounds of all emergency admissions and acute patients took place seven days a week.

General surgery and critical care and anaesthetic registrars were resident on site supported by senior house officers in general surgery, orthopaedics, ENT and critical care.

Within general surgery, consultants provided on site emergency cover between 8am and 5pm, Monday to Friday. Registrar and senior house officers were resident on site 24/7. 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.

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.

A surgical trauma list was carried out at weekend between 8am and 5pm by either a consultant or other senior doctor.

Physicians had recently commenced a service to manage the care of medical outliers. This ensured patients received appropriate medical care when they were on surgical wards.

A consultant ortho-geriatrician was present on Sycamore ward and provided specialist support to older orthopaedic patients whose needs could be more complex than those of younger patients. A consultant psychiatrist specialising in the needs of older people was available to support older people with dementia.

We spoke with six junior doctors who all told us it was a good place to work. They said they had had good experience and support.

Major incident awareness and training

The trust told us that there had recently been a suspected fire on Poplar ward. No one was injured but the ward was evacuated. We asked staff on the surgical wards what lessons were learned from the incident. We asked general questions about awareness of recent incidents and awareness of any fire safety incidents. We also asked if they had received fire safety training and whether they felt confident that they would know what to do in the event of a fire. We found few staff were aware the fire safety incident had occurred or the lessons learned.

Emergency planning was included in the trusts mandatory training programme, completed by the majority of staff. However, data provided by the trust showed that fire safety training had been completed by less than half of eligible staff.

The trust had revised and updated their major incident plan in April 2018. In addition to the trust-wide plan, business continuity plans had been developed for general surgery and urology, ophthalmology, theatres, trauma and orthopaedics and critical care. Senior medical and nursing staff we spoke with were aware of the major incident plan

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and had been involved rehearsing the arrangements. Junior medical staff were aware of the plan but many were new to the trust and told us they were not familiar with the content.

Are surgery services effective?

Requires improvement



We rated effective as requires improvement which was the same as our previous rating because:

- As we found during our last inspection, not all patients were screened for malnutrition as required by NICE guidelines. The trust target of 95% for completion of MUST was not being met consistently.
- The service was still not providing patients with access to an enhanced recovery programme. However, the trust told us they had recently appointed an enhanced recovery nurse and that implementation plans were underway.
- The National Emergency Laparotomy Audit (NELA) the hospital had mixed results. Performance had declined in three out of six key measures and, although the remaining three measures had improved, overall the hospital performed worse than the national average.
- The mix of surgical specialities, as well as medical outliers, on most surgical wards created challenges to effective communication between medical and nursing staff.
- Consent was taken on the day of surgery, which was not in line with the trust's policy.
- Staff told us that patient information on the electronic system was not always updated which sometimes led to patients being listed under the wrong clinical team. This caused confusion and delays.

However:

- Results for the 2017 Hip Fracture Audit showed that there had been an improvement in several measures including mortality rate and length of stay.
- Staff appraisal rates had improved and now exceeded the trust's 90% target.

- The trust had developed action plans in response to national audit results and actions had been agreed to improve data collection.
- The service had developed a comprehensive audit plan addressing both local and national priorities and NICE guidelines.
- The number of unplanned returns to theatre had reduced in the last 12 months.
- Clinical guidelines and policies were developed and reviewed in line with the National Institute for Health and Care Excellence (NICE), the Royal Colleges and other relevant bodies.
- The trust had developed local surgical safety checklists for a number of procedures.

Evidence-based care and treatment

Clinical guidelines and policies were evidence based, developed in line with the National Institute for Health and Care Excellence (NICE), the Royal Colleges and other relevant bodies. Staff accessed policies and protocols on the hospital's intranet.

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.'

Safety guidelines from the association of anaesthetists of Great Britain and Ireland (AAGBI) were available for staff in theatres and staff followed these guidelines appropriately. The anaesthetic machine logbook and anaesthetic rooms in theatres were checked every three months to ensure daily equipment checks were taking place and being recorded and to check the cleanliness of these areas.

Patients were assessed prior to surgery. The pre-assessment process was a nurse led service. Nurses had criteria for assessing patients which was based on NICE guidance. For example, guidance on offering pre-operative testing and an anaemia pathway. Nursing staff saw all the patients. If they had any concerns, they referred patients to an anaesthetist for further assessment. An anaesthetist reviewed patients' notes on a daily basis along with the results of the assessments.

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An annual audit plan had been developed for surgery for 2018-2019. The plan was divided into trust priorities, NICE audit, national and local priorities. Trust priorities included a record keeping audit, VTE audit, mortality review, never event, serious incidents, clinical handover, over ordering investigations, central venous catheter, cannula peripheral audit, DNAR (Do not attempt to resuscitate) order. There were a total of 22 local priorities, 10 trust wide audits, 87 NICE audits and 15 national audits. There were 88 additional projects which included: sepsis audit, surgeons logbook, ultrasound guided fine needle aspiration (FNA) of thyroid nodules (from audit live royal college radiologist) IMAGINE: Ileus Management International. An international, observational study of postoperative ileus and provision of management after colorectal surgery, reducing waiting time for cholecystectomy for gallstone pancreatitis.

NICE audits included (CG50) Acutely ill adults in hospital: recognising and responding to deterioration - Response time to referrals from A&E and in-patient, (CG50) Acutely ill adults in hospital: recognising and responding to deterioration - Transfer of critical care patients to general wards, (QS158) Rehabilitation after critical illness in adults. Adults in critical care at risk of morbidity have their rehabilitation goals agreed within 4 days of admission to critical care or before discharge from critical care, whichever was sooner.

The trust had developed local surgical safety checklists for a number of procedures including percutaneous tracheostomy, intubation, central line insertion, bronchoscopy, chest drain and nasogastric insertion.

We saw the results of monthly audits, for the period March 2017 to February 2018, carried out in theatre to check infection control and safety procedures. The audit checked that consent forms were completed, perioperative hygiene routines followed and scrub count correctly carried out. Other issues such as staff wearing jewellery or equipment stored incorrectly were also highlighted. The audits highlighted the person responsible and followed up on the actions identified to ensure these were completed.

During our previous inspection, we were told that the service had introduced an enhanced recovery programme (ERP) to improve patient outcomes but a post to lead the programme had not been filled. Enhanced recovery is an evidence-based approach that helps people recover more

quickly after having major surgery. At this inspection, the trust told us they had recently appointed an enhanced recovery nurse and that implementation plans were underway.

Pain relief

Staff used the Abbey pain scale to assess patients' pain and the effectiveness of pain relief. Patients were asked to score their pain from zero to three, with zero meaning no pain and three severe pain. Staff told us if a patient's pain score went up then they were reviewed by a doctor and given pain medication.

A dedicated pain team visited wards daily and out of hours which was managed by an on-call anaesthetist. We observed the pain team visiting patients on the wards.

The pain team carried out a hospital wide pain audit across the hospital including across medical and surgical wards. We reviewed 10 care records and saw pain assessments were carried out and completed correctly.

We saw the results of quarterly acute pain audits carried out between April and December 2017 for patients following surgery. There were 50 patients reviewed for each audit. The September 2017 audit results were similar to the previous quarter with 80% of surgical patients with a formally recorded pain assessment. Thirty-eight percent of surgical patients reviewed on the day reported clinically significant pain (moderate to severe) and 90% patients were either satisfied or extremely satisfied with their pain management. The audit findings were presented by the pain team to the surgical nurse forum and additional teaching provided around monitoring of patients on pain scoring.

Patients who had patient controlled analgesia (PCA) and epidurals were also reviewed. The findings of these reviews were reported at a ward managers meeting. A training session based on the outcome of the audit was held in June 2017. Advanced link nurses for PCA and epidural were identified on surgical wards and all day teaching session for those nurses was held in February 2018. The trust had appointed two practice development nurses for surgery who were trained to provide support and guidance for surgical nurses.

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The audits also identified three patients who were not monitored after the removal of an epidural catheter. As a result, the pain team made this the focus of their next training session at the surgical nurse forum.

The team also reviewed the number of similar reported incidents and identified that these had reduced in the period April – November 2017 compared with the same period in 2016.

One patient said staff repeatedly asked them to wait five minutes for pain relief but did not return and they had to call them again to remind them. Another patient told us if they needed pain relief the nurses were there straight away. One patient told us a nurse had to deal with three patients with dementia and they required so much attention that they did not feel able to ask for anything.

Nutrition and hydration

During our last inspection, we found that not all patients were screened for malnutrition as required by NICE guidelines. The trust target of 95% for completion of MUST (malnutrition universal screening tool) was not consistently being met. During this inspection, we found that trust target continued not to be met and that compliance varied significantly between wards.

We saw the completion of a MUST for patients was audited between March 2017 and March 2018. These showed 71% of patients were assessed against the trust target of 95%. There was wide variation between wards, for example the proportion of assessments carried out on patients on Rowan ward ranged from 12% in April 2017 to 79% in November 2017. The latest figures for March 2018 showed 82% of patients were assessed on Primrose ward, 56% on Rowan 56%, 88% on Sage and 83% on Sycamore. A MUST audit was not completed in Poplar ward in March 2018 because of staffing pressures.

A nutritional study day to raise awareness about the importance of nutritional assessments was provided by dieticians on 5 October 2017. Ward managers were producing action plans for presentation to the director of nursing at Ward Managers Forums monthly and nutritional link nurses were carrying out regular audits.

We saw from the records of staff safety meetings that ward managers were reminding staff about the importance of assessing patients' nutritional needs. At our previous inspection, we found that nutritional needs were not always being identified.

A nutrition board was located in an area nursing staff could access. Information about each patient's dietary requirements was recorded on the board recording, for example, if the patient required softened foods 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. A new contractor had recently taken over the catering service. We observed staff from the company discussing food choices with patients.

We saw two incident reports for inappropriate food being provided which did not meet patients' needs.

Patient outcomes

The trust provided us with information about the number of patients who returned to theatre following surgery. These showed there were 49 unplanned returns to theatre during the period April 2017 to March 2018. We saw the reasons listed which included bleeding or post-operative complications. This had improved from the previous inspection where the trust told us there were 94 unplanned returns to theatre between May 2016 and May 2017.

During our previous inspection, we found the hospital's performance in national surgical audits was mixed. In the 2016 Hip Fracture Audit, the hospital performed significantly worse than the national average in five key measures and fell within the lowest 25% of all trusts. The trust did not provide us with any evidence that action had been taken to address areas for improvement.

However, the results for the 2017 Hip Fracture Audit showed that there had been an improvement in several measures.

The risk-adjusted 30-day mortality rate for the hospital had improved to 5.8% from 7.3% in 2016, which was within the expected range and better than the national average (6.7%). The proportion of patients not developing pressure ulcers was 96.6%, which was better than the national average (95.6%) and had improved from 91.5% in 2016. This meant the hospital was no longer in the bottom 25% of trusts for this measure.

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The overall average length of patient stay was 22.1 days, which was an improvement on the 2016 figure of 23.6 days, although still slightly worse than the national average of 21.6 days.

The peri-operative medical assessment rate was 94.2%, which did not meet the national standard of 100%. However, this was better than the national average of 88.7%, despite showing a slight decline on the 2016 figure of 96.8%.

The proportion of patients having surgery on the day of or day after admission was 67.6%, which did not meet the national standard of 85% and was worse than the national average (70.6%). Performance in this measure had also declined from 2016 (79%).

The hospital continued to perform worse than the national average for case ascertainment (gathering and submitting data for all eligible patients). The hospital has submitted data for 294 patients to the 2017 audit, which represented 87.2% of all eligible patients. The national average for this measure was 95% putting the trust in the bottom 25% of all trusts for this measure. There was also a slight decline on the 2016 figure of 89.8%.

In the 2017 National Emergency Laparotomy Audit (NELA) the hospital had mixed results. Performance had declined in three out of six key measures and although the remaining three measures had improved, overall the hospital performed worse than the national average. During the last inspection, the clinical lead told us that work was underway to improve data capture and submission to NELA. In the 2016 audit, the hospital submitted data for only 12 patients, which represented only 8% of eligible patients (against the national standard of 80%). In the 2017 audit, this had improved to 36 cases (28% of eligible cases) but was still significantly worse than the national average of 82%.

We saw that the service had developed action plans in response to the results of both NELA and the Hip Fracture audit however, both action plans primarily focussed on improving data collection with limited focus on driving local improvements in patient outcomes.

In the 2017 Bowel Cancer Audit, post-operative mortality and unplanned readmission rates for surgery at the trust were within expected ranges. Case ascertainment performance was much worse than the national average (95%) at 44%, which had declined significantly from 89.1%

in 2016. However, audit was only provided for the trust as a whole and was not available by hospital site. Changes in audit methodology meant performance in post-operative length of stay was not comparable with data for the previous year, although the trust continued to perform worse than the national average for this measure.

The trust's Patient Reported Outcome Measures (PROMS) survey results for 2016/17 were generally in-line with national results. In the PROMS survey, patients are asked whether they feel better or worse after receiving the following operations: groin hernias, varicose veins and hip or knee replacements.

Competent staff

Data provided by the trust for between April 2017 and March 2018 showed that 92% of nurses and 95% of medical staff had completed an appraisal. This exceeded the trust's 90% target for appraisal and the position had improved since our last inspection.

Two band 7 practice development nurses had recently been appointed. Their role was to support staff appraisal and provide training and education. The practice development nurses shadowed newly qualified staff to provide advice and support. They trained staff to teach other staff and cascade the learning for example in tracheostomy care, dressings and continence. They also checked staff competencies for giving medicines. The practice development nurse provided cover on the wards to enable staff to undertake training. Their priorities include developing a ward orientation pack for students and new staff. They worked alongside colleagues in the trust's corporate education team to help staff access appropriate external training. Nurses whose performance needed to improve were supported by the practice development nurses.

Agency nurse's skills and competency were discussed and checked by the ward manager during their induction on the first day of their shift.

Teaching and development was incorporated into monthly surgical nurses' forum.

Tracheostomy patients were nursed on Primrose and Rowan wards only in Surgery. There were 39 staff, 43% trained on Primrose ward and 42 staff, 47% on Rowan ward.

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All acute speech and language therapists (SLTs) could access training to support patients with tracheostomies and also had access to the Bart's Health trachea simulation course.

We spoke with six junior medical staff who told us teaching and training within the service was good.

Multidisciplinary working

During our previous inspection, we found communication between some teams and clinical areas was poor and created challenges to effective multidisciplinary team (MDT) working. At this inspection, we found communication between teams had improved in some areas, for example between recovery and the wards. However, issues in some other areas, for example between pre-assessment and the wards were still being worked on.

We saw positive examples of multidisciplinary team (MDT) working on all the wards we visited. We spoke with therapy staff on one ward who described the work that had taken place to improve multidisciplinary working in response to previous concerns. We attended several of the daily MDT board rounds, which were attended by the nurse in charge, discharge coordinator, rehabilitation support worker, physiotherapists and an occupational therapist. The team discussed patients, updated their discharge plans and agreed what further action was required to enable patients' discharge. The MDT board rounds were well organised, each discipline was asked to contribute to the discussions. A whiteboard was updated with any information pertinent to the patients care plan or discharge.

We observed effective MDT working in theatres. Staff communicated effectively and there was good teamwork and collaboration. However, staff told us that a lack of effective communication between clinical and administrative teams continued to be an issue and sometimes led to theatres being underutilised. We were told that issues were not always picked up on until the day of surgery, which could lead to last minute cancellations and gaps in surgical lists.

Pre-operative assessment information was recorded on the hospital's clinical information system. The results of the assessment and patient contact details were also kept as hard copies as a backup in case of IT problems and patient details were unavailable. There were links to patients' GP records if patient lived in the local borough. Ward staff told us they only learned that a patient had special needs when

they arrived on the ward. They said information was either not identified or not passed on in order that they could make the appropriate preparation prior to the patient's arrival.

Nursing staff told us that most medical staff were approachable and they felt their opinions and contributions were valued and respected. Ward rounds took place daily led by consultant medical staff. Most wards had a mixture of patients from different surgical specialities as well as a number of patients who were medical outliers. Ward managers said this meant that up to nine clinical teams visited daily. Nursing staff told us this caused difficulties in communication as they were unable to attend all ward rounds and did not always know when they would take place.

We attended the hospital's bed management meetings and saw surgical services were represented by the ward matron. We saw examples of where teams worked together to resolve issues for example by reviewing and reallocating staffing between wards according to the number of patients and their needs.

Seven-day services

The pharmacy department was open seven days a week for medicines supply with an on-call service provided out of hours. The department was open between 9am and 6.30pm with an on call until 8pm on weekdays and 10am until 2pm at the weekends with a site-based on call available until 4pm. After this time, there was an on-call service available via switchboard.

The radiology department (CT, X-ray, U/S and MRI) was open Monday to Friday 9am to 5.30pm. The service was provided 24/7 for inpatients. MRI for inpatients operated from Monday to Friday 8am to 8pm.

The imaging team consisted of consultant radiologist, sonographers, radiographers and advanced practice-reporting radiographers. The team was supported by of imaging nurses and health care support workers.

Occupational therapy and physiotherapy provided a Monday to Friday service from 8am to 6pm with a prioritised weekend physiotherapy service for surgical patients. Prior to the introduction of the seven day prioritised service patients only had access to on-call physiotherapy at the weekends. On-call rotas were reviewed with the introduction of the seven-day service to

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ensure they were adequately staffed. All band 5 and 6 rotational physiotherapists participate in the on-call rotas. There was no occupational therapy service on the surgical wards at weekends.

Speech and language therapy provision (SALT) was provided an 8.30am – 5pm service Monday to Friday. Members of the SALT team attended ward rounds for tracheostomy patients and were members of the tracheostomy working group.

The dietetic service provided an 8.30am to 5pm service Monday to Friday. The dietitians operated a referral based system on the surgical wards.

Access to information

Staff told us patient information was stored on the computer and in paper records. They told us the computer system was not always updated which sometimes led to patients being listed under the wrong clinical team which caused confusion.

At our previous inspection, staff told us there were problems in theatres with the IT system. When we asked staff about this at this inspection they told us they had not experience any problems recently. A junior doctor told us that the IT systems worked well as there was just one system to access for clinical information, X-rays, order tests and review GP records.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

We observed that the majority of patients consented to surgery on the day of their procedure. When we spoke with the service's leadership team about this, they said medical staff were encouraged to discuss consent prior to admission, during outpatient consultations. They accepted that for the majority of patients consent was obtained on the day of surgery, which was not best practice.

The trust's consent policy stated that, "Consent should be obtained prior to any intervention involving contact with the patient. In most cases it would be inappropriate to ask a patient to sign the consent form on the morning of surgery or after they have begun to be prepared for treatment."

Consent was audited as part of monthly theatre peri-operative audit. We saw the results of nine audits for the period up to the end of March 2018. The results of the

audits showed there were two occasions where the information on the patient consent form did not match the information on the operating list. Another audit found one occasion where a consent form had not been completed because the procedure was undertaken as an emergency. In January 2018, the audit highlighted that there was no site marking on the patient but the information was included on the consent form. In the same month, the consent form was signed by the surgeon but they were not present in theatre and several patients' names were not recorded on the operating list.

Are surgery services caring?

Good



We rated caring as good which was the same as our previous rating because:

- The majority of patients described their care positively.
- We saw that staff treated patients with compassion and demonstrated a genuinely kind and caring attitude, even when the service was busy and staff were under pressure.
- We observed staff were professional and compassionate and worked as a team to support patients.
- Staff in theatres and on the wards ensured patients' dignity was maintained.
- Staff ensured patients' relatives were involved in discussions and decisions about care and treatment.

However:

- All the patients we spoke with told us how busy staff were particularly if there were patients on the ward living with dementia. Some patients told us they were reluctant to ask for assistance because of this.
- Several patients told us that they wanted clearer information about their care and treatment and communication between staff and patients could be better.
- The response rates for the friends and family test were low for some wards sometimes less than 10%.

Compassionate care

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Staff we spoke with were committed to providing good standards of care despite the pressures on staffing and the number of medical outliers on surgical wards.

The trust provided us with information from the friends and family survey for the period April 2017 to February 2018. This showed that in February 2018, 88% of patients would recommend Poplar ward to friends and family, 90% would recommend Primrose ward, 76% would recommend Rowan ward, 80% would recommend Sage ward and 80% would recommend Sycamore ward. The percentage of patients providing a positive response varied between wards, and over the period survey, with 68% to 100% of patients responding that they would recommend care on the ward.

However, response rates were low, sometimes less than 10%. In February 2018, response rates over the five wards varied between 7% and 12%. Response rates for Sycamore and Sage wards results were generally better than other wards with 100% in one month.

In the course of our inspection, we spoke with 21 patients. The majority of patients gave us positive feedback about staff; including one patient who told us staff were, “amazing.” However, most patients told us they thought there were not enough staff. Five patients told us they waited longer for pain relief or to go to the bathroom than they wished.

All the patients we spoke with told us they were treated with dignity and respect. We observed that staff took time to ensure that patients’ privacy was respected, for example, by drawing curtains around the patient’s bed when they were providing personal care. We also observed staff in theatres ensuring patients were covered up during surgery.

One member of staff we spoke with described an incident where a member of staff had spoken inappropriately to a patient. The member of staff told us that they reported the incident and the ward manager immediately dealt with it.

Staff were allocated to work on particular bays. Staff told us this helped them get to know the patients on their bay. We saw good examples of positive interactions between staff and patients, with staff taking time to explain things to patients and to listen to their concerns. All the patients we spoke with told us medical staff were very helpful and able to answer their questions. One patient told us they had spoken with a specialist nurse who had reassured them about coping with a stoma.

We saw therapy staff were actively involved to support patients to be as soon as possible following surgery. Therapy staff assessed patients on the ward and some patients attended the therapy department for rehabilitation. Ward staff were asked to encourage patients to mobilise as soon as possible to build their confidence as well as to regain strength and mobility.

Understanding and involvement of patients and those close to them

We observed patients being admitted to the ward and saw staff introduce themselves and describe the role and other members of staff would play in providing their care.

Staff told us all patients should know four things – what is their diagnosis, what was happening to them that day, when they were going home and what needed to be put in place for them to go home. We found most patients were aware of their planned discharge date. Some patients, for example medical and general surgery patients told us they did not understand why they were on an orthopaedic ward. They said no one had explained the reasons for this to them.

We observed staff discussing patients’ preferences for sharing information with family members and the best way of keeping them informed. We spoke with a relative who told us they were kept informed if their relative’s condition changed and staff told them they could ask questions or for an update when they visited. We observed patients being discussed at one of the huddle meetings. Nursing staff reported that one patient had a joint assessment with their family to discuss their needs and how they should be supported when they returned home. Another patient was due to go home later that day. Ward staff had rung the patient’s relative that morning to confirm they were going home to give them time to prepare and check if there were any problems with transport or anything else the ward should do to prepare the person for discharge.

We observed a multidisciplinary meeting on Sycamore ward. Members of the patient’s family attended and they were able to contribute to the discussion about their relative’s care.

Staff on one ward told us they encouraged the relatives of patients with dementia to write a little note when they

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visited. They said patients with dementia sometimes became distressed if they could not remember when their relative last visited. Recognising the handwriting and understanding their relative had visited reassured them.

Several patients told us that they wanted clearer information about their care and treatment and communication between staff and patients could be better. We spoke with one patient who told us they felt staff did not listen to their concerns. They described how they had been in pain and spoke to several staff before one nurse realised what the problem was and organised the appropriate intervention. Another patient was concerned about communication with social services. They said they were due for discharge but they could not go home until their care was organised and staff on the ward seemed unable to tell them what was happening. One patient told us they had moved ward four times since they were admitted. They said no one ever explained why they were moved. Another patient told us medical staff seemed unable to decide what was wrong with them and they were told different things by different doctors.

Emotional support

We observed staff discussing a patient's needs and suggesting the person might benefit from the help of a befriending service to counteract loneliness.

Theatre staff reassured patients as they waited for surgery. They told us they understood patient's anxiety and the need to provide clear communication and reassurance.

Clinical nurse specialists (CNSs) were available to provide additional support for patients over and above the support provided by ward nurses. CNSs were specialists in their field and were able to answer more detailed questions about patients' conditions. They were also able to provide additional information or suggest where patients could access further advice and guidance.

Eye clinic liaison officers (ECLOs) provided ophthalmology patients with both emotional and practical support. ECLOs helped patients understand their diagnosis, deal with their sight loss and maintain their independence. They spent time with a patient to discuss the impact the condition may have on their life.

Colorectal services provided emotional support to patients undergoing stoma-forming surgery by offering

pre-operative counselling and 'buddy' system peer support. Patient support group meetings were held monthly in the local community to support patients post-procedure.

Patients' spiritual needs were met by a multi faith chaplaincy centre on site. Spiritual support was available for Muslim, Catholic and Hindu patients in the form of prayer rooms and services. Access to pastoral, spiritual or religious support from the chaplaincy team was available 24 hours a day via an emergency phone number.

Are surgery services responsive?

Requires improvement



At our previous inspection, we rated responsive as inadequate. At this inspection, we rated this responsive as requires improvement because:

- The overall 18-week referral to treatment time (RTT) performance for patients waiting for surgical specialties at the hospital had improved from 69% to 79% since our previous inspection. However, this was still lower than the 92% national indicator.
- The hospital was still not publishing waiting times. A new patient-tracking list was in the process of being rolled out with plans for this to be in place by August 2018.
- Surgeries were cancelled without notice given patients due to lack of available beds and over-running and late starting theatre lists. Cancelled operations as a percentage of elective cases booked was 1.8%, which was slightly worse than the cancellation rate for the previous 12 months (1.6%).
- Theatre utilisation rates had shown some improvement but were still below the trust's target. Theatre utilisation rates for the period April 2017 to February 2018 across the 10 main theatres varied between 68% and 72% against the trust's target of 85%. Performance had improved at our previous inspection but further improvement remained a high priority for the service.
- Patients continued to be discharged out of hours (after 8pm) due to delays including waiting for medication.

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- Staff told us the handover of information from pre-assessment to the wards post operatively was not robust. Ward staff told us the first time they were aware a patient had special needs was when they arrived on the ward after surgery. They told us patients were admitted to whichever ward had a bed available. A nurse from the pre-assessment unit was working with the ward managers to improve the process.
- There was no facility for confidential discussions with patients. Patients with special needs such as those living with dementia or a learning disability waited for their procedure in the recovery alongside patients who had undergone surgery. There were not always enough staff to provide one to one care for patients requiring additional support.

However:

- The patient discharge process had improved and was managed more effectively. There were daily meetings where staff discussed all aspects of a patient's discharge. Patients were all given an estimated date of discharge. Discharge co-ordinators liaised with community services and local authorities to inform them about planned discharge dates. They ensured equipment and care packages were in place in time for discharge.
- The trust told us that there had been no breaches of the 28 day standard and that all patients were re-booked within 28 days of a last-minute cancellation.
- The time taken to respond to complaints had improved. At our previous inspection, 14% of complaints were responded to within the trust's target of 25 working days. At this inspection, 79% of complaints were responded to within 25 days.
- Doctors from medical specialties were visiting medical outpatients on surgical wards. This was a recent development but ward staff told us this was a welcome development ensuring patients with complex long-term medical conditions received appropriate medical care.
- Staff could access support from a mental health team specialising in dementia.

Service planning and delivery to meet the needs of local people

Since January 2018, and at the time of our inspection, Poplar and Sage wards were being used as 'surge' beds.

These were beds re-designated to accept patients from a range of specialties, admitted as emergencies over the winter period. The trust informed us this was a temporary measure and the wards would return to their original functions once winter pressures subsided. Sage ward usually functioned as an elective orthopaedic ward. However, elective orthopaedic surgery was suspended over the winter months. During our inspection, the ward was being used for emergency orthopaedic surgery. Patients from other surgical specialties and medicine were also on the ward. The trust told us they planned to reopen Sage ward as an elective orthopaedic ward but were unable to do so because of the volume of emergency work.

The surgical division's strategy described how the service would meet the needs of the local population. The population of Waltham Forest was estimated to be 268,000, and was expected to grow by 32,500 by 2021. The largest projected growth was under 20s and over 50s, which meant a potential increase in patients dealing with chronic diseases. Significant growth in the proportion of people over the age of 61 was predicted to be greater than in the other East London boroughs. Patients were more likely to be over 80 years old with a high risk of dementia. The service recognised it brought considerable challenge when considering the provision of health and care services.

The service also recognised the importance of working with partners across the local health and social care system to provide integrated care, ensuring patients were discharged from hospital appropriately with the right support in place, resulting in reduced lengths of stay and fewer delayed discharges.

Access and flow

During our previous inspections, we identified that poor collaboration, communication and lack of understanding between different clinical areas within the service resulted in staff blaming each other for poor patient flow. The national 18-week incomplete pathway referral to treatment time indicator was not met by most surgical specialties and procedures were being cancelled due to a lack of beds and over-running theatre lists.

At this inspection, we found there were still issues with waiting times and patient flow, including delays, cancellations, and staff awareness of patient's individual support needs. However, communication between recovery and the wards had improved.

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The trust provided us with referral to treatment waiting times (RTT) for surgery for the period April 2017 to February 2018. The figures showed that the RTT for February 2018 was 79.7%. This was an improvement on the previous inspection when the figure was 69%. However, this was still lower than the national indicator for patient waiting times, which was 92%. Performance had improved in most specialties with trauma and orthopaedics at 77.4% compared with 61% at our last inspection, general surgery at 76%, previously 62%, urology at 82.2% compared with 64% and ophthalmology 84.3% compared with 67%, ENT 83.2% compared to 78%. Performance in breast surgery was above the national standard with 95% of patients admitted within 18 weeks. The services inability to meet RTT was the top risk on the risk divisional risk register.

The trust was reviewing the processes in place to enable the service to measure RTT performance. A new patient-tracking list was in the process of being rolled out with plans for this to be in place by end July 2018. The trust suspended monthly mandatory RTT reporting from September 2014 onwards because of data quality concerns. The trust was preparing to return to national reporting in May 2018.

Between April 2017 and March 2018, 1,167 patients had their operations cancelled on the day surgery was due to take place. These represented 9% of all elective cases booked (13,135). Of these last-minute cancellations, 240 were cancelled by the hospital for non-clinical reasons. The service's cancelled operations as a percentage of elective cases booked was 1.8%, which was slightly worse than the cancellation rate for the previous 12 months (1.6%).

Of these 1,167 cancelled procedures, 742 (64%) were patient-initiated, with 239 recorded as patient 'did not attend' (DNA). There were 240 hospital-initiated cancellations for non-clinical reasons, which included: lack of time (56), lack of beds (62), emergency priority (45), lack of staff (30) and equipment issues (26). The trust recorded that 185 procedures were cancelled for clinical reasons either because further tests or investigations were needed or the patient was unfit for surgery.

In the same period, there were 167 repeat cancellations, of which 31 were cancelled by the hospital for non-clinical reasons due to lack of beds (12), equipment issues (5) and lack of time (5).

The trust told us that there had been no breaches of the 28-day standard and that all patients were re-booked within 28 days of a last-minute cancellation. Although this showed an improvement on the trust's previous performance against this standard, data provided by the trust showed that the number of repeat cancellations for the same period had increased (167 compared to 21 during the previous 12 months).

The surgery division's improvement plan included a project for reducing non-clinical theatre cancellations on the day of surgery due to theatre over-runs. A target was set to reduce the cancellations to less than 5% of the total procedures undertaken. Senior staff told us that daily operations meetings were improving the monitoring and management of any problems.

Theatre utilisation rates for the period April 2017 to February 2018 across the 10 main theatres varied between 68% and 72% against the trust's target of 85%. Performance had improved from our previous inspection where utilisation ranged from 41% to 82%.

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 last inspection where 79% of lists started late between November 2016 and April 2017.

Data provided by the trust showed that only 20% of late starting lists had reasons recorded. The trust told us that reasons for delay had not been routinely recorded but a new process was now in place and going forward the theatre delivery manager was ensuring this information is captured.

Reasons recorded for delays included: patients were not prepared on time by the ward (52), the order of the list was changed (44), the first patient was cancelled (44), surgeon was unavailable (42), incomplete paperwork (41), no porter to transfer (35), previous case ran over (34), and no ward bed (32).

At our previous inspection, we saw that patients frequently stayed in recovery overnight because there was no ward bed available. The hospital's standard operating procedure (SOP) for the use of theatre recovery overnight had been

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reviewed and updated in August 2017. The SOP stated clearly that it was not appropriate to keep ward-ready patients in recovery overnight and patients could be only kept overnight in recovery for clinical reasons.

Between April 2017 and March 2018, 85 patients experienced an overnight stay in recovery. This was a significant improvement compared to the 166 patients for the previous 12 months. Data provided by the trust showed that only three patients had stayed overnight in recovery in the past six months. All three patients were recorded as requiring intensive or high dependency care. For the same period, 12% of patients experienced a delay between recovery and transfer to the ward. The trust told us they did not currently record reason for the delayed transfers but planned to collect this information going forward.

Between April 2017 and March 2018, 534 (7.4%) of patients were discharged out of hours (between 8pm and 8am). This was similar to what we found when we last inspected (7.3%). The proportion of patients discharged out of hours was similar each month ranging from 5% - 8% of patients. Staff told us that one of the main reasons for delays in discharging patients was waiting for medicines.

The trust carried out a discharge planning audit in August 2017. As part of the audit, discharge planning checklists were reviewed for completeness and the reasons for any delayed discharges and transfers of care (DTC) were identified. The audit found that the main reason for delays was that patients were waiting for medicines to take home. This accounted for up to 50% of delays on some wards.

The audit showed that only between 10% and 20% of patients' prescriptions been prepared. This meant that ward staff were waiting for doctors to write up patients' prescriptions before they could submit them to the pharmacy to enable the medicines to be dispensed. Data provided by the trust showed that the pharmacy team met four out of five dispensing key performance indicators (KPIs) between December 2017 and March 2018 with 85% of urgent or more urgent discharge medicines (TTAs) being dispensed within one hour and non-urgent TTAs within three hours.

The discharge audit also reviewed whether an estimated discharge date (EDD) had been agreed between medical and nursing staff. Results were mixed for surgical wards, varying between 16% of patients having an EDD set on Primrose ward and 89% of Sage ward. Overall, only 55% of

patients on surgical wards had an EDD agreed. The audit found that the majority of patients with an agreed EDD were aware of what this was, although the orthopaedic wards (Sage and Sycamore) performed poorly in this area. Similarly, the orthopaedic wards performed significantly worse than the general surgery wards for multidisciplinary team (MDT) and next of kin involvement in, and awareness of, the patient's discharge arrangements.

Although the audit identified a number of important areas for improvement within the discharge process there was no evidence of any action plan to address these. It was not clear from the service's audit plan when the next discharge audit was due to take place.

Nursing staff told us the discharge process had improved significantly compared with a year ago. Occupational therapists assessed patients home equipment needs before it was ordered by district nurses. Therapy staff told us discharge pathways were much more effective although still challenging for patients who lived outside London.

The medicine directorate had designated teams to support the review of medical outliers on surgical wards. The respiratory team were responsible for reviewing medical patients on Primrose ward, an ortho-geriatric consultant looked after patients on Sycamore ward, a further medical team supported patients on Rowan and Sycamore ward, and the metabolic team reviewed medical patients on Poplar ward. We observed physicians reviewing patients on surgical wards. Staff told us this was a recent development but they welcomed the support. They told us medical patients added to the complexity of the case mix on the ward and it was preferred for them to be supervised by medical staff who understood their needs.

The surgical division's quality improvement plan aimed to produce a standard operating procedure which would describe the processes clinical teams would follow when reviewing patients. The plan showed the work was due to be carried out between February and May 2018 but this had slipped.

The hospital was participating in a London wide improvement collaborative aimed at improving urgent care. Ensuring patients moved through the system as quickly as possible was a key focus. The survey took place at 17 sites that allowed practice between sites to be compared. 'Day of care' surveys were carried out over two days in October 2017 on all inpatient beds to identify how

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the treatment and discharge process could be improved. On the day of the survey, the site was at 98% occupancy with 11 patients in the emergency department awaiting admission. 46 patients (10%) were considered to be in a ward bed not related to their main specialty needs (outliers) which was higher than average compared to the other London sites. Seventy-five patients (17% of the beds surveyed) did not meet the criteria for an inpatient acute stay; although this was good compared to the other London sites.

The survey included a review of delayed discharges and found that 28% of the delays were in control of the hospital and 69% due to the wider system in the community.

Meeting people's individual needs

Staff told us there were systems in place to support individuals with additional support needs but we found that these were not always effective or consistently applied by staff. For example, we saw an incident where a patient with a learning disability was listed for surgery with a local anaesthetic despite the consultant stating that they required a general anaesthetic. The patient's surgery was cancelled and had to be re-booked. However, we also saw an example of good responsive care of where a patient with a learning disability was admitted as an emergency. Staff contacted the hospital's learning disability lead to inform them about the patient's admission and contacted the patient's carer to obtain their patient passport, which contained important information about their health and other needs.

There was a learning disability nurse on Plane Tree (day case) ward available to assist patients with a learning disability. However, there was no facility for confidential discussions with patients and patients with special needs such as dementia or a learning disability waited for their procedure in the recovery alongside patients who had undergone surgery.

The hospital did not supply dosette boxes even for patients who were admitted with one. Dosette boxes are used to organise the medicines patients required on a daily basis. Patients could take their medicines without having to access different packets or other containers and they are particularly helpful for patients who might forget about their medication regime. Nurses report this often causes delays to discharge. Practice at Whipps Cross Hospital was different in this regard to other sites within the trust which

did provide medicines to take home in dosette boxes. The site pharmacy lead told us they did not have the capacity to provide this service. Of 25 charts we reviewed, three patients were on dosette boxes pre-admission.

The trust provided a language service for patients, relatives and carers who either did not speak English as a first language or were users of British Sign Language. The service was available from 9am to 5pm, Monday to Friday. Services operating outside of these hours were also provided in some circumstances. The service was known as the bilingual health advocacy and interpreting service (BHAIS). Access to interpreting support over the telephone was available 24 hours a day. We saw a leaflet with the telephone number and an explanation in 34 languages explaining how to contact the service.

Health advocates could be contacted by bleeps and could attend ward rounds and meet with patients on the ward if requested. The service covered a wide range of languages including sign language and 'touch communication'. Health advocates and interpreters could be booked to attend appointments in various clinics and locations. Staff and patients were encouraged to use the service rather than relatives or staff acting as interpreters as they were not trained as interpreters, there was a risk for confidentiality to be breached, and staff recognised it was not best practice.

Staff working in the pre-assessment unit told us that the assessment process aimed to identify individual needs and signposted patients to the relevant services for example the learning disability team or dementia, drug and alcohol liaison team and mental health teams. Staff carrying out pre-assessment also referred patients to the safeguarding team if the person was vulnerable or risk of abuse was identified. Information about patients' needs was shared with the anaesthetic team and a plan was prepared for admission and their anaesthetic. This information was flagged up on the hospital's patient information system and on the documentation which appeared on the theatre list. A patient alert was available on the trust's patient administration system to alert the clinical teams of vulnerable patients. Any adjustments needed were discussed once a date for surgery was identified, for example, putting the patient first on the list, reducing the time the person had to wait and their anxiety. Staff told us

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they involved carers, social care where appropriate and GPs to gather information and plan a safe admission for a patient in particular around medication and pre-operative fasting.

We were told that information gathered before the operation was shared with post-operative wards to enable them to access further support. However, ward staff told us the first time they were aware a patient had any additional support needs was when they arrived on the ward after surgery. They told us patients were admitted to whichever ward had a bed available. Staff told us the handover of information from pre-assessment to the wards post operatively was not robust. The ward sister from the pre-assessment unit was working with the ward managers to improve the process.

Between April 2017 and March 2018, the hospital recorded 518 'failed' day cases (4.7% of all booked day cases), where day case patients had been admitted as an inpatient following surgery, rather than going home on the day as planned. This was similar to rate we found when we inspected previously. Staff told us that there were sometimes issues with communication with the pre-assessment team which meant that patients were wrongly recorded as a day case rather than an inpatient.

Sycamore ward had recently been refurbished. The service had taken the opportunity of making the ward more dementia friendly by providing large yellow clocks and skylights which enabled patients to see the sky above the ward. There were also large colourful paintings and pictures which helped patients distinguish between different areas of the ward. In the waiting area of pre-operative assessment unit there was a 'dementia friendly' clock and a radio which staff had fundraised to buy.

The dementia team included clinical nurse specialists, dementia nurses and dementia support workers. A dementia nurse attended the surgical board rounds if the ward had any patients with dementia. All staff wore yellow name badges, which were easier to read for patients with dementia.

As part of the process of intentional rounding ward staff checked patient call bells were being answered promptly. We observed call bells were answered and staff were

directed to respond to patients if a call bell was activated. The hospital did not have a specific audit programme for monitoring call bell response times and that call bells were not connected to an automated recording system.

The ward managers told us they if they had a patient with dementia they tried to provide one to one support, however, staffing levels meant this was not always possible. We observed a support worker was supporting several people with dementia in one ward bay. One patient was quite distressed and seemed to be disturbing other patients. Another patient told us patients with dementia had kept them awake for several nights and they had taken a pillow and slept on the corridor. Staff said it was upsetting not to be able to provide patients with a better environment.

At our last inspection, the trust told us they had recently introduced 'enhanced care' to the wards to provide additional support to patients who required it, to involve carers and family in the care of patients. The enhanced care document bundle provided a comprehensive pathway to help identify each patient's support needs.

We saw the results of an enhanced care audit carried out in September 2017. The audit showed that 100% of patients identified as requiring enhanced care (EC) had an EC care bundle in place but only 20% of documentation was fully completed. 20% of patients had a documented daily review but no patients had a documented senior review. We spoke to eight staff about the enhanced care process. We found staff understood the process but they told us they did not always have time to complete the necessary documents.

Learning from complaints and concerns

The service received 172 formal complaints between April 2017 and March 2018. This had increased from 61 complaints the previous year. Of these 172 complaints, the trust told us that 11 were open at the time of our inspection. The proportion of surgery complaints meeting the agreed deadline was 79% against the trust's target of 80%. This was an improvement on the previous year's performance when only 14.5% of complaints were responded to within the 25-day target.

Of these complaints, 49 related to surgical wards, with almost 15 relating to Plane Tree (day case) ward and 16

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relating to orthopaedic wards (Sage and Sycamore). The most common reasons for complaints related to delays and cancellations (74), dissatisfaction with treatment or diagnosis (61) and poor communication (19).

There were three how to complaint leaflets on the table in one of the waiting areas on the pre-assessment unit. These were not easy to see as hidden behind another leaflet. We did not see any posters explaining how patients could complaint or provide feedback about the service.

One patient told us that they had made a complaint about a member of staff speaking to another patient disrespectfully. They told us that the nurse in charge took their concerns seriously and told them the matter was being investigated but they had not heard anything further about the outcome.

Are surgery services well-led?

Requires improvement



At our previous inspection, we rated well-led as inadequate. At this inspection, we rated well-led as requires improvement because:

- We noted improvements since our last inspection this included making the service safer for patients and more responsive to their needs. However, a number of areas of concern highlighted during our last inspection still needed to be addressed by the service.
- We were not assured that there was sufficient management oversight of risk. Problems with medicines management had been highlighted; both by internal audit and external review, but the scale and extent of the issues had not been identified or addressed by the leadership team.
- The hospital's clinical governance structures had been further developed. However, the leadership team acknowledged there were still issues with attendance rates at clinical governance meetings.
- The service had made some progress with recruiting nursing staff and reduced the reliance on agency staff, however, patients and ward staff told us staff were

under pressure. Staff employed by the trust had an additional workload because temporary staff were not able to carry out all the tasks permanent staff were required to undertake.

- The results of the NHS staff survey showed the response rate for surgical and cancer services at Whipps Cross Hospital improved from 29.4% to 34.7%. Although the response rate had improved, it remained lower than the overall trust response rate of 47.8%.
- The service performed significantly worse than the trust average in 33 of the 88 staff survey questions including in questions about: interactions with managers, bullying and harassment and their confidence in organisation addressing concerns about unsafe clinical practice.
- Improvements were being made to the referral to treatment time (RTT) monitoring process but the hospital was still not reporting waiting times externally. During the previous inspection, managers told us that the trust were on track to start re-reporting RTT in October 2017, however, this had been delayed. The surgical division's quality improvement plan showed May 2018 as an anticipated date.
- Staff turnover rates were slightly worse, at 13.7%, when compared with 12.9% at our last inspection.

However:

- The leadership team had developed an action plan in response to the staff survey incorporating approaches that had worked successfully in theatres.
- A strategy had been developed outlining the key objectives for surgical services. Individual specialties had reviewed their strategic objectives.
- A nursing strategy had been developed addressing quality and safety issues as well as staff development, training and education.
- A quality improvement plan for surgery had been developed. This included a range of improvements to patient's pathways and the environment.

Leadership

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The surgical service had a site based leadership team. The surgical service had a site based leadership team. A clinical director, associate director of nursing (ADoN) and two divisional general managers provided leadership of the service.

Staff we spoke with told us they found working conditions challenging. There had been a number of initiatives aimed at making improvements but the wards were so busy that it was not always possible to achieve change at the pace managers expected. We heard mixed reports about recent management changes. Some staff told us managers were visible and approachable others said they rarely saw managers and that they were not always responsive when staff raised concerns for example about staffing levels.

Some staff told us they lacked leadership continuity after the associate director of nursing for surgery left (ADoN). There had been a gap of several months between the previous ADoN leaving and the new ADoN starting. A new ADoN had been appointed who took up the post the week before our inspection. A new ward matron had joined a few months prior the inspection, one ward manager had only been in post for a month and there were some wards without a permanent ward manager. The situation in theatres was more stable; they had a more consistent management team, which meant they had been able to address many of the issues highlighted in our previous report.

Vision and strategy for this service

We saw a presentation which described the surgical division's strategy. The service aimed, "To be a high performing department within Whipps Cross and Barts Health. Providing safe, compassionate, high quality care for our patients as well as achieve financial and operational sustainability".

The strategy described the key challenges of recruiting nursing staff and providing services in an environment which was over 100 years old. A larger scale redevelopment of the hospital site, including surgery, was also being discussed. This included a programme of internal and external involvement and consultation. Capital investment was considered a high priority and it targeted refurbishing existing underutilised estate within theatres rather than

new build. The leadership team recognised site redevelopment would take around 5-10 years to complete and wanted to ensure the current facilities did not deteriorate further.

The service's strategy included implementing two methodologies for improving quality and safety on surgical wards. Staff were able to tell us about the 'safer' and 'perform' - work programmes and we saw this in action where staff met at several points in the day to review patient's care. They were also used when staff planned discharge and chased up any outstanding processes for example trying to find suitable nursing or residential home placements. Discharge planners liaised with local authority's social services department to organise home care support or residential placements. Discharge meetings involved a wide range of healthcare professionals including therapists, medical staff service managers and discharge planner. Staff described how they had been helped to work as a team to co-ordinate and plan patients' care.

The division planned to improve their referral to treatment time (RTT) performance. The strategy described how this would be achieved by ensuring each speciality had a plan to achieve delivery of the RTT standard. This was governed through the weekly access standards meetings and outcomes were reported to hospital management board. The strategy committed the leadership team to involving and engaging clinicians so they felt empowered to deliver the solution and were fully informed.

We observed patients on surgical wards from other specialties including medicine. New arrangements had been recently introduced where teams of doctors from medicine visited outlying medical patients on surgical wards. Nursing staff told us they found this helpful but it meant there were a large number of clinical teams visiting the wards throughout the day and it was difficult to keep track of all the clinical decisions made. When we spoke to the leadership team about this, they told us their strategy was not to have specialty led wards. They described how emergency admissions had increased so significantly over the winter months they had no alternative but to accommodate medical patients on surgical wards. Staff we spoke with understood the pressures the service was under but said the complexity of the speciality mix combined with the challenges of recruiting permanent staff made the provision of high quality care challenging.

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The leadership team told us they acknowledged the pressures staff were feeling and that this had contributed to the responses they received in the staff opinion survey. They highlighted some changes and discontinuity in nursing leadership, which had contributed to delays in developing and implementing an effective improvement strategy. It affected surgical wards and less theatres where the leadership was more stable. However, they had recruited to vacant posts and were adopting a new approach to recruitment, which they hoped would be successful.

A workforce plan had been developed with a focus on reducing the use of agency staff. Reductions in the use of agency staff was to be achieved through increased recruitment into substantive post using overseas recruitment and 'one stop' recruitment days. Staff engagement activities were also being led by the 'people and values committee'.

The strategy also covered the development of effective governance, risk management framework and strategy and promoting nursing staff's understanding of the trust's vision and values. An organisational development programme was planned to develop a better understanding of 'human factors' which influenced the quality of care. Several workforce projects were underway for example a theatre productivity work stream.

The division was also working on service improvement by redesigning emergency and ambulatory care pathways. A trajectory for reducing non-elective admissions by 3% each year for 2018/19 had been agreed. The division was working with colleagues from the trust's other sites to develop proposals for adult and children's' surgical hubs and new ways of delivering outpatient services.

Within the wider divisional strategy, individual specialities had their own strategies. For example, the urology service aimed to "be the safest urology department in the UK, serving the needs of the community in the most innovative ways possible, promoting collaborative working with community teams to provide care as close to home as possible".

The vision for ophthalmology was for "Whipps Cross to upgrade to a specialised eye hospital based on the hospital site."

General surgery's strategy was to "develop surgical hubs, to give patients access to the right treatments, in the right place at the right time".

ENT's strategy (ear nose and throat department) was to "improve patient flow by expanding capacity of sub specialities and complex work to cater to the growing population demand".

The strategy for orthopaedics was to "develop pathways with the other Barts Health sites to ensure that services across the group are accessible to all patients".

Staff we spoke with on the wards were not aware of the division's strategy. They told us pressures on the wards made it difficult for them to get involved in anything not concerned with the day to day running of the wards.

Governance, risk management and quality measurement

We were not assured that there was sufficient management oversight of risk. We found significant safety concerns with medicines management on the surgical wards.

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 our last inspection, we found clinical governance structures were not well embedded and that there were inconsistencies in the quality, content, and structure of clinical governance meetings across surgical specialities. At this inspection, we reviewed a sample of clinical governance meeting minutes provided by the trust across a range of surgical specialities and found that although there were still inconsistencies in quality of format and content, there was evidence of a clear structure and set agenda in most specialities. However, the service's leadership team acknowledged there was further work required and that meetings were not always well attended. The meeting minutes for general surgery were the most inconsistent, with the minutes for the most recent meeting in March 2018 documenting that due to poor attendance the meeting was not quorate and therefore staff present were only able to have a limited discussion.

The leadership team told us they discussed risks at every management team meeting to identify what further action

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could be taken to mitigate the risk. The risk register for surgery and theatres contained 48 items. At our previous inspection, we found many items had been placed on the risk register several years ago and these had not been revised or reviewed.

At this inspection, we found that all the items had a review date in 2018, with most risks due to be reviewed in July 2018. The risk register contained information, which rated risks according to likelihood of occurrence and severity of impact. The initial level of risk and target level of risk were identified when the item was first raised and then again when the risk was reviewed. The consequences of the risks were described as minor, medium or major. Each risk had 'controls' identified. Of the items recorded on the risk register 26 related to equipment which was obsolete or needed replacement. These included 15 anaesthetic machines. The anaesthetic machines were causing problems on a daily basis resulting in delays to lists starting. When we asked the leadership team about this they told us the trust was planning to make a bulk purchase for several sites but they did not know when this would be.

In January 2018, the service had undergone an external review led by NHS improvement. The purpose of the review was to provide the trust with independent assurance on the implementation and outcomes of the improvement plan, following the previous CQC inspection. The review team made several recommendations based on their findings, including that the trust should ensure close attention was made to improving practices around the safe storage of medicines. At our inspection, we found that there were significant safety concerns with medicines management on the surgical wards. Access to medicines, including controlled drugs was not appropriately restricted and the trust's medicines management policy was not being followed in relation to medicines storage. Expired medicines were in stock on all of the surgical wards we visited. It demonstrated a significant risk to patient safety and a lack of oversight and governance of medicines management, these risks were not reflected on the service's risk register.

We saw anaesthetic governance presentations used as part of monthly governance events held in December 2017,

January and February 2018. The minutes from these events showed that incidents, never events, complaints, mandatory training, audits and risks had been reviewed and discussed.

We saw the programme for an ENT department audit (half day in March 2018), which showed morbidity and mortality data was reviewed, recent serious incidents discussed including the key learning points and the results of recent audits presented.

Culture within the service

Staff told us they felt the management of the service had improved and there was a focus on recruitment. They said there had been a meeting with the leadership team where staff could discuss how to make improvements. They discussed the staff survey results and felt as if managers were listening to the concerns raised. They said this was the first meeting like this and felt it was a good development.

At previous inspections, staff told us they were unhappy with their working environment. At this inspection, the majority of staff we spoke with were concerned about pressures on the ward staff. Some staff told us their managers were not responsive to their concerns whilst others told us recent management changes had a positive impact. Some staff said staff felt so under pressure that they decided to change jobs.

At our previous inspection, we learned that a number of staff had left the hospital in the previous six months. Data provided by the trust for the 12 months up to March 2018 showed that overall turnover for all nursing staff at the hospital ranged between 11.8% and 13.7% in March 2018 compared to 13.8% to 12.9% for the rest of the hospital. The turnover rates were slightly worse than the overall rate of 12.9% at our previous inspection. Sickness rates were similar to the rest of the trust ranging from 3.28% to 3.47% against the trusts target of 3%.

Staff on some wards told us the continued reliance on agency staff resulted in additional work for the permanent staff because there were many tasks agency staff were unable to complete, for example, agency staff were not able to sign the controlled drug registers. Figures supplied by the trust showed the shifts filled by bank staff had increased and the number of shifts filled by agency staff had reduced.

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At previous inspections, we identified poor collaboration and communication between recovery area team and ward's staff. Staff told us efforts had been made to improve the situation but there were still problems which resulted in patients waiting for beds. The leadership team described how patients no longer stayed overnight in recovery area whilst they waited for a bed on surgical ward. The number of incidents recorded in relation to this issue had consistently reduced over the last 12 months.

In the 2017 NHS staff survey, the surgical service performed worse than the trust average in questions about bullying from managers and colleagues. Seventy-four percent of staff agreed with the statement that they had 'not experienced harassment, bullying or abuse from managers' (81% trust average) and 68% agreed with the statement that they had 'not experienced harassment, bullying or abuse from other colleagues' (trust average of 75%). Responses to both questions had declined from the previous year by 4% and 5% respectively.

Public engagement

Patients' views were gathered through the NHS Friends and Family Test. However, individual ward response rates fluctuated and were generally very low, between 7% and 12% for the five surgical wards in February 2018.

Staff engagement

The service had recently received the results of the 2017 NHS staff survey. This was an annual on-line survey, carried out between September and December 2017. The survey questions were the same as the previous year, which meant the results could be compared. The response rate for surgical and cancer services at Whipps Cross Hospital improved from 29.4% in 2016 to 34.7%. However, it remained lower than the overall trust response rate of 47.8%.

Responses for 33 of 88 questions asked were significantly worse for the service than the trust's average. Areas where the results were worse included, staff being able to make suggestions to improve the work of their team or department (61% compared with 72%), being involved in deciding changes that affect work (39% compared with 52%) and feeling satisfied with recognition for good work (41% compared with 51%). Only 22% of staff responded that they thought there were enough staff to do their job properly compared with an average of 31% across the trust.

Staff responses to the majority of questions about managers were significantly worse than the trust average and were very similar to the results of 2016. Questions where the service performed significantly worse than the trust average included: 'I know who senior managers are' (71% against 82%), 'Communication between senior management and staff is effective' (32% against 42%), 'senior managers try to involve staff in important decisions' (25% against 36%) and 'senior managers act on staff feedback' (22% against 35%).

The service scored better than the trust average in eight questions. These included access to training which helped staff stay up-to-date with their professional requirements (92% compared with 89%) and identifying development needs at appraisal and performance reviews (79% compared with 76%).

However, more staff, than during previous years, reported that they were not supported by their manager to receive training, learning or development and that they did not feel valued in their appraisal. The deterioration was particularly noticeable in comparison with the rest of the organisation. There was also a significant decline in staff confidence that the organisation would address concerns about unsafe clinical practice.

Areas where results had improved on previous year's included feedback about changes made in response to reported errors, the organisation making adequate adjustment(s) to enable staff to carry out work, and updates on patient/service user feedback in the directorate/department. Results had also deteriorated for questions related to harassment from patients/service users, their relatives or members of the public and in questions about bullying from managers and colleagues.

When we discussed the results with the leadership team, they acknowledged that there had been little improvement in the staff survey results. They told us they now fully understood the issues and had developed an action plan to address staff concerns. The approach was based on a successful approach used in theatres that had led to improvements. The actions included managers spending time listening to staff views in small meetings, focusing on training and education plan ensuring staff were aware of opportunities, and enabling staff ability to make improvements in their own services.

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Surgical nursing staff forums were held monthly. Staff told us a representative normally attended and fed back to other staff on the ward. They said sometimes no one was able to attend because the ward was short staffed or too busy.

We saw evidence that monthly ward team meetings were taking place and that feedback was provided to staff on a range of quality and safety issues including incidents, complaints and audits. Notes of the meetings indicated that staff had raised concerns about staffing and were provided with feedback where they had identified risks to patient's safety.

Innovation, improvement and sustainability

A quality improvement plan for surgery included a range of improvements to patient pathways and the environment. The plan contained 45 pieces of work. Three pieces of work had been completed, 31 were on track and 11 had been delayed. The improvement plan aimed at addressing issues raised at our previous inspection and an NHS peer review in January 2018. For example, theatre capacity and demand was reviewed to improve theatre utilisation. Anaesthetic capacity had been reviewed and specialist surgery was in the process of being reviewed. A process for stock rotating was developed to ensure there was no out of

date stock in theatres. Standardised cleaning records for anaesthetic rooms were implemented in November 2017. A business case had also been developed for refurbishment of theatres 3 and 4.

The reasons for delayed discharges were being investigated to identify and implement improvements for patients waiting to receive medication and test results. Plans to ensure all elective patients had an estimated discharge date prior to admission were being implemented. The need to work with other support services to support improvement, for example radiology, had been highlighted and action taken to address this. Radiology department planned to align working hours to accommodate for the needs of surgical patients.

The division organised fortnightly meetings between theatres management and specialties to discuss timetabling and scheduling issues and to ensure theatres were used as effectively as possible.

The hospital planned to open a surgical assessment unit for patients attending emergency department with a view to reduce unnecessary admissions. The plan showed the work was scheduled to take place between March and May 2018 but had been delayed.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital **MUST** take to improve

- Ensure that there are appropriate systems of medicines management at ward level and that staff are aware of their responsibilities in relation to this.

Action the hospital **SHOULD** take to improve

- Ensure that patients' care records are accurate, complete, legible, up to date and stored securely.
- Ensure that consent to procedures is taken in line with trust policies and best practice.
- Ensure staff have access to reliable equipment which does not represent a risk to patient safety or delays treatment.
- Ensure there is an agreed replacement programme for theatre equipment.

- Ensure the facilities used by the pain service are fit for purpose.
- Ensure all ward and theatre environments are maintained in a good state of repair.
- Ensure equipment is stored safely and securely.
- Improve its referral to treatment time performance and reporting.
- Ensure there are adequate numbers of qualified, skilled and experienced staff employed and used to meet the needs of patients.
- Improve the flow of patients across the hospital to reduce late and cancelled operations.

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements

Where these improvements need to happen

1. Access to medicines was not appropriately restricted on the surgical wards.

1.1 Medicines were stored in treatment rooms which could be accessed by all clinical staff and housekeeping staff. In the treatment room on Rowan ward medicines were being stored in drawers and cupboards without locks. Locks were broken on medicines cupboards on Poplar ward and on the fridge in Sycamore ward. On Sage ward we found a cupboard containing oral medicines unlocked and unattended.

1.2 The issue of medicines security was listed on the pharmacy risk register since 2015. The pharmacy department conducted a quarterly "Safe and Secure Handling of Medicines Audit". Results from 2017-2018 showed that some but not all of these issues had been identified during the audit. Our findings during inspection show that action plans were not being adequately implemented following these audits.

1.3 The security of controlled drugs was not being maintained. On Sycamore ward we found controlled drugs which were stored in the intravenous (IV) medicines cupboard and in one theatre found controlled drugs unattended. This meant that access to controlled drugs was not appropriately restricted. This issue had not been identified during the quarterly controlled drugs audits undertaken by pharmacy.

2. The trust's medicines management policy was not being followed in relation to medicines storage and expired medicines.

2.1 Regular checks of medicines required by the trust's medicines management policy were not being undertaken on the surgical wards. On Rowan and Sycamore ward we found that fridge temperature checks were not always completed. On Primrose ward records showed that the fridge temperature had been above the recommended range every day for the last three months. Staff could not tell us about any action they had taken in relation to this. This meant the Trust

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Enforcement actions (s.29A Warning notice)

could not be assured that medicines kept in the fridge were suitable for use. During our inspection, we reported this to the ward pharmacist who had not been aware of the issue. Most staff we spoke with were unaware of the need to contact the pharmacy department although a ward manager told us an air conditioning unit was located in the treatment during the hot summer months.

2.2 On Poplar ward we also found other medicines checks were not being undertaken. The hypobox (containing medicines to treat hypoglycaemia) had not been checked since December 2017. We found expired fluids in the sepsis trolley and informed the ward sepsis champion. Staff on Poplar ward told us that these checks were not being completed because they did not have time to do them.

2.3 Expired medicines were in stock on each of the surgical wards. During our inspection, we brought this to the attention of staff who disposed of the expired medicines. Some medicines had expired in August 2017. This meant regular checks of stock were not taking place on the wards. This was against the trust's medicines management policy. Staff told us this requirement was difficult to fulfil as there was no pharmacy top up service to the surgical wards, an issue which had been on the pharmacy risk register since 2015. Some of the expired medicines, such as adrenaline, amiodarone and heparin, were on the trust's critical medicines list, this is a list of medicines that should not be omitted and should be given within two hours of prescribing.

2.4 We checked four spillage kits in the sluice and found three had expired in 2016, one had expired in 2011. We checked two spillage kits for cytotoxic medicines and found these had expired in April 2017.