

Barts Health NHS Trust

R1H

# Community health inpatient services

## Quality Report

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# Summary of findings

## Locations inspected

<b>Location ID</b>	<b>Name of CQC registered location</b>	<b>Name of service (e.g. ward/ unit/team)</b>	<b>Postcode of service (ward/ unit/ team)</b>
R1H13	Mile End Hospital	Mile End Hospital	E1 4DG

This report describes our judgement of the quality of care provided within this core service by Barts Health NHS Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Barts Health NHS Trust and these are brought together to inform our overall judgement of Barts Health NHS Trust

# Summary of findings

## Ratings

Overall rating for the service	Not sufficient evidence to rate	●
Are services safe?	Not sufficient evidence to rate	●
Are services effective?	Not sufficient evidence to rate	●
Are services caring?	Not sufficient evidence to rate	●
Are services responsive?	Not sufficient evidence to rate	●
Are services well-led?	Not sufficient evidence to rate	●

# Summary of findings

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# Summary of findings

## Overall summary

Essential elements to keeping the service safe were being routinely collected and regularly monitored. Individual assessments monitored specific areas of patient risk although subsequent action plans had not always been documented. The trust had taken appropriate action over safeguarding concerns that had been raised and had acted on poor practice.

Referrals came from the trust's local acute hospital and consultants worked across both sites for continuity of

care. Therapy teams worked with patients and their families towards more independent living and the service was hoping to improve upon discharge processes and had taken on a discharge coordinator.

We observed staff and patients interacting in a positive way. All of the patients we spoke with were positive about the friendliness of staff and their readiness to offer help and support. We also came across examples where people had not been treated or spoken to with due dignity and respect. Senior staff had recently taken action on this and expressed a desire to raise standards of kindness and compassion.

# Summary of findings

## Background to the service

Barts Health NHS Trust provided inpatient care from two wards at Mile End Hospital, both providing care to older people; Gerry Bennett and Jubilee wards. There were also a number of other services provided from Mile End Hospital by different healthcare providers.

Jubilee ward was a 24 bed rehabilitation ward for the care of older people with most patients aged 85 plus. St the time of our inspection Gerry Bennett ward was a 16 bed ward offering the same service and had two continuing care beds on it.

## Our inspection team

The team was made up of two CQC specialist advisers with professional experience in the fields of care we were inspecting, one 'expert by experience', one CQC inspection manager and one CQC hospital inspector.

## Why we carried out this inspection

This was an unannounced, risk based inspection that took place following two recent reports of concern about patient care. The focus of this visit was on essential elements of patient care and safety.

As this was not a comprehensive inspection. We therefore did not have sufficient evidence to rate the five domains of safe, effective, caring, responsive and well led.

## How we carried out this inspection

We carried out an unannounced inspection of the premises on 24 May 2016, observed interaction between staff and patients and spoke with seven patients about their experiences of care. We also spoke with twelve members of staff that included physiotherapists,

occupational therapists, nurses, junior doctors, ward managers and senior nurses. We reviewed ten patient files and other documents including audits, meeting minutes and staffing rotas.

## What people who use the provider say

- All of the seven patients we spoke with were positive about the friendliness of staff and their readiness to offer help and support. For example, one patient told us, "they look after me well. All nice, all talk to you". Other comments included, "food is okay" and "it is always clean. If you want anything they get it for you.

They do a lot for you". Another patient told us "so far I've been treated well, with dignity and confidence" and "physiotherapy is very nice. Staff have time to talk". Another patient told us "I'm looked after very well, they treat me with respect", and "the food is okay and I can sleep well".

# Summary of findings

## Areas for improvement

### **Action the provider MUST or SHOULD take to improve**

- The provider should ensure that when action planning as part of individual assessments, there was some indication as to whether this was needed or not.
- The provider should ensure that patients' dignity is maintained with the clothing they wear.
- The provider should ensure that wheelchairs have footplates.
- Staff should always treat and speak to people with due dignity and respect.

Barts Health NHS Trust

# Community health inpatient services

Detailed findings from this inspection

Not sufficient evidence to rate

## Are services safe?

By safe, we mean that people are protected from abuse

### Summary

- Essential elements to keeping the service safe were being routinely collected and regularly monitored in areas such as infection, falls and pressure ulcers. Case notes regularly updated patient progress. Patient assessments to monitor specific areas of risk such as nutrition and hydration, continence and falls were being completed although subsequent action plans were not always being documented.
- Gerry Bennett ward had experienced some performance issues that included recent blips in harm free care and a safeguarding concern. The trust had taken appropriate action on these that included seconding a matron to the service and acting on poor practice. This had impacted on staffing numbers for which the trust had also acted on by reducing the bed numbers on Gerry Bennett in order to continue safe staffing levels.

### Safety performance

- Safety crosses were completed on both wards. On Gerry Bennett ward, we found safety crosses for May displayed on the ward. They monitored a number of safety related

topics: cardiac arrest- zero so far this month (our visit took place on 24 May) and zero last month. C Diff and MRSA- zero so far for this month and zero last month. Falls- three so far this month and three last month, all without harm. There had been zero falls with harm since October 2015.

- The safety crosses for Jubilee for May showed: Cardiac arrest- zero so far this month (our visit took place on 24 May) and zero last month. C Diff and MRSA- zero so far this month and zero last month. Pressure ulcers- zero so far this month and 3 in April. Falls- one so far this month and three last month, all without harm.
- The quality and safety dashboard recorded a number of quality measurements on a weekly basis. The number of acquired infections, patients with catheters, and venous thromboembolism that had occurred on each ward were part of this. Harm free care was 98 per cent for Jubilee ward and 95 per cent for Gerry Bennett ward.
- A safety briefing took place at every handover and followed set formats. On Jubilee ward it specifically identified people whose National Early Warning Score



## Are services safe?

(NEWS) was greater than five, patients with catheters or venous cannula, at risk of falls as well as those with off site appointments and those for discharge today. This was not standardised across both wards. It also reminded staff to cover the 'Big 4'. These were: escalate the deteriorating patient if NEWS was greater than 2, medicines management, continence assessments asap on admission and check on all invasive devices. The safety briefing used on Gerry Bennet ward was more basic and identified those at risk of falls and those with allergies and pressure ulcers. We were also told that urinary tract infections were monitored at the safety briefings. The safety briefing documentation seen on Gerry Bennett for the 21, 22 and 23 May showed that three patients had been identified as at risk of fall and allergies had been identified in two.

### Incident reporting, learning and improvement

- We saw data for the most recent three month period for which data was available, February to March 2016, showed the percentage of harm free care for Gerry Bennett and Jubilee was 95 and 98 per cent respectively but with dips to 83 and 75 per cent in all three months for Gerry Bennett. The number of incidents reported for Gerry Bennett and Jubilee were 184 and 216 respectively.
- Identifying the deteriorating patient had been identified as a theme for learning due to an incident last year, when a patient with multiple traumas was inappropriately admitted from the trust's local acute hospital. Lists for transfers from the local acute hospital were now reviewed prior to any admission and the team now spoke to the medical teams and were able to delay transfers for more treatment.
- The monthly governance meeting minutes for March 2016 showed 12 incidents were reported for the previous month on Gerry Bennett and 11 on Jubilee. Ten of the 23, were falls and seven were pressure ulcers, including one serious incident of a pressure ulcer deteriorating from a grade 2 to a 3.
- A matron had been seconded to the hospital from the trust's local acute hospital to work on a falls reduction programme and provide leadership to Gerry Bennett ward. Part of the matron's role had been to understand

where both assisted and unassisted falls occurred, at what times of the day or night, in order to identify themes and trends. Their role was to also work on practice development across both wards.

- Pressure care was captured on the online incident reporting tool, Datix, for all grades. Grades 3 and 4 were automatically picked up via Datix reporting by the trust tissue viability team. The ward would also call the tissue viability nurse. Care plans were reviewed and root cause analysis was completed for grades 3 and 4.

### Safeguarding

- Staff liaised and referred to safeguarding when this was required. We were given examples where they had been concerned about patients at risk of abuse or overly vulnerable. They were able to name safeguarding leads and coordinators at the trust.
- On Gerry Bennett ward, following a family reporting concerns, a safeguarding investigation took place. It found that a patient had been prevented from leaving the ward and therefore covertly restrained. Some staffing issues had been identified as well as a need for staff development. In discussions with senior staff we learned that there had also been issues with some staff attitude which they did not consider to be caring when interacting with patients. Some staff were identified for training and performance management. Some staff were relocated within the trust and some had left. Bed capacity was reduced from 24 to 16 to accommodate this loss of staff.
- A matron had been seconded to the hospital following the safeguarding investigation to provide support and visible leadership on the ward, implement the falls prevention programme and work with staff development. She stated that she would be meeting with the trust development lead on 1 June with a view to enhancing learning with staff on Jubilee and Gerry Bennett with ongoing development review.

### Assessing and responding to patient risk

- The hospital had recently changed from using the patients at risk score (PARS) to the National Early Warning Score (NEWS) observation. Training in its use took place in December 2015 and it was introduced in January 2016. There was use of two hourly checks in place. There was 24 hour medical cover in place and

## Are services safe?

opportunity for staff to liaise with consultants. The hospital wards were designated rehabilitation wards. If patient conditions became medically unstable and in need of more acute care they could be transferred back to an acute hospital.

- There were modern beds with pressure relieving mattresses. Beds were alarmed for falls prevention, so when a patient at risk of falling left their bed it would notify staff..
- We looked at 19 sets of notes in total for both Jubilee and Gerry Bennett. All contained evidence of regularly completed SSKIN bundles, MUST tools, falls assessments and observation charts. We found that daily records of care were updated on a daily basis. A daily care record, consisting of two hourly checks, were all filled in on the day we visited. There was clear identification of allergies.
- Activity of life assessments and nutritional score had been completed on admission but not always reviewed. Manual handling risk assessments had been completed although there was no action plan or review in two of three sets of notes we looked at in detail. Continence pathways were not always completed. We looked at six in detail and three were fully completed. It would have been helpful if those that had not been completed had some sort of explanation. For instance, stating that the patient did not have any continence issues.
- The audit of the use of the 'MUST' screening tool to identify adults who were malnourished or at risk of malnutrition was on display for both wards. For Gerry Bennett the most recent was for April 2016, which showed all scores as amber or red on the RAG rating system. None were green. Items that scored red were BMI documentation at 88%, BMI accuracy 82%, weight loss documented 65%, steps 1 to 4 accurate 76% and appropriate action taken 65%. For Jubilee, there had been a month on month improvement of audit results with May's showing as 100% for all but two scores. Files were audited by a dietician.

### Staffing levels and caseload

- Staff acuity and dependency was measured and monitored on a daily basis through e-rostering, using the NICE endorsed Safer Nursing Care Tool. Acuity and

dependency was coded for each bed number on each ward along with the number of escorts and discharges. This was submitted each month and pulled in to the e-roster.

- The senior sister we spoke with told us that when she had raised safety concerns around staff and patient care she had been listened to and had not encountered resistance around agency/bank booking of staff.
- On Jubilee Ward, a 24 bed rehabilitation ward, there was one band 7, two band 6s, 15 band 5s and 11 band 2s. There were three band 5 vacancies and two band 2 vacancies. On Gerry Bennet Ward, currently operating with a reduced bed capacity of 16, there was one band 7, two band 6s, ten band 5s and 13 band 2s. There was currently one long term sick and one on maternity leave and five band 5 vacancies.
- Agreed staffing levels were on display for Gerry Bennett: four nurses and three health care support workers (HCSW) were scheduled to be on duty during the day and three and two respectively at night. Staffing was part of the safety cross information on display. For Jubilee it showed there had been eleven staffing incidents so far this month where they were short by one member of staff on three occasions and short by more than one eight times. For Gerry Bennett, they had been short by one member of staff on one occasion so far this month and four last month.
- Staff shortages were covered by bank staff who were ordinarily in substantive posts at the hospital thus enhancing continuity of care. Agency staff were otherwise used, the majority of which had worked at the hospital before and were familiar with its processes. On some occasions when there were staffing shortfalls, staff would move across the two wards to ensure to fill the greatest need.
- It was reported that patients being escorted to appointments at the local acute hospital, which was located ten minutes' drive away, was complicated by the transport system which was poorly organised, leaving patients having to spend up to 5 hours travelling for what was a straightforward 20 minute procedure such as a CT scan and other radiography. The knock on effect of the poor patient transport system was that it placed additional pressures on staffing.

## Are services safe?

- Gaps in the consultant rota that were filled by locum consultants. We were told that there was a low number of consultants across the trust per se. We spoke with a locum doctor who worked regularly at the trust who told us that consultants regularly stretched themselves to meet the demands of the service. Consultants from the two care of older people's wards at one of the trust's

local acute hospitals, located nearby, also saw patients and held ward rounds at the hospital for continuity of care, Monday to Friday and there was an on call geriatrician after 5pm and at weekends. From 5pm and overnight there was a junior doctor on duty with support from band 7s.

## Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

### Summary

- People received timely pain relief and nutrition and hydration needs were being managed. Referrals were almost exclusively from the trust's local acute hospital and consultants worked across both sites for continuity of care. Consultant led multidisciplinary team meetings took place weekly on each ward.
- Admission was for more complex rehabilitation and therapy teams worked with patients and their families towards more independent living. Community teams became involved in patient care prior to discharge although the service was hoping to improve upon discharge processes and had taken on a discharge coordinator.

### Pain relief

- People's care plans included pain assessment and management. Patients were asked about their pain levels every two hours and also during medication rounds. Patients were able to request pain relief and did do. We observed the ward sister and another nurse checking out pain relief for a patient who was complaining of pain.

### Nutrition and hydration

- People's care plans included nutrition and hydration assessment and management. In terms of nutrition many of the patients had small bottles of food supplement drinks on their bed tables. The dietician was present on the unit during the whole time of our visit, reviewing patient notes. A red tray system was being used for vulnerable patients whose nutritional status was assessed as a risk, allowing all members of staff to recognise patients' nutritional status. We observed at least three patients being weighed in order to monitor progress.
- On Jubilee we observed a patient telling staff she was hungry, about 40 minutes before lunch. The nurse went and got her a biscuit. Patients that were able to were

given their meals in the dining room. We observed good interaction between patients and staff at lunch. Patients with mobility issues were well supported. Staff also supported patients to eat.

### Patient outcomes

- Senior staff told us that a number of audits took place. A documentation audit looked at ten files on each ward every week and looked at day to day paperwork such as SSKIN bundle, MUST and NEWS. There was also a NEWS observation audit which looked at ten on each ward on a monthly basis. Also falls audit. Senior sister on Jubilee told us there was hand hygiene, peripheral vascular device insertion, catheter care, nursing documentation, MUST audit, pressure care audit. Audit results were put on display on wards and communicated in ward meetings and safety briefings.
- Audit results were on display Jubilee ward but not for Gerry Bennett. Results followed a month on month comparison through the 2015/2016 year. The most recent results displayed were for January and February 2016 and showed: IPC and MRSA screening documentation completed on admission as 100% for both months. Bowel chart documentation as 60% in Jan and 100 in Feb. Aseptic Non Touch Technique training was 100% for both months. VIP scores completed as 0 and 33%. Documenting devices as 0 and 60%.
- The quality and safety dashboard was on display in the senior sister's office on Jubilee and on the wall outside the office on Gerry Bennett. Information for Gerry Bennett's dashboard was incorrect, showing instead data for the whole trust. This was discussed on site and the correct data was supplied.

### Multi-disciplinary working and coordinated care pathways

- There were weekly consultant led multidisciplinary team (MDT) meetings on each ward. They were also attended by nurses, psychologists, support workers, occupational therapists, physiotherapists, speech and language therapists, junior doctors and a social worker.

## Are services effective?

- The MDT were involved in assessment, planning and treatment which was all written up in case notes.

### Referral, transfer, discharge and transition

- We were told that the consultants were gatekeepers to the beds. Referrals to the hospital were almost exclusively from the Royal London Hospital (RLH), one of the trust's acute hospitals, located nearby. Consultants knew the patients as they worked across both sites, and we were told that the service did not take patients whose condition was not stable. Admission was for more complex rehabilitation and the commissioned length of stay was 42 days. The service was currently averaging 45 days although this was due to be brought in line by two short admissions due to end this week.
- Initial screening of patients took place on the acute ward prior to transfer. There was a handover form and a verbal handover also took place. Information handed over included details of patient mobility, transfers, cognition, self care/activities of daily living (ADL) and pressure ulcers. On admission, joint assessment with physiotherapy took place and included transfers, mobility, oxygen saturation and blood pressure. This was written up in bedside notes and thus shared with the nursing team.
- The occupational therapist or physiotherapist contacted the family to ask if they would like to be involved in care planning and to what extent they were involved in care. Meetings were set up with the family and patient to set rehabilitation goals. Therapy staff liaised with acute inpatient therapy staff, social workers, speech and language, social services and equipment provision services.
- Patients had access to escorted visits to their home environment, to observe patients at home or to scope a care home, both with an occupational therapist and their family. Senior staff told us that district nurses and community teams were involved with people's care prior to discharge. However, ward staff told us that they did not attend. The ward had recently recruited a discharge coordinator to strengthen these links and make the transition from hospital to home smoother. Senior staff told us it was too early to assess the effectiveness of this as they had only started a week ago.

## Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

### Summary

- We observed staff and patients interacting in a positive way and staff offered practical assistance to those who needed it. Patients told us they were treated with dignity and respect. All of the seven the patients we spoke with were positive about the friendliness of staff and their readiness to offer help and support.
- A lack of accessing to appropriate clothing had led to people wearing open backed hospital gowns when leaving the ward for groups. These were closed to differing degrees and which did not observe their dignity.
- We also came across examples where staff had not treated people with due dignity and respect. We reported back our observations to senior staff. They elaborated on action that had been taken recently on Gerry Bennett ward and generally because they wanted to raise standards of kindness and compassion.

### Compassionate care

- We observed staff and patients interacting in a positive way that was sympathetic to their needs. We also observed staff offering practical assistance to those who needed it. They also told us they were treated with dignity and respect.
- All of the seven patients we spoke with were positive about the friendliness of staff and their readiness to offer help and support. For example, one patient told us, “they look after me well. All nice, all talk to you”. Other comments included, “food is okay” and “it is always clean. If you want anything they get it for you. They do a lot for you”. Another patient told us “so far I’ve been treated well, with dignity and confidence” and “physiotherapy is very nice. Staff have time to talk”. Another patient told us “I’m looked after very well, they treat me with respect”, and “the food is okay and I can sleep well”.
- However, we also came across examples where people had not been treated with due dignity and respect. We observed an example where a member of staff was attempting to take a blood sample from a female patient with dementia on Gerry Bennet. It took place in

the middle of the ward area near to the nursing station and in full view of patients, staff and inspectors. She did not explain what she wanted to do or why she needed to take a sample or engage the patient in any way. The patient withdrew her arm from the staff’s touch. Staff responded by stepping away, pulling gloves off and muttering ‘fine, I won’t do it then’. This was dismissive and disrespectful behaviour with no demonstrable insight in to dementia care.

- In one person’s case notes some weeks ago, that a member of staff had written that the patient had phoned their son for him to come and pick her up from hospital because one of the nurses had spoken to her rudely and she does not want to be in hospital.
- A relative of a patient wrote to us recently to tell us that some members of staff were not respecting patients or treating them with dignity.
- We reported back our observations to senior staff. They elaborated on the recent safeguarding investigation that had partly found that more emphasis was needed on the way some staff had interacted with patients. We were told that action had been taken on Gerry Bennett because they wanted to raise standards of some members of staff and treating patients with more kindness and compassion. This had included staff being performance managed and some transferred to other wards within the trust. They acknowledged their own role in staff development and workloads. To this end they had brought in a matron, seconded from the trust’s nearby acute hospital, to provide leadership and work with practice development.
- We observed an exercise and balance group. It took place on a weekly basis and was led by rehab assistants with overall responsibility taken by a band 5 physiotherapist. There were seven patients and two members of staff. Patients were taken downstairs to the gym, in wheelchairs. All patients were wearing ‘grippy’ socks. However, six of the patients were wearing open backed hospital gowns, which were closed to differing degrees and which did not observe their dignity. For instance, one patient’s gown had ridden up and exposed a catheter. We discussed this afterwards with

## Are services caring?

the senior staff. We were told people often did not have access to any clothing and that there was some old clothing on the ward but that it was very limited and did not dignify people who also refused to wear it. Four of the seven wheelchairs did not have footplates so patients had to lift up their legs for the duration of the journey to and from the ward.

- Staff explained the exercises well and gave each patient some individual attention. Patients were asked if they would do certain things such as stair practice. Staff demonstrated a positive caring attitude towards patients.

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

- The patients we spoke with were positive about the friendliness of staff and how they felt involved in their own treatment and care. We were told “staff explain things to me clearly”. Another patient told us that staff

were “very good. They are sympathetic. They talk to me. Always got a smile and respect my wishes“. However, we received one negative comment when we were told “staff just give me the pills, they don’t tell me the treatment path”.

- Friends and family results for April 2016 showed there were twelve responses which represented 85% of all discharges. The average score for the five questions was 4.81 with 100% likely to recommend and 0% likely to not recommend. The hospital was 42nd out of 175 trust services, which was an improvement from 89th six months ago.
- The occupational therapist or physiotherapist contacted the family of patients to ask if they would like to be involved in care planning and to what extent they were involved in care. Meetings were set up with family and patient to set rehabilitation goals.

# Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

## Summary

- A falls prevention programme was being implemented at the time of our visit. The length of stay reflected the more complex rehabilitation that patients were in need of and patients were assessed and involved in a number of rehab groups.

## Meeting the needs of people in vulnerable circumstances

- An extra matron had been recently seconded from within the trust to work at the hospital following requests for a site based person to support staff competency and practice. She had been working on the implementation of a falls prevention programme which was due to be formally launched the week after our inspection visit. Band 6 nurses had completed training on falls prevention and other staff were due to follow. There was a half day workshop that took place monthly for all staff to attend over the course of time. It covered assessment, post fall planning, manual handling following a fall and treating injury. Bedside competency assessment of staff and practice support was also planned as was audit. A pilot audit took place the week prior to our visit and were planned to continue on a weekly basis. Audits were to check on the timeliness of assessments and if patients found to be at risk had a care plan, whether a bed rail assessment had been completed, whether patient information had been sufficiently handed over and whether reassessment had taken place.

- We were told that the hospital was looking at themes around falls which they had identified usually occurred by beds, which had led to bed and chair sensors, 'wander guard', which indicated when people moved between the two. The hospital was compared with RLH in terms of the number of falls but have more because they are a rehabilitation service and by nature take more risk as they prepare people for the community.

## Access to the right care at the right time

- Patients were prioritised in to two levels to determine transfer ability and risk. With level 2 patients, a therapy assistant could treat them. Mobility and risk of falls assessments were documented in care plans.
- Referrals tended to be more complex than straightforward rehabilitation and there was a longer length of stay that reflected this. We were given examples where it could take a lot of therapy to get someone walking or out of bed. We were given an example where a recent patient was admitted with multiple pressure sores. If patients' mobility and cognition allowed, patients were involved in group therapies that included breakfast club food preparation, social club and a cognitive group. Nutrition was addressed in the breakfast club. All groups occurred weekly except the cognitive group which occurred twice weekly.



## Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

### Summary

- There was a governance structure in place that enabled the hospital to monitor the quality of the service it provided. There was a clear leadership structure and the visibility of local leadership had recently been increased to meet the needs of the service.
- There was some uncertainty among staff over planned future change to the service that had affected morale and placed recruitment on hold.

### Governance, risk management and quality measurement

- The service fed in to the trust's Emergency Care and Medicine (ECAM) directorate and governance structure through the general manager for older people's services' attendance at directorate meetings.
- There was a monthly governance meeting for senior staff working in older people's services across both the hospital and the trust's local acute hospital. It was attended by ward managers, consultants, matrons and a pharmacist. The most recent agenda showed that standing items included review of incidents, risk register, complaints and compliments, infection prevention and control and audit.
- Band 7 nurses for older people's service across both the hospital and the trust's local acute hospital met on a fortnightly basis. The most recent meeting had taken place a few days prior to our inspection. The agenda for this meeting showed a number of governance and quality issues being discussed. They included updating staff on trust issues, such as orientation of temporary staff and end of life study days, discussing complaints and investigations, recruitment and practice development. Minutes from the previous meeting showed attendance of seven of eight nurses.

### Leadership of this service

- Each ward had a band 7 manager, and two band 6 nurses. The trust's senior nurse for the care of older people had an office located next to the two wards and an extra matron had been recently seconded from within the trust to work at the hospital following requests for a site based person to support staff competency and practice. There were physiotherapy and occupational therapy leads and consultants for the two wards. The hospital was supported by the associate director who reported to the head of nursing.
- We were told that the associate director of nursing with responsibility for the hospital had held a large brief. This had meant that historically they were not able to devote much time to the service. As part of the trust's improvement processes they now had more support in this role which had meant more senior support for older people's care. We were told they felt they were more 'on the map' of the trust and not such an outpost.

### Culture within this service

- While staff were engaged in an improvement programme, it was taking place in an atmosphere of uncertainty about job security. The Tower Hamlets Integrated Care Pathway was part of a programme of change through an integrated community service programme managed by the Tower Hamlets Integrated Provider Partnership. The plan was that in two years, the service will have transformed to provide an 18 plus service for local and long term conditions. This had affected morale and staff recruitment; there was uncertainty around what was seen as a 'take over' as the service will be run by another trust. Discussions were underway over the transfer of contracts from 1 October 2016. Recruitment was also now on hold.