Barts Health NHS Trust

Newham 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

Overall rating for this hospital	Requires improvement
Medical care (including older people's care)	Good
Surgery	Good
Maternity and gynaecology	Requires improvement
Services for children and young people	Requires improvement
End of life care	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

Newham University Hospital, in Plaistow, East London is part of Barts Health NHS Trust, the largest NHS trust in the country. The hospital offers a range of acute services to a population of approximately 300,000 people living in the London Borough of Newham. The hospital has approximately 344 inpatient beds, with over 1548 staff working there. The services the hospital provide include The Gateway Surgical Centre that offers elective surgery and diagnostic procedures in many different specialties, as well as housing the Trust's sports injuries clinic and fracture clinic.

Newham is deprived, coming third out of 326 of local authorities, with 80% of the local population having a minority ethnic background. The population is predominantly young, with the majority of residents aged between 20 and 39.

As part of an inspection we carried out in 2014/15 of Barts Health NHS Trust, we inspected Newham University Hospital in January 2015 and rated the hospital overall as inadequate. Since 2015, significant changes were made to the leadership of the organisation at both an executive and site based level. We therefore recently returned to inspect Barts Health NHS Trust to follow up on our previous findings where we had found a number of concerns around patient safety and the quality of care. In July of this year we carried out an inspection of Whipps Cross Hospital and The Royal London Hospital, and returned to inspect Newham University Hospital on 1 November 2016.

We returned on this occasion to carry out a focused, unannounced inspection of five core services: Medicine (including older people's care), Surgery, Maternity & Gynaecology, End of Life Care and Services for Children.

Our key findings were as follows:

Are services safe?

- Insufficient consultant cover in maternity resulted in less than 50% of women in labour with a consultant present on the labour ward. Staff told us this meant patients were waiting longer for pain relief and treatment.
- Maternity services lacked enough appropriately skilled midwives to meet the demand of a high proportion of complex cases. Despite this, staff did their best to ensure they provided the best care.
- Systems were in place to ensure that incidents were recorded, and staff were predominantly familiar with the process. However, incidents were not always investigated in a timely way. In maternity services there was a backlog of more than 150 incidents waiting to be reviewed. Whilst incidents related to end of life care were not easily identifiable.
- Learning from incidents was not consistently shared amongst staff. However, in medical care, we found root cause analyses were comprehensive and senior consultants had begun to develop a tracking system for factors that contributed to such incidents.
- There was insufficient consultant cover in end of life care services.
- At the previous inspection in May 2015, the security of babies in maternity services had been identified as a risk because of insufficient staff to monitor access to the unit. Although approval had been given, security measures had not been implemented and this remained a concern.
- There were low levels of training amongst certain groups of staff in Level 2 safeguarding adults and safeguarding children.
- Compliance levels with the World Health Organisation (WHO) surgical safety checklist were inconsistent, especially in The Gateway Centre.

Summary of findings

- We found that infection control procedures were not followed for safe storage of deceased patients in the mortuary. We found that the mortuary area was dirty and there were no daily cleaning check lists available for completion by staff.
- Mortuary fridge temperatures were not routinely checked. There was no policy to determine correct transfer of deceased patients in the event of a fridge breakdown
- Sluice rooms on surgery wards were not always locked and chemicals were easily accessible.
- Hazardous waste was not always managed in line with national and international best practice safety guidance, including in storage and access control.

However:

- There were no surgical site infections for knee and hip replacements between October 2015 and June 2016.
- Medical care services reported no never events between October 2015 and September 2016.
- There were improvements in the number of maternity patients with management plans in their notes. Use of the modified early obstetric warning score (MEOWS) chart was at 97%.
- The hospital and community midwifery team worked proactively to support women to breastfeed and provided continuing support to women at home. The percentage of women breastfeeding remained high.
- There was good compliance with infection control training on surgical wards.
- On medical wards staff demonstrated consistent infection control practices in relation to hand washing, decontamination of the use of personal protective equipment and adherence to the bare below the elbow policy.
- Risks to children and young people were assessed, monitored and managed on a day-to-day basis; and risk assessments were child-centred, proportionate and reviewed regularly.
- There were business continuity and major incident plans in place. Senior staff were aware of the plans and were able to explain their roles in the event of an interruption to normal service.

Are services effective?

- Between March 2015 and February 2016, patients had a higher than expected risk of readmission than the national averages for both elective and non-elective medical admissions.
- In the 2015 National Lung Cancer Audit, 64% of patients were seen by a cancer nurse specialist. This was lower than the audit minimum standard of 80% and all measurements in the audit were below national targets. General hospital performance had deteriorated since 2014.
- Performance in the national lung cancer audit indicated the hospital had deteriorated in standards, including a 26% reduction in the number of patients who were seen by a cancer nurse specialist.
- Some staffing issues in maternity services impacted on women receiving timely pain relief.
- Results from the patient-led assessment of the clinical environment (PLACE) indicated significant deficiencies in the provision of appropriate nutrition for patients living with dementia. However, the dementia and delirium team had introduced improved monitoring of food and fluids for patients living with dementia as well as improvements to staff competencies, training and resources.
- Rainbow Ward was unable to deliver adequate pain management for patient controlled analgesia (PCA) and nurse controlled analgesia (NCA).
- Patient Reported Outcome Measures (PROMs) were worse than the England average for most measures.

Summary of findings

- The trust contributed to the National Care of the Dying Audit (NCDA). The trust was below the England average on three out of the five clinical indicators and only achieved one out of the five organisational key performance indicators (KPI).
- An audit of the use of the Compassionate Care Plan (CCP) undertaken by the specialist palliative care team showed that only 8 (28.6%) out of 28 sets of patient notes had a documented CCP in their notes.
- The end of life CQUIN audit undertaken in August 2016 looked at 17 deceased patient notes. These showed that only 6 patients (35.3%) had their preferred place of care (PPOC) documented and only one patient was transferred to their PPOC.
- Not all the patient records we reviewed had pain assessments recorded, despite having diagnosed conditions which often cause pain and discomfort.
- Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) audits for the period January 2016 to October 2016 showed that 66.6% (201) forms were completed incorrectly.
- Levels of training in Mental Capacity Act and Deprivation of Liberty Safeguards were 74.4% which was below the Trust target of 90%

However:

- Medical services presented a comprehensive programme of 73 audits, pilot programmes and benchmarking exercises that took place in 2015/16, which staff used to establish compliance with national best practice guidance. Learning from audits was evident and staff demonstrated a commitment to on-going improvements.
- The hospital achieved a B grading in the Sentinel Stroke National Programme in March 2016, reflecting effective practice.
- Procedures and policies were up to date and reflected recent evidence for best practice and NICE guidelines in CYP services.
- Performance in the 2015 Heart Failure Audit was better than the national average for all four standards relating to inpatient care and in three of the seven standards relating to discharge. This included higher performance than the national average in multidisciplinary working, including in referrals to cardiology follow up and the heart failure liaison service.
- Outcomes for women and their babies in maternity services were within national guidelines.
- The maternity service was working towards level 3 of the UNICEF UK Baby Friendly Initiative to promote good care for new-born babies.
- There was a weekly hospital palliative care multidisciplinary meeting. Medical staff, nurses, social services and the chaplaincy attended this meeting.
- The hospital performed higher than the national average in the national British Thoracic Society Smoking Cessation Audit, with smoking status documented in 90% of records compared with 80% nationally.
- Multidisciplinary working and information sharing between wards and departments was effective.
- Surgical pathways were delivered in line with referenced national clinical guidance.
- There was effective pain management provision available in surgery.
- There were good continuing professional development opportunities for staff.
- All eligible nursing and medical staff had in-date revalidation at the time of our inspection.

Summary of findings

Are services caring?

- We observed kind and compassionate care given to patients. Children, young people and parents were observed to be treated with dignity, respect and kindness during interactions with staff and relationships with staff were positive.
- However, in medical services, scores relating to privacy, dignity and wellbeing assessed in the patient-led assessment of the care environment audit (PLACE) indicated a sustained decline of 25% in scores between 2013 and 2016, with 2016 results ranging from 45% to 80% for individual wards.
- The majority of patients we spoke with were happy with the care and treatment they received. However, women using maternity services commented that at times there was a lack of respect, care and compassion and that midwives were often abrupt.
- Women using maternity services described good support around the choice of place of birth, including home birth and partners were welcome to stay.
- The trust had developed a Compassionate Care Plan to replace Liverpool Care Pathway for end of life care patients. However, we did not see evidence that this document was embedded across the trust.
- Palliative care patients were not prioritised for side rooms and there was a lack of facilities for dying patients and their relatives.
- The results from the bereavement survey undertaken between January and September 2016 showed that only 8% (1) of the respondents rated their overall experience as excellent, and only 15% (2) rated their experience as good.
- There was a poor response rate to the Friends and Family Test. Albeit, that recommendations rates were generally high.

Are services responsive?

- Although 140 additional bed days had been provided in September 2016 and October 2016 to meet winter pressure demand, the hospital could not fully staff these
- The trust suspended reporting on all 18-week referral to treatment target (RTT) waits from September 2014 and had not resumed reporting at the time of this inspection.
- There was variation within surgical specialisms about length of time taken to respond to complaints.
- Staff reported regular difficulties meeting demand in the maternity unit. This caused delays, including in planned induction of labour and in elective caesarean sections.
- The recovery facilities in theatre were not child friendly due to an absence of a recovery bay with appropriate décor.
- Emergency readmissions for non-elective patients under the age of one year and children between the age of one and 17 years were worse than the England average.

However:

- Between April 2015 and March 2016 the average length of stay for non-elective medical patients was 3 days, which was lower than the national average of four days.
- The hospital had implemented a patient flow coordinator role that worked proactively with a dedicated discharge consultant to prioritise medical discharges at weekends.

Summary of findings

- The Greenway Centre provided daily walk-in appointments with a 60-minute target for each patient to be seen. Staff in the endoscopy unit were able to see patients who urgently needed a procedure but who had mixed up their appointment time.
- In response to the needs of the local population, a dedicated overseas team provided support and liaison for patients with complex needs around immigration, refugee or asylum status.
- An enhanced care bundle had been introduced to each inpatient ward area that provided staff with a care pathway and contacts to help those with complex social needs.
- Flow within the surgery system was well managed and theatre utilisation was around 84%.
- The average length of stay for elective and non-elective surgical patients was better than the England average.
- There was a substantial decrease in the percentage of surgical patients not treated within 28 days.
- There was an enhanced recovery programme and joint school for patients booked to have a hip or knee replacement.
- Between April and October 2016, 97% of end of life care patients had been seen by the specialist palliative care team within 24 hours of referral.
- Complaints were dealt with effectively, with learning identified, implemented and shared. Staff apologised to patients where a mistake had been made and offered a resolution to the problem.
- West Ham Ward was not a purpose built paediatric ward. However, The Rainbow Unit rebuilding project would provide modern inpatient and outpatient facilities for children and young people and was due to open in February 2017.

Are services well led?

- There were concerns about the categorising and length of time the trust took to complete incident reports and serious case reviews. Targets were not being met and there were concerns about the processes for managing incidents. There was a lack of evident assurance that learning was properly followed up and embedded.
- The risk register in maternity services did not reflect all the current risks. For example, it did not include the low levels of consultant cover in maternity services or the possible risks to patients.
- The hospital senior management team did not have sufficient oversight of the mortuary as it was managed centrally from Royal London Hospital by the Clinical Support Services which operated trust wide.
- The trust had an End of Life Care Strategy 2016 - 2019, which was based on the 5 priorities of care for the dying. This had been ratified by the trust on the 19th October 2016. However staff we spoke with were not aware that the strategy had been ratified by the trust and many nursing staff knew nothing about it.
- Many staff told us that culture and morale was much improved since the time of the last CQC inspection in Jan 2015. However, medical staff spoke variably of morale and working culture, including individuals who said they were concerned about the long-term impact of morale because of high levels of sickness and vacancies in nursing teams.
- A small proportion of staff said that there were pockets of bullying and harassment in existence.
- There was limited evidence of consistent and structured leadership on some wards, including on Tayberry ward and Silvertown ward. On Tayberry ward there was evidence staff did not always feel safe because of short-staffing and the volume of work.

Summary of findings

- Medical staff did not always feel they were recognised for their skills, supported to develop or had access to appropriate management support.
- Staff engagement in the most recent NHS staff survey was lower than the national average.
- Although some services such as the endoscopy unit and Greenway Centre conducted their own patient engagement programmes, there was limited evidence information from engagement was used at a hospital-wide level.

However:

- There was a clearer governance structure with clearer lines of management accountability across services at Newham University Hospital, following Barts Health NHS Trust introduction of a new leadership operating model in September 2015. Many staff reported this as a positive and effective change.
- A quality improvement programme that included monthly monitoring of staff engagement, safety improvements, patient feedback and access and flow performance, had led to an increase in staff engaged through social media, over 1000 staff engaged through face-to-face meetings and a 6% increase in compliance with staff training between March 2016 and June 2016.
- Individual specialist teams were empowered to establish new policies and improve existing policies as a result of patient engagement
- Although some difficulties remained in gaining the support of midwifery staff affected by changes the trust had imposed, morale among many midwives had improved since the last inspection.

We saw several areas of outstanding practice including:

- Safeguarding practices in the Greenway Centre were highly specialised and staff proactively developed these to meet the increasingly complex needs of the local population. This included multidisciplinary specialist input and monthly tracking of patients with specific needs, including through the provision of advocates who spoke Romanian or Portuguese.
- Staff took innovative steps to improve engagement with patients living with diabetes. For example, to improve the care of young people with diabetes, staff introduced remote video chat appointments. This reduced the number of wasted appointments and patients gave very positive feedback about the flexibility this afford them.
- Staff introduced innovative measures to improve access and flow, particularly at a weekend. This included the implementation of consultant-led discharge ward rounds and a new patient flow coordinator post. In addition staff had negotiated 24-hour, seven-day-a-week access to a social worker that meant complex discharges could be planned outside of the previous Monday to Friday model.
- An overseas team provided dedicated support to patients cared for on an inpatient basis who had complex needs relating to immigration, asylum or refugee status.
- There was a clear, sustained focus on offering opportunities to student nurses and medical trainees. Feedback from site visits by sponsoring universities were consistently good with continuous levels of compliance against quality markers for developmental education.

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

Importantly, the trust must:

Summary of findings

Services for children

- The trust must ensure incidents are investigated in a timely way and in accordance with published guidance. 12 (2)(b)

Maternity

- The trust must ensure steps are taken to provide additional consultant posts to mitigate the risks and meet the care and treatment needs for women and babies at NUH. 18 (1)
- The trust must ensure that measures to ensure the security of babies in maternity services are implemented. 15 (1)(b)
- The trust must ensure the backlog of incidents awaiting review are addressed; and serious incidents are correctly identified. 17 (2)(a)(b)(f)
- The trust must ensure learning from incidents, complaints and peer reviews is used for the purposes of continually evaluating and improving services.17 (2)(e)(f)
- The trust must ensure staff are clear about their roles and responsibilities under legislation around capacity and deprivation of liberty. 11(3) & 13(5)

End of Life Care

- The trust must ensure that reporting processes are able to identify, review and learn from information that relates to the end of life care it provides such as through complaints, incidents and satisfaction surveys. 17(1)(2)(a)(b)
- The trust must ensure that the Compassionate Care Plan it has developed is embedded across the hospital. 9(3)
- The trust must ensure that it meets the national guidance ['Commissioning Guidance for Specialist Palliative Care: Helping to deliver commissioning objectives' (Dec 2012.)] which recommends a minimum requirement of 1 whole time equivalent consultant in palliative medicine per 250 hospital beds (NUH has 344 beds). 18(1)
- The trust must ensure that systems and processes are in place to enable proper management and oversight of the mortuary to be assured. 17(1)
- The trust must ensure that standards of cleanliness and hygiene are maintained in the mortuary. 15(1)(2)
- The trust must ensure that the premises and equipment within the mortuary are properly maintained and fit for purpose. 15(1)(c)(e)
- The trust must ensure there are systems in place to determine appropriate transfer of deceased patients in the event of a fridge breakdown. 17(1)
- The trust must ensure that pain for patients at the end of life, is properly assessed and treated.9(3)(a)(b)
- The trust must ensure that Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms are completed correctly. 9(1)(a)(b), 11(1)
- The trust must ensure that due consideration is given to the privacy and dignity of patients at the end of life in relation to facilities available for them and their relatives. 10(1)(2)(a)
- The trust must ensure that systems are in place to effectively monitor the effectiveness of services provided to the dying patient in relation to its fast track process and patients' preferred place of care. 17(1)(2)(a)

In addition the trust should:

Summary of findings

Medical care

- The trust should ensure learning from infection prevention and control audits is communicated to all staff.
- The trust should ensure interpreting services are readily and proactively provided to reduce the safeguarding risk associated with relying on relatives and friends to interpret clinical care.
- The trust should ensure the nutritional and hydration needs of patients are met. This includes patients with complex needs including dementia, co-morbidities and where they are cared for as a medical outlier.
- The trust should ensure premises and equipment are clean and secure in relation to the control of substances hazardous to health.
- The trust should ensure staffing levels are actively monitored and reflected accurately in daily safer staffing meetings. This means the senior nurse in charge on each ward should agree with the staffing level reflected by the site manager in the safety briefing.
- The trust should ensure staff are supported to work safely and effectively through the provision of consistent and structured support.
- The trust should ensure nurses have access to training and professional development in line with their career plans and/or professional development plan.
- The trust should ensure staff who wish to undertake additional qualifications relevant to their role are supported to do so.

Surgery

- The trust should ensure there is clear differentiation between adult and paediatric resuscitation equipment on the resuscitation trolley.
- The trust should ensure there is good compliance with all steps of the World Health Organization surgical safety checklist.
- The trust should ensure that referral to treatment time is evidenced.
- The trust should ensure that all staff have level 2 safeguarding training and safeguarding children.
- The trust should ensure all staff have training in Mental Capacity Act and Deprivation of Liberty Safeguards.
- The trust should ensure that there is better feedback about incidents to surgery staff and that there is shared awareness of the top three departmental risks.
- The trust should ensure sluice room doors on surgical wards are kept locked and all chemicals are locked away in a cupboard.
- The trust should endeavour to recruit to anaesthetic staff grade vacancies.
- The trust should improve upon data collection of appraisal rates.
- The trust should improve upon Patient Reported Outcome Measures (PROMs) measures.

Services for children

- The trust should ensure infection prevention and control on Rainbow Ward always complies with the trust's policies for infection prevention and control.
- The trust should ensure expressed breast milk is stored separately from other products.

Summary of findings

- The trust should address maintenance issues in a timely way, ensuring thorough investigation and repairs.
- The trust should ensure CYP services should have a robust plan and system of clinical audit in place to monitor adherence to evidence based practice.
- The trust should ensure staff on the NNU make themselves aware of the UNICEF Baby Friendly accreditation programme, a global accreditation programme to support breast feeding.
- The trust should ensure Rainbow Ward delivers adequate post-operative pain management of children.
- The trust should ensure there are facilities for parents to prepare or purchase food.
- The trust should ensure there is a range of information leaflets for children and their parents or carers across both Rainbow Ward and the NNU.
- The trust should improve recovery facilities in theatres to ensure areas for children are child friendly with appropriate décor.
- The trust should improve on emergency readmissions for non-elective patients under the age of one year and children between the age of one and 17 years.
- The trust should develop a long-term local strategy for CYP services.
- The trust should ensure the agendas for governance meetings always reflect the governance meetings terms of reference.
- The trust should ensure identified risks are always included on the trust's risk register in a timely way, and record actions the service is taking to mitigate risks clearly on the risk register.

Maternity

- The trust should ensure further recruitment to providing sufficient number of appropriately skilled midwives to meet the needs of the service.
- The trust should consider funding for staffing a second obstetrics theatre to improve waiting times for caesarean
- The trust should ensure better working relationships across the maternity service; fostering better communication and morale.
- The trust should ensure that midwifery staff are supported to attend the role specific training programme.

End of Life Care:

- The trust should ensure that medical and nursing files are easy to navigate and in order.
- The trust should give consideration to all services that link in to the overall vision of end of life care, such as chaplaincy and therapies, in its draft business case to increase staffing.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Medical care (including older people's care)	Good	Annual nurse turnover had stabilised at an average of 9% between March 2016 and May 2016, which was better than the trust target of 14%. Daily multidisciplinary safety huddles enabled staff to identify patients who were deteriorating, review patients with complex needs and plan for safe and effective discharges. The hospital achieved a B grading in the Sentinel Stroke National Programme in March 2016, reflecting effective practice. In response to an increasing number of patients living with dementia and those with needs such as alcohol dependency, a nursing team had introduced an enhanced care bundle. This helped ward staff and other clinicians to provide person-centred care and treatment planning that was adaptable to individual needs. A patient flow coordinator role and dedicated discharge consultant worked together to plan discharges and ensure each patient had a package of care in place as well as prescribed to take home medicine where needed. This team had established innovative links with local social services, who provided 24-hour seven day cover to help reduce discharge delays by providing a single point of referral for patients with community social needs. The endoscopy unit had reduced the backlog for procedures and six-week-wait breaches by 76% to August 2016 through improved staffing and equipment reliability. The hospital demonstrated it was responsive to local needs and challenges. For example, a dedicated overseas team provided specialist liaison and support with immigration authorities and the police to help patients with complex immigration, asylum or refugee status needs. This meant patients could be discharged safely without putting them at risk and without blocking bed capacity in the hospital. Staff spoke positively about the introduction of a ward manager role, which they said helped to stabilise their teams and provide a structured

Summary of findings

approach to local leadership support. Ward managers had increased their clinical presence to 40% of their workload, which meant they were more visible and readily available to clinical staff.
Performance in the national heart failure audit was significantly better than the national average. This included a 38% higher overall compliance rate with cardiology inpatient care and a 34% higher rate of consultant cardiologist input.
An enhanced care bundle enabled staff to provide person-centred holistic care. The tool could be adapted for patients with a learning disability, living with dementia, at risk of self-harm or at risk of falls. The care bundle could be used with relatives to establish a patient's normal daily routine and identify factors that could be used to reduce anxiety and distress, such as talking about their favourite topic or providing access to music.
A dementia and delirium team and dementia strategy group had worked with patients and carers to introduce a range of improvements to the hospital environment and services to improve the experience for patients living with dementia. This included improved support for carers and resources for patients that included access to a reminiscence room and use of technology such as sound amplifiers.
There was substantial evidence of continual improvement to services as a result of engaging with patients and the people close to them, including the use of remote video technology to support young adults with long term condition management.
However we also found:
Medical staffing levels were generally consistent although out of hours the number of doctors was significantly reduced. However, the trust did take steps to ensure long-term consultant sickness in neurology was covered by a locum consultant.
Nurse staffing levels were inconsistent and vacancy rates were up to 29% in care of the elderly services. Although a team of healthcare assistants provided support, some staff told us their level of training had been reduced and they were no longer able to provide cannulation, catheter care or wound care,

despite their workload being increased as a result of nurse shortages. However, after our inspection the trust said they had not reduced healthcare assistant's opportunities for training.
There was no dedicated junior anaesthetist input into multidisciplinary ward rounds, which meant the pain management team was not able to provide a full specialist service.
The standard of infection control processes, including hazardous waste management and adherence to the control of substances hazardous to health guidance, were variable. This was because not all areas we inspected were clean and there were areas of unrestricted access to waste and chemicals.
Although risk assessments in most records we looked at were comprehensive and completed routinely, there was a lack of consistency where patients had complex needs, where nurse teams were short staffed and where patients were cared for as an outlier.
Staff in some teams said they felt morale was low and decreasing and talked about their worries in relation to increasing workloads and ongoing nurse shortages due to vacancies and sickness.

Surgery **Good**

We found that there was much improvement made in the hospital's surgical services from the time of our last inspection in January 2015, when four domains were rated as requires improvement and one as inadequate. During this inspection, we found that four domains were good and one required improvement.
There was a new site based management team and a more robust clinical governance structure which meant there was better oversight of risk. Staff expressed a greater level of confidence in management and general morale was high. We found that there were reduced numbers of staff vacancies and better planning of skill mix. Staff reported on a supportive learning environment with good continuous professional development opportunities.

Summary of findings

Patient flow was well-managed and there were no surgical site infections for knee and hip replacements and length of stay for elective and non-elective surgical patients was better than the England average.
The majority of patients we spoke with were happy with the care and treatment they received and we observed kind and compassionate care being given.
However, we also found:
There were low levels of training amongst certain groups of staff in Level 2 safeguarding adults and safeguarding children.

Maternity and gynaecology — **Requires improvement**

There was insufficient consultant cover resulting in less than 50% of women in labour with a consultant present on the labour ward. Staff told us this meant patients were waiting longer for pain relief and treatment.
Out of hours medical cover at all levels was overstretched, leading to delays in care. The trust had not approved the proposal to fund additional consultant posts at the time of our inspection.
Although there had been some staff recruitment there were shortages of midwifery staff at the time of our inspection. Many midwives were inexperienced and midwives were overstretched.
The trust had recruited additional nursing staff from overseas that were expected to be in post by the end of October 2016. Seventeen newly qualified band 5 nurses had been recruited but that still left 14 whole time equivalent (WTE) vacancies across midwifery services. The service had submitted a paper to the trust board outlining the case for further recruitment. Several staff told us that the lack of appropriately skilled midwives meant they were often spread thinly and this could impact on women's care.
There were concerns about the management of incidents and serious incidents. There was a backlog of more than 150 incidents waiting to be reviewed, which had led to a delay in learning. However, the trust were working closely with commissioners to review overdue serious incidents and incidents, with a plan for completion by December 2016.
Trust guidelines for the reporting of serious incidents and root cause analyses were being

Summary of findings

followed. However, not all incidents were correctly identified as a serious incident. We saw examples where similar outcomes had been categorised differently and the reason given by the trust did not follow their own policy.

There was only one staffed obstetric theatre. Many staff commented on the difficulties this caused for women such as having to wait longer for a caesarean. This was raised as a concern at the last inspection. In response a bid had been put forward for funding for staffing a second theatre; however this had not progressed. Staff were dependent on operating time being available and nursing and medical staff being available to use the second theatre.

At the last inspection staff told us they felt like the poor relation to one of the trust's other acute hospitals even though Newham University Hospital had the larger maternity unit. They perceived the senior leadership as remote and that leaders imposed decisions rather than listening to the concerns and ideas for improvement. At this inspection we found staff repeating the same concerns. Several staff commented that middle managers as well as senior managers were not listening to them.

Mortality and morbidity meetings were held regularly and doctors gave presentations on specific cases. It was not clear how learning was drawn from this or how it influenced future practice because no minutes or actions were recorded.

Some staffing issues impacted on women receiving timely pain relief. Some women had to wait longer than 45 minutes when an epidural anaesthetic was called for, exceeding national guidance. Midwives had to regularly call on operating department practitioners (ODPs) from the main theatres for epidurals, which also delayed pain relief for some women.

At the previous inspection in May 2015, the security of babies in maternity services had been identified as a risk because of insufficient staff to monitor access to the unit. Although approval had been given, security measures had not been implemented.

Summary of findings

Midwifery, nursing and medical staff were not up to date with safeguarding adults and safeguarding children's training. The trust had not met its targets for medicines management and equality and diversity training in midwifery services.
Most staff we spoke with were not clear about their roles and responsibilities under legislation around capacity and deprivation of liberty. Staff responses were variable and several staff thought it was about health and safety issues.
There was an effective training programme for midwifery staff, although some midwives felt they did not have time to develop their skills outside the framework of mandatory training because they were so busy. Trainee doctors were well supported and had opportunities to put their learning into practice
However, we also found:
Staff did their best to ensure they provided the best care they could. A clinical educator had been employed to support recently recruited midwives from overseas to the hospital. The practice development midwife had recently been supported with administrative support to help with maintaining an accurate database of staff training. The education team had a rolling system for looking at skills gaps and putting in place development opportunities for midwifery staff. There were 12 supervisors of midwives and a preceptorship programme for band 5 and 6 midwives. Supervisors of midwives helped to develop all midwives' skills and expertise. Several staff commented on the benefit in having a named member of staff to refer to if they had any concerns or queries.
Some women we spoke with were happy with the care they had received. They were treated with dignity and their privacy was respected. Women were informed and involved in their care and treatment.
There was a clear care pathway in the maternity unit, according to women's clinical needs. Women felt that the level of communication from midwives and doctors was good. They felt listened to and well supported.
The inpatient environment was spacious and clean. Women were involved in choices about their care; there were initiatives to encourage natural birth.

Summary of findings

Processes were in place to assess and manage risk. These included the use of team briefings and the World Health Organisation (WHO) surgical safety checklist in obstetric theatre

Services for children and young people

Requires improvement

The service had systems in place to ensure that incidents were reported. However, incidents were not always investigated in a timely way and in accordance with published guidance.
Infection prevention and control on Rainbow Ward did not always comply with the trust's policies for infection prevention and control.
Expressed breast milk was stored in the same fridge as other products. For instance, two expressed breast milks were stored in the Rainbow Ward fridge together with a carton of soya milk.
Maintenance issues were not always addressed in a timely way. There were leaks in the ceilings of Rainbow Ward and the Neonatal Unit (NNU) which had not received thorough investigation and repairs. Some senior staff on the NNU we spoke with were unaware of UNICEF Baby Friendly accreditation, a global accreditation programme to support breast feeding.
Rainbow Ward was unable to deliver adequate pain management for patient-controlled analgesia (PCA), nurse controlled analgesia (NCA) and epidurals for the post operative pain management of children.
Parents did not receive food on the ward, unless they were diabetic or breast feeding. There were limited facilities for parents to prepare or purchase food.
There was a limited amount of information leaflets for children and their parents or carers across both Rainbow Ward and the NNU.
West Ham Ward was not a purpose built paediatric ward, conditions for staff in the ward were cramped.
There were a number of comments from staff and patient/relative surveys in 2016 that were negative about the environment on the ward and outpatients department.
The décor of Rainbow Ward did not cater for children and young people and was not child friendly Bay 1 was of particular concern due to its multi-purpose usage and lack of natural light.

Summary of findings

The recovery facilities in theatre were not child friendly due to an absence of a recovery bay with appropriate décor.
Emergency readmissions for non-elective patients under the age of one year and children between the age of one and 17 years, were worse than the England average.
There was a trustwide strategy for children and young people's services at Newham Hospital, but this was not embedded. There was no long-term local strategy for children and young people's services.
There were new governance arrangements for children's services, but these were not fully embedded.
The agendas for governance meetings did not always reflect the governance meeting terms of reference.
Identified risks were not always included on the trust's risk register in a timely way. Actions the service had taken to mitigate risks were not always recorded on the risk register.
However, we also found:
The hospital reported data on patient harm each month to the NHS Health and Social Care Information Centre (HSCIC) Safety Thermometer. From August 2015 to August 2016, Rainbow Ward and neonatal unit (NNU) had reported 100% harm-free care during this period.
Staffing levels and skill mix were planned, implemented and reviewed to keep children and young people safe. Any staff shortages were responded to quickly and adequately.
Risks to children and young people were assessed, monitored and managed on a day-to-day basis; and risk assessments were child-centred, proportionate and reviewed regularly.
Risks to safety from anticipated changes in demand and disruption were assessed, planned for and managed effectively. Plans were in place to respond to emergencies and major situations.
Staff we spoke with understood their safeguarding responsibilities and knew what to do if they had concerns.
There were sufficient numbers of nursing staff to ensure that shifts were filled. However, this was sometimes based on the use of bank staff.

Summary of findings

The were business continuity and major incident plans in place. Senior staff were aware of the plans and were able to explain their roles in the event of an interruption to normal service.
Procedures and policies were up to date and reflected recent evidence for best practice and NICE guidelines.
The children's service had a practice development nurse who monitored staff training and competence.
There was evidence of multi-disciplinary team working in all children's and young people's departments.
Information sharing between wards and departments, and medical and nursing staff was effective.
Parents were involved in giving consent to examinations, as were children when they were at an age to have a sufficient level of understanding.
Children and young people and their primary carer were supported, treated with dignity and respect, and were involved as partners in their care.
Feedback from children, young people and parents was positive about the way staff treated patients.
Children, young people and parents were treated with dignity, respect and kindness during all interactions with staff and relationships with staff were positive.
Staff helped children and young people and those close to them to cope emotionally with their care and treatment.
Children and young people were involved in making decisions.
Admission pathway protocols were in place.
There had been no formal closures to admissions to Rainbow Ward in the previous 12 months.
The NNU had three rooms available for parents staying overnight. The rooms were homely and had en-suite toilet and shower facilities.
Complaints were managed in accordance with trust policy and lessons were learnt. Staff and managers told us that they preferred to resolve concerns "on the spot."
Staff were aware of the trust's vision and values.
There was a new governance framework in place and responsibilities were defined.

Summary of findings

Department level leadership was effective.
Consultants' roles and responsibilities were defined by the trust's job planning process.
Staff supported each other well. Staff told us the culture of the service was very focused on meeting the needs of children and young people who used the service.
Staff were provided with information on developments at the trust and information on projects the trust was focusing on such as the new children and young people's Rainbow Unit.
The Rainbow Unit rebuilding project would provide modern inpatient and outpatient facilities for children and young people, the new ward was due to open in February 2017.

End of life care

Requires improvement

The reporting process meant that the trust were unable to identify, review or learn from incidents or complaints that were related to end of life care.
There were no risks identified on the risk register that related to end of life care. Minutes of one meeting stated that end of life care incidents were not easy to identify. The trust reported two incidents and zero complaints that related to palliative and end of life care between November 2015 and October 2016. This was raised as an issue at the last inspection.
There were no specific care plans in place for patients receiving palliative and end of life care. The trust had developed a Compassionate Care Plan (CCP) to replace Liverpool Care Pathway (LCP). This was still not embedded across the hospital. This issue was raised as a concern at the last inspection and although progress has been made, further work is needed.
The SPC team had 0.5 of a whole time equivalent (WTE) consultant in post. This did not meet the 'Commissioning Guidance for Specialist Palliative Care: Helping to deliver commissioning objectives' (Dec 2012.) which recommended a minimum requirement of 1 WTE consultant in palliative medicine per 250 hospital beds (NUH has 344 beds).
There were poor standards of cleanliness, dignity and upkeep in the mortuary for which the hospital's

Summary of findings

senior management team knew little about and had poor oversight of. It was managed centrally from Royal London Hospital by the clinical support services, which operated trust wide.

We found that the mortuary area was not clean. There were no daily cleaning check lists available for completion by staff. This meant the hospital had no assurance that areas were cleaned routinely and in a specific time scale.

There was no policy or guidance in place for how the mortuary should be cleaned to ensure that health and safety requirements were met and that deceased patients were treated with dignity throughout cleaning processes.

Within the mortuary we found that there was a hole in the wall exposing electrical cabling. Staff told us this had been reported in early October 2016. There was no signage on the fridges or in the mortuary to identify correct location of bodies to indicate how many days they had been stored in the fridges.

We found that infection control procedures were not followed for safe storage of deceased patients. Fridge temperatures were not checked between 11th October and 1st November 2016 which meant the trust had no assurance that the body storage facility was at the correct temperature.

There was no policy to determine correct transfer of deceased patients in the event of a fridge breakdown.

Medical and nursing notes were not always easy to navigate, there were loose sheets and they were not in any order.

Barts Health NHS Trust contributed to the National Care of the Dying Audit (NCDA) March 2016. The trust was below the England average on three out of the five clinical indicators and only achieved one out of the five organisational key performance indicators (KPI).

An audit of the use of the CCP undertaken by the SPC team, showed that only 8 (28.6%) out of 28 sets of patient notes had a documented CCP in their notes.

A hospital survey undertaken in July 2016 to identify awareness of patients approaching end of life was low amongst medical staff and clinical nurse specialists.

Summary of findings

The end of life CQUIN audit undertaken in August 2016 looked at 17 deceased patient notes. These showed that only 6 patients (35.3%) had their preferred place of death (PPD) documented and only one patient was transferred to their PPD.
Not all the patient records we reviewed had pain assessments on file, despite having diagnosed conditions which often cause pain and discomfort.
T34 syringe pump training was not mandatory for all registered practitioners working on the wards.
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) audits for the period January 2016 to October 2016 showed that 66.6% (201) forms were completed incorrectly.
Palliative care patients were not prioritised for side rooms. There was a lack of facilities for dying patients and their relatives; this meant that patients privacy and dignity was compromised.
The results from the bereavement survey undertaken between January and September 2016 showed that only 23% (3) of the respondents rated their overall experience as excellent or good.
The Fast Track process was not routinely audited; without this information, the hospital was unable to monitor their progress or improve.
The trust was not routinely auditing patients' preferred place of care (PPOC). Without this information, they were unable to monitor their progress or improve.
There were no designated facilities for relatives' or carers' overnight accommodation. Wards could provide chairs for relatives who wished to remain at their relatives' bedsides.
The trust had an 'End of Life Care Strategy 2016 - 2019'. It had been ratified by the trust on the 19th October 2016. However, staff we spoke with were not aware that the strategy had been ratified by the trust and many nursing staff knew nothing about it.
The trust had a draft business case to increased staffing to improve end of life care and specialist palliative care across the trust. However, this business case had not taken into consideration other services such chaplaincy and therapies and how they would link in to the overall vision of end of life care.
There were no risks identified on the risk register that related to end of life care. However the 'end of

life care key line of enquiry report' presented to the quality assurance committee meeting in September 2016 highlighted two risks. These related to the recruitment of additional staff for end of life care.
The trust carried out surveys for patient and staff satisfaction. However, these did not specifically identify end of life care results.
However, we also found:
We fed back our immediate concerns regarding the mortuary on 1 November 2016. On 11 November 2016 the trust reported what actions had been taken. An infection prevention and control review had been undertaken on 3rd November 2016, two days after being made aware of our findings, and a deep clean of the environment and equipment carried out. A new cleaning schedule was put in place with weekly reviews for the following four weeks and monthly reviews thereafter. The trust reported that the site management team were assessing the risks and logistics associated with a specialist deep clean of the fridges. On the 18 November 2016 the trust reported that the mortuary was closed on 17 November as a temporary measure for deep cleaning of the fridge to take place, which was scheduled for 23rd November. Contingency plans had been made for all deceased patients to be looked after by a local undertaker. The capital cost to replace the fridge from the current year's capital budget had been identified and the hospital's managing director reported that the estates team were sourcing a supplier and establishing the quickest route to replacement.
We were also provided with information regarding leadership and management of the mortuary, giving the hospital greater oversight and management.
There was guidance for prescribing palliative medication and guidance for use of anticipatory medication at end of life.
The trust provided evidence of a maintenance schedule and asset list of syringe drivers including when they were purchased and last service date.
We found that most patients under the care of the SPC team were prescribed anticipatory medication.

Summary of findings

We saw that the hospital had recently introduced 'End of Life Care Wednesdays'; a series of one hour interactive workshops led by the SPC team for all clinical staff.
There was a weekly hospital palliative care multidisciplinary meeting. Medical staff, nurses, social services and the chaplaincy attended this meeting.
The DNACPR forms were stored at the front of the patients' notes. They were easily identifiable and allowed easy access in an emergency.
We saw that verbal consent to treatment was recorded in all the patient records we reviewed.
Relatives we spoke with told us that the staff communicated with them and their relative in a way that helped them understand their care, treatment and condition. They told us discussions with staff had been handled very sensitively.
We saw staff carrying out care with a kind, caring, compassionate attitude. Staff spoke to patients politely and respected their privacy and dignity, asking for consent to proceed with tasks.
The chaplaincy service visited patients on a daily basis to provided support for patients and their relatives irrespective of their individual faith. They could be called upon 24 hour a day seven days a week.
Between April and October 2016 97% of the patients had been seen by the SPC team within 24 hours of referral.
There were no visiting time restrictions for family and friends visiting a patient in the last days or hours of life. This allowed family and friends un-limited time with the patient.
The trust had a defined management and governance structure for end of life care. The trust's Chief Medical Officer (CMO) and a Non-Executive Director had specific responsibility for end of life care on the trust board.
The trust had an end of life strategy which identified priorities to improve care and treatment delivered at the last stages of life.
The SPC team attended the trust wide palliative care team meetings which were held monthly.

Newham University Hospital

Detailed findings

Services we looked at
Medical care (including older people's care); Surgery; Maternity & gynaecology; Services for children and young people; End of life care

Detailed findings

Contents

Background to Newham University Hospital

Newham University Hospital, in Plaistow, East London is part of Barts Health NHS Trust, the largest NHS trust in the country. The hospital offers a range of acute services to a population of approximately 300,000 people living in the London Borough of Newham. The hospital has approximately 344 inpatient beds, with over 1548 staff working there. The services the hospital provide include

The Gateway Surgical Centre that offers elective surgery and diagnostic procedures in many different specialties, as well as housing the Trust's sports injuries clinic and fracture clinic.

Newham is deprived, coming third out of 326 of local authorities, with 80% of the local population having a minority ethnic background. The population is predominantly young, with the majority of residents aged between 20 and 39.

Our inspection team

Our inspection team was led by:

Head of Hospital Inspections: Nicola Wise, CQC

Inspection manager: Max Geraghty, CQC

The team included CQC inspectors and a variety of specialist advisors; such as consultants and doctors of different grades; nurses, midwives and allied health professionals; as well as experts by experience.

How we carried out this inspection

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

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

The inspection team inspected the following core services at this location:

- Medical care (including older people's care)
- Surgery
- Maternity and gynaecology
- Services for children and young people
- End of life care

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Requires improvement	Good	Good	Good	Good	Good
Surgery	Requires improvement	Good	Good	Good	Good	Good
Maternity and gynaecology	Inadequate	Good	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Services for children and young people	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
End of life care	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	N/A	N/A	N/A	Requires improvement	Requires improvement

Medical care (including older people's care)

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

Information about the service

Medical care services at Newham University Hospital includes six inpatient wards, a coronary care unit, an endoscopy day unit and an acute care unit. Patients have access to a range of specialties, including older people's medicine, stroke care, endocrinology, diabetes care, respiratory medicine, cardiology and gastroenterology. A range of additional services are also available, including psychologists, allied health professionals, alcohol and drugs liaison officers and social workers.

Between April 2015 and March 2016 the hospital reported 13,597 spells of inpatient medical care. Of this figure, 46% of admissions were for general medicine, 10% were for gastroenterology and 20% were for geriatric medicine.

The hospital is part of Barts Health NHS Trust and provides networked services such as renal, sexual health and HIV medicine.

As part of our inspection on 1 November 2016, we returned to conduct a weekend unannounced inspection on 6 November 2016. We visited every inpatient medical ward, the coronary care unit, discharge lounge, endoscopy day unit, observation ward, acute care unit and sexual health and HIV services in the Greenway Centre.

We spoke with 49 members of staff from a range of specialties and areas of responsibility, including clinical and non-clinical staff. This included five consultants, nine doctors in training, site managers, a patient flow coordinator, a GP trainee, three ward managers, three allied health professionals, the pain management team, 23 nurses, nine healthcare assistants, executive managers and leaders, seven patients and eight relatives.

To help us come to our ratings and in addition to speaking with staff, patients and relatives, we reviewed 30 sets of patient records including risk assessments and care plans, observed ward rounds and multidisciplinary meetings and took into account a further 72 individual pieces of evidence.

We last inspected the hospital in May 2015 and rated medical care services as inadequate. This was because staffing levels were insufficient to provide safe care, the standard of medical records did not protect patients from avoidable harm and the service was not well led. There was a pervasive culture of bullying and staff were not empowered or well supported.

Medical care (including older people's care)

Summary of findings

Overall we rated medical care services as good because:

- Annual nurse turnover had stabilised at an average of 9% between March 2016 and May 2016, which was better than the trust target of 14%.
- Daily multidisciplinary safety huddles enabled staff to identify patients who were deteriorating, review patients with complex needs and plan for safe and effective discharges.
- The hospital achieved a B grading in the Sentinel Stroke National Programme in March 2016, reflecting effective practice.
- In response to an increasing number of patients living with dementia and those with needs such as alcohol dependency, a nursing team had introduced an enhanced care bundle. This helped ward staff and other clinicians to provide person-centred care and treatment planning that was adaptable to individual needs.
- A patient flow coordinator role and dedicated discharge consultant worked together to plan discharges and ensure each patient had a package of care in place as well as prescribed to take home medicine where needed. This team had established innovative links with local social services, who provided 24-hour seven day cover to help reduce discharge delays by providing a single point of referral for patients with community social needs. The endoscopy unit had reduced the backlog for procedures and six-week-wait breaches by 76% to August 2016 through improved staffing and equipment reliability.
- The hospital demonstrated it was responsive to local needs and challenges. For example, a dedicated overseas team provided specialist liaison and support with immigration authorities and the police to help patients with complex immigration, asylum or refugee status needs. This meant patients could be discharged safely without putting them at risk and without blocking bed capacity in the hospital.
- Staff spoke positively about the introduction of a ward manager role, which they said helped to stabilise their teams and provide a structured approach to local leadership support. Ward managers had increased their clinical presence to 40% of their workload, which meant they were more visible and readily available to clinical staff.
- Performance in the national heart failure audit was significantly better than the national average. This included a 38% higher overall compliance rate with cardiology inpatient care and a 34% higher rate of consultant cardiologist input.
- An enhanced care bundle enabled staff to provide person-centred holistic care. The tool could be adapted for patients with a learning disability, living with dementia, at risk of self-harm or at risk of falls. The care bundle could be used with relatives to establish a patient's normal daily routine and identify factors that could be used to reduce anxiety and distress, such as talking about their favourite topic or providing access to music.
- A dementia and delirium team and dementia strategy group had worked with patients and carers to introduce a range of improvements to the hospital environment and services to improve the experience for patients living with dementia. This included improved support for carers and resources for patients that included access to a reminiscence room and use of technology such as sound amplifiers.
- There was substantial evidence of continual improvement to services as a result of engaging with patients and the people close to them, including the use of remote video technology to support young adults with long term condition management.

However we also found:

- Medical staffing levels were generally consistent although out of hours the number of doctors was significantly reduced. However, the trust did take steps to ensure long-term consultant sickness in neurology was covered by a locum consultant.
- Nurse staffing levels were inconsistent and vacancy rates were up to 29% in care of the elderly services. Although a team of healthcare assistants provided support, some staff told us their level of training had been reduced and they were no longer able to provide cannulation, catheter care or wound care,

Medical care (including older people's care)

despite their workload being increased as a result of nurse shortages. However, after our inspection the trust said they had not reduced healthcare assistant's opportunities for training.

- There was no dedicated junior anaesthetist input into multidisciplinary ward rounds, which meant the pain management team was not able to provide a full specialist service.
- The standard of infection control processes, including hazardous waste management and adherence to the control of substances hazardous to health guidance, were variable. This was because not all areas we inspected were clean and there were areas of unrestricted access to waste and chemicals.
- Although risk assessments in most records we looked at were comprehensive and completed routinely, there was a lack of consistency where patients had complex needs, where nurse teams were short staffed and where patients were cared for as an outlier.
- Staff in some teams said they felt morale was low and decreasing and talked about their worries in relation to increasing workloads and ongoing nurse shortages due to vacancies and sickness.

Are medical care services safe?

Requires improvement

We rated medical care services as requires improvement for safe because:

- Serious incidents were not always resolved in a timely manner and the trust's renewed focus on reducing hospital-acquired pressure ulcers had not resulted in a sustained improvement. However, investigations and root cause analyses were comprehensive and senior consultants had begun to develop a tracking system for factors that contributed to such incidents.
- Screening for methicillin-resistant Staphylococcus aureus (MRSA) was inconsistent. On one day of our inspection, only 63% of patients on Silvertown ward had a documented MRSA screen and none of the patients had their result recorded.
- Medical cover at night was provided by a middle career doctor and two career-grade senior house officers. Consultant cover was provided on-call. Although the doctors were supported by the critical care outreach team, their ability to provide safe cover to the entire hospital depended on their colleagues during the day limiting how much work was left for them. This was not a structured system and meant there could be delays in assessing new or deteriorating patients overnight.
- Nurse staffing levels were inconsistent and none of the five core medical care and older people's services wards had a full establishment of staff as at August 2016. However, temporary staffing ensured that at least 100% of planned shifts were covered. There were inconsistencies in the safe staffing levels nurses in charge believed were needed and the establishment considered safe by the senior hospital team.
- Although risk assessments were generally completed adequately, this was not always evident for patients that were cared for as an outlier or in the observation ward. This included one patient in the observation ward who had no nurse-led risk assessments for 12 hours after admission despite significant risk to them; and a patient cared for as an outlier with complex mental health needs.
- There was room for improvement in environmental cleaning standards, including on the observation ward where we found black dust on curtain rails.

Medical care (including older people's care)

- Hazardous waste was not always managed in line with national and international best practice safety guidance, including in storage and access control.
- Staff training in fire safety and basic life support was lower than the trust's minimum target of 90% as at June 2016. An audit in the observation ward in June 2016 found deficiencies in fire safety but there were no documented updates or actions.
- Although medicines management policies were followed consistently in relation to their administration to patients and stock, there were gaps in the recording of safe storage temperatures. This was because staff did not record regular temperature checks of medicines stored in ambient rooms. In the Greenway Centre, technicians did not consistently record the storage temperatures of medicines stored in fridges. This meant services could not be sure medicines were stored within the manufacturers' safe range.

However, we also found:

- Staff demonstrated consistent infection control practices in relation to hand washing, decontamination of the use of personal protective equipment and adherence to the bare below the elbow policy.
- Nurses documented risk assessments for patients on admission, including for pressure sores, venous thromboembolism and malnutrition. Processes were in place to monitor deteriorating patients, including use of the national early warning scores and the chronic respiratory early warning scores.
- Medical care services reported no never events between October 2015 and September 2016.
- Our review of incident reports and root cause analyses showed us staff at an appropriate level of experience investigated incidents and identified learning. This was communicated to clinical teams and resulted in changes to practice such as in new procedures for labelling samples and reviewing results in the Greenway Centre.
- The pharmacy governance structure was embedded in the safety processes of the hospital and ensured medicine incidents and errors were reviewed by appropriate staff and learning identified and shared. Local ward procedures ensured Controlled Drugs were appropriately stored and managed.

Incidents

- Between October 2015 and September 2016 the hospital reported no never events. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- In accordance with the Serious Incident Framework 2015, medical care services reported 18 serious incidents (SIs) that met the reporting criteria set by NHS England between October 2015 and September 2016. Fourteen reports related to pressure ulcers. A senior consultant led a root cause analysis of each SI that included a review of each patient's pathway through the hospital and appropriateness of their care and treatment. We looked at ten SI root cause analysis outcomes in the period May 2016 to September 2016. In each case the consultant had identified factors that contributed to the SI, where staff had acted appropriately and where there was an opportunity for learning. Each report included evidence of compliance with the duty of candour, multidisciplinary communication and the effectiveness of the care pathways used.
- The Greenway Centre reported one SI in the 12 months prior to our inspection that involved a delayed diagnosis of tuberculosis following a routine appointment. The director of clinical education led a root cause analysis and as a result a 12 point action plan was implemented with a target completion date of October 2016. The action plan identified required improvements in safety processes and the handling of diagnostic and test results, the implementation of an electronic ordering process for diagnostic imaging and significantly improved clinician ownership of following up test results.
- Between November 2015 and October 2016 staff in medical care services, including the coronary care unit and the observation ward, reported 933 incidents, which equated to 74% of all incidents submitted in the hospital. Of the incidents, 83% resulted in no harm to patients, 15% resulted in low level harm to patients and 2% resulted in moderate harm. Of all incidents, 20% related to pressure ulcers.
- Between May 2016 and November 2016 the Greenway Centre reported 14 incidents. Eleven incidents related to problems with specimen labelling or missing results.

The service manager was aware of this risk due to IT problems with the labelling printer and had entered this onto the service risk register for escalation to the senior team. In addition, a new documentation system had been implemented that meant pathology samples were checked by two members of staff for accurate labelling before they were sent to the laboratory. Also, a failsafe procedure had been implemented to ensure samples were tracked electronically and patients were automatically recalled if an adverse result was found.

- There was evidence of learning from incidents. For example, following an incident in which a relative of a vulnerable patient became aggressive with a doctor in training, the medical team reviewed how doctors were trained to engage with people who might not understand clinical processes.
- Serious incidents were not always investigated and resolved in a timely manner. For example, a serious incident reported in April 2016 had a resolution deadline of July 2016. However, this had not been completed by August 2016 and the lead investigator had noted they had resubmitted the root cause analysis to the director of nursing for approval. Also as at August 2016, three serious incident reports relating to grade three pressure ulcers remained unresolved and overdue by at least 10 days. The trust noted reasons for the delays as changes in clinical governance structures. While this formed part of a quality improvement plan, it meant there was not a contingency plan for delays to serious incidents.
- Staff submitted an incident report for each pressure ulcer either acquired on site or that deteriorated on site. A harm free panel led a weekly pressure ulcer meeting to identify themes in the root cause analysis of each pressure ulcer. Between April 2016 and October 2016, the eight themes identified included poor evidence of repositioning, poor nursing care, failure to follow pressure ulcer policy and a lack of wound assessment. A pressure ulcer training and education programme had been implemented for all staff as part of a wider strategy to reduce pressure ulcer incidents.
- Pharmacy staff and senior nurses met monthly in the medicines, safety and management committee to review incidents. Outcomes from the meetings were disseminated to the quality and safety team, the governance team and the pharmacy governance board. Senior nurses in each clinical area briefed their own teams on the outcomes of meetings. There was evidence of learning from medicines incidents. For example, following an error in which a member of staff administered an expired Controlled Drug (CD), a new auditing policy was implemented to more closely monitor the processes.
- After our inspection we received information from a person wished to remain anonymous about safety on Tayberry ward. They told us staff were under pressure to not submit incident reports in relation to safety issues connected to short staffing. None of the staff we spoke with on-site reflected this but this ward was consistently very busy and short-staffed.

Safety thermometer

- The NHS safety thermometer is used to record the prevalence of patient harm in wards and clinical areas and to provide immediate information and analysis to teams to monitor their performance in delivering harm free care.
- Each inpatient ward displayed a safety cross board that tracked monthly safety thermometer events such as falls and pressure ulcers. Although this information was readily accessible, staff were not always aware of the information and said this information was not always discussed at staff meetings. In addition, the safety cross display on Heather ward was blank.

Cleanliness, infection control and hygiene

- An infection prevention and control practitioner provided a number of preventative services in the hospital to support staff and protect patients from the risks associated with infection. The practitioner worked with bed managers to ensure side room allocations were made available for patients who presented with an infection risk. They also managed infection control alerts and ensured new policies and safety information was disseminated to all staff in the hospital. The practitioner contributed to the trust's cross-centre infection control network to ensure best practice and learning was shared with colleagues.
- Personal protective equipment such as disposable gloves and antibacterial hand gel was readily available in most areas we visited. This included at the entrance to ward areas and in each bed space or private room. However, there was no hand gel available in the reception area or entrance of Jasmine ward and there was no gel available in the vicinity of hand hygiene signs for visitors to Heather ward. We observed staff

consistently follow hand hygiene procedures including hand washing between patients or when leaving a private room used to look after a patient with an infectious condition.

- The trust had a 'bare below the elbows' policy to prevent the risk of cross-infection between patients and wards. During all of our observations staff adhered to this policy and we saw nurses challenge visiting clinicians who did not immediately follow this guidance.
- Disposable curtains separated bed spaces and were labelled with the first use date. Staff used this to ensure they were disposed of in line with the manufacturer's guidance.
- Staff used 'I'm clean' labels to indicate when an item of equipment or furniture had been cleaned and decontaminated. We observed consistent use of this process by housekeeping staff, healthcare assistants (HCAs) and nurses.
- Cleaning staff did not always adhere to best practice infection control processes. For example, in the observation ward cleaning mops were stored in the buckets used for cleaning. This increased the risk of bacteria accumulation and the mops should have been stored inverted and out of the buckets.
- Monthly hand hygiene audits took place in each clinical area or ward and the trust had a minimum compliance target of 95%. Between April 2016 and October 2016, average overall compliance was 97%. This reflected consistent levels of compliance with hospital policy that met or exceeded the minimum target, with the exception of doctors' actions after patient contact, which reflected an average of 85%.
- Most clinical areas and wards displayed hand hygiene audit results. In The Greenway Centre, the most recent results were for May 2016 and June 2016, with an average 95% compliance. In the respiratory ward, the latest results were for October 2016 where hand hygiene compliance was 85% and Thistle ward achieved 100% hand hygiene compliance.
- Trust policy was that each medical patient would be screened for methicillin-resistant Staphylococcus aureus (MRSA) on admission. We looked at the records for all 19 patients in the respiratory ward on one day of our inspection and found 12 patients had a documented MRSA test but staff had not recorded the tests results for any patient. Overall MRSA screening between May 2016 and October 2016 for medical care services ranged from a low of 70% in Heather ward in May 2016 to 100% for Thistle and Silvertown wards in October 2016.

Environment and equipment

- Resuscitation equipment was located in each ward or clinical unit. Staff documented daily checks on this equipment, which we checked in all areas for the three months prior to our inspection. Daily checks were recorded consistently with only one missing entry from equipment in the respiratory ward.
- The environment in the observation ward, Jasmine ward and the endoscopy recovery unit complied with the Department of Health (DH) Health Building Notes 00-09 and 00-10, in relation to the condition of the flooring and bed spaces. Although the observation ward was tidy and well maintained, there was room for improvement in standards of cleaning. For example, there was black dust on the top of some curtain rails, which indicated they had not been cleaned recently. In addition there was thick black dust on a fan above a bed in Thistle ward, which presented an infection control risk to the patient in bed bay.
- Storage of chemicals was not always maintained in line with the control of substances hazardous to health regulations (COSHH). For example, we found unlocked dirty utility rooms in the observation ward and respiratory ward and both had chlorine tablets and solution on display. These substances should be stored in a locked facility. In addition, boxes in the dirty utility room in the respiratory ward were unstable, unsecured and presented a risk of injury if they fell on someone. A corporate COSHH policy was in place that identified the health and safety team as holding responsibility for safe management of chemical products. It was not evidence during our inspection that there was a relationship between senior ward staff and this team.
- Waste storage and management did not always meet the requirements of the European Waste Framework Directive (2008/98/EC) or the DH Health Technical Memorandum 07-01 on the management and disposal of healthcare waste. This was because waste trucks that contained infectious waste were readily accessible and open in the observation ward and respiratory ward during our weekend unannounced inspection.
- Sharps bins were stored off the floor with closed apertures and signed labels. This was in line with

national best practice safety guidance. Although processes were in place to ensure sharps bins were disposed of securely, we saw one sharps bin in the Greenway Centre that was overfilled and in situ in an unlocked treatment room with an open aperture, which presented a risk of needle stick injury. Monthly environmental audits from this unit indicated there were on-going problems with the safe management of sharps bins, including incorrect assembly and inconsistent labelling.

- The hospital participated annually in the patient-led assessment of the care environment (PLACE). PLACE is an audit conducted by patients and other visitors to the building with support from staff to assess cleanliness, condition, appearance and maintenance. Provisional scores for 2016 indicated scores of 99% for cleanliness and 95% for condition, appearance and maintenance, both of which were comparable to the previous three annual audits.
- On one day of our inspection in Tayberry ward, we noted the door to the dirty sluice room was propped open and the waste bin was overfilled with used syringe drivers on show. This presented an immediate safety risk.
- On the respiratory ward, the pantry door had a 'fire door keep shut' label on it but the door was broken and could not close fully. In addition, there was no handle and a hole in the door where this should have been. This presented a fire risk.
- Each clinical unit or ward audited environmental cleanliness on a monthly basis and displayed their results. For example, the respiratory ward displayed results of 96% compliance in the latest results from October 2016 and Thistle ward displayed results of 100% compliance.
- Staff did not have access to climate control in the discharge lounge and kept a stock of blankets to keep patients warm as the area could get cold. The lounge was an open area between two wards with access directly from the main hospital corridor. This meant it was challenging to maintain patient confidentiality as there was no private seating area in which discharge instructions or medication instructions could be given.
- The observation ward manager conducted a workplace and staff safety and welfare audit in June 2016. The audit found the ward was compliant with accident reporting processes and the provision of equipment to contain chemical or infectious spillages, sharps safety and manual handling. The audit identified poor fire safety arrangements and a lack of conflict resolution training for staff. There were no documented outcomes from the audit.
- A fire risk assessment had taken place in the observation ward and surrounding areas in June 2016. The assessor rated the environment as 'high risk' with immediate requirements for safety improvement in relation to fire drill training and practice. We did not see evidence that this had been completed.

Medicines

- A pharmacy assistant visited medical wards daily and two nurses checked stocks and documentation of controlled drugs (CDs) and emergency medicines on a daily basis. We looked at the stock documentation for medicines for the three months prior to our inspection in every inpatient area we visited. We found this was consistent with no omissions. A pharmacist conducted a weekly check of stock on all CDs.
- Staff checked and recorded temperatures for fridges used to store medicine twice daily. In all cases we saw temperatures were maintained within manufactures' safe limits. A contingency plan was in place in case of a fridge failure to ensure the cold chain was maintained, which reduced the risk medicine would be stored unsafely and therefore would become unfit for use. A sexual health technician in the Greenway Centre sexual health clinic was responsible for stock checks and rotation of medicines, including antibiotics, with support from pharmacy. A senior nurse completed this in the HIV clinic. Although staff were assigned to daily checks, there was a lack of consistency in documentation. For example, the sexual health clinic did not have a temperature recording log and although the HIV clinic had a temperature log, there were gaps in recording.
- Intravenous medicines and antibiotics were stored securely and in line with the medicines policy and all of the 15 items we checked were within their expiry date.
- All staff who were responsive for providing or monitoring intravenous (IV) fluid therapy had undergone appropriate competency training and assessment, in line with National Institute of Health and Care Excellence (NICE) quality standard 66 in relation to prescribing and administering IV fluids.
- Rooms used to store medicine did not have thermometers installed. Although staff used fans to

keep them cool, for instance on Silvertown ward, they could not be sure medicine was always stored within the manufactures' safe range because they did not record temperatures.
- The site manager had access to emergency medicines out of hours when pharmacy support was not available on-site.
- A governance pharmacist led an intervention audit in January 2016. This was due to be repeated in November 2016 to assess the safety of pharmacy systems in the hospital. In addition, a pharmacist completed a quarterly audit of controlled drugs to ensure they were safely stored in line with national guidance, including a check of expiry dates.
- Pharmacy technicians used a 'roadmap' that enabled them to transcribe agreed medicines prescribed by a doctor and support GPs within input into the discharge letter.
- Appropriately qualified staff on Jasmine ward used the FP10 prescribing system. We looked at a sample of 15 records and reviewed the process with a senior nurse, which was well monitored and reviewed weekly by a pharmacist.
- Between November 2015 and October 2016 staff in medical care services submitted 121 incident reports relating to medicines, including 37 in October 2016. Overall this represented 13% of all hospital incidents. In each case a senior clinical member of staff and pharmacy member of staff was involved in the investigation, which led to improvements in practice. This included more consistent recording of medicine fridge temperatures, improved processes for medicine management when patients were transferred between wards and safety systems for handling patient's own medicine. The medicines, safety and management committee reviewed each incident and shared learning with the trust's other sites.

Records

- There was evidence of documented risk assessments in most of the patient records we looked it, including an early skin integrity assessment, venous thromboembolism (VTE) risk, waterlow score and a completed malnutrition universal scoring tool. However, there was room for improvement in how nurses in the observation ward prioritised these for new patients. For example, we saw one patient who had been admitted for 12 hours did not have risk assessments for skin integrity, VTE or malnutrition. The nurse in charge was not able to explain this although there was significant risk to the patient because of the injuries that led to their hospital admission. We escalated this to the site manager who said they would ensure the risk assessments were completed. The hospital had implemented new nursing documentation in July 2016 in line with the quality improvement plan. As part of this, monthly compliance audits took place and the clinical quality review group expected to achieve 100% compliance by February 2017.
- Staff used a combination of paper and electronic records. We previously found a lack of computers led to delays in documenting patient observations and notes by doctors. There had been some improvement with the provision of new computers and improved IT infrastructure.
- Patient records and tests in the sexual health service were electronic and in the HIV service staff were transitioning from a paper system to an electronic system.
- The security of patient records was generally in line with information governance, including locked storage units and constant staff supervision when records were removed. However, we saw a patient records desk had been left open, unlocked and unsupervised on Stratford ward. We checked back one hour later and the desk had been secured.
- Staff used a risk assessment for the use of bed rails. However, it was not always clear what processes were used to ensure the assessment was fit for purpose. For example, staff had used the risk assessment tool for two patients on different wards and found the results did not recommend bed rails. However, we saw bed rails were in use and a nurse had noted 'for patient safety' as the reason for each case. This meant it was not clear why staff had overridden the risk assessment or what tools they had used to identify this as a strategy to reduce patient risk.
- A drug chart audit in 2016 highlighted the need for improved documentation of patient height and weight on Stratford ward. As a result new training sessions were implemented for nurses.

Safeguarding

- Between November 2015 and October 2016 staff in medical care services submitted 25 safeguarding incident reports. The senior member of staff in each

ward or unit had investigated each incident and escalated concerns to the hospital and local authority safeguarding teams in each case. Learning was identified and led to improvements in practice, such as more direct discharge communication with GPs, more appropriate allocation of staffing based on skill mix and more rapid involvement of the multidisciplinary team when staff had concerns.

- A clinical safeguarding lead was in post and all of the staff we spoke with knew who they were and how to contact them. There was evidence this took place in practice when we reviewed patient notes in each area.
- All clinical staff had a minimum safeguarding training requirement of levels one and two for adults and children and consultants and senior nurses were trained to level three safeguarding.
- Staff had direct access to a community rapid response team that supported patients with safeguarding needs. This team acted as a liaison between the clinical care team in the hospital, social services, patients and their relatives when they had complex social needs.
- Safeguarding training included an introduction to recognising and responding to abuse, escalating concerns and recognising female genital mutilation.
- Clinical staff in the Greenway Centre worked with hospital and local authority safeguarding teams to provide care for young people who presented in the service, including those under the age of 16. The clinical governance team recorded and tracked safeguarding referrals through monthly meetings to ensure appropriate follow-ups took place and to ensure appropriate action where patients were highly vulnerable, such as in the case of sexually transmitted infections amongst patients below the age of consent.

Mandatory training

- As at June 2016, 80% of staff had up to date fire safety training and 76% had up to date basic life support training. Both items were part of the hospitals' quality improvement programme with a minimum target of 90%. As at August 2016, 95% of staff in medical care services were up to date with statutory and mandatory training.
- We spoke with nurses and HCAs about mandatory training. Most staff we asked spoke negatively about the training provision. One senior nurse said they felt the infection control training had been pared down and it was no longer useful for clinical areas. Another nurse said they only ever had time to complete mandatory training in their own time because they were not given protected time at work, which meant they were not paid for training.

Assessing and responding to patient risk

- All staff had undertaken basic life support training, including non-clinical support staff. Clinical staff undertook immediate and advanced life support training depending on their level of responsibility. For example, all nurses working in the acute care unit (ACU) had up to date immediate life support training to ensure they could care for patients with high dependency needs.
- Staff in each inpatient area used the national early warning scores (NEWS) system to monitor patient acuity and recognise when they were deteriorating. The NEWS protocol was used to establish the frequency of patient observations, from between 12 hourly for stable patients to continual monitoring for acutely unwell patients. Staff monitored patients with a respiratory condition using the chronic respiratory early warning score system (CREWS).
- A daily morning safety huddle and 'board round' took place with the site manager, head nurse, ward managers or senior ward representative, duty pharmacist, radiographers and allied health professionals. Multidisciplinary staff used the safety huddle to review safeguarding concerns, planned discharges, new pressure sores, Deprivation of Liberty Safeguards (DoLS) applications and the demands on the critical care outreach service. The dementia team attended the meeting and planned support to wards that were caring for patients with dementia or a DoLS in place. Individual ward safety huddles took place between the ward manager, senior nurse, medical team, staff nurses and healthcare assistants. Any staff providing enhanced care to patients joined the safety huddle.
- In October 2015 the hospital introduced a new approach to assessing pressure ulcer risks that involved improved working between medical teams. This resulted in a decrease in hospital-acquired pressure ulcers (HAPUs) to the lowest level in two years recorded between October 2015 and March 2016. Between April 2016 and October 2016, 30 HAPUs were recorded in medical care services. The hospital took action and convened a risk

summit to review each HAPU and identify how instances could be reduced. This included earlier escalation of deteriorating patients and increasing needs as well as more effective risk assessment.

- Staff used the national NHS Improvement SSKIN care pathway to prevent pressure ulcers through early monitoring and effective moving and handling. Staff on individual wards monitored this. The respiratory ward had achieved 43 days free from new pressure ulcers although there were gaps in the consistency of patient risk monitoring on this ward. For example, one patient had an elevated waterlow score that meant staff should have used the SSKIN bundle to prevent a pressure sore developing. The SSKIN bundle is a national initiative directing nurses to best practice skincare to help reduce the risks of skin breaking down. Although this had been started, there had been no update for over 29 hours. The agency nurse caring for this patient was not able to explain this.
- In October 2016 a tissue viability nurse completed a review of the quality of nursing documentation in relation to pressure ulcer prevention. This found inconsistencies in documentation, including a lack of evidence that nurses were completing skin assessments on a regular basis, despite documentation being signed. The tissue viability nurse also found inconsistencies in the SSKIN documentation similar to our findings, including inaccuracies in recording times of care.
- A serious incident report from May 2016 indicated the hospital was not sufficiently staffed to provide safe care if multiple demands were placed on the service at one time. This included two simultaneous cardiac arrests, a deteriorating patient and a referral for an emergency medical procedure. As at August 2016 this incident remained unresolved and there was a notable lack of documented senior input into the investigation.
- Staff used a sepsis screening and management tool that followed the principles of the Sepsis Six. This is national best practice guidance to identify risks in patients using predetermined criteria.
- In addition to the NEWS and CREWS processes, staff used an enhanced care bundle to plan and deliver care for patients with additional or complex needs. This was provided using a 'red amber green' (RAG) system that helped staff to understand if the patient needed intermittent extra care or 1:1 care.
- As part of the enhanced care bundle, staff completed an environmental risk assessment for patients at risk of falls, self-harm or violence. This included identification of ligature points, doors that patients could use to lock themselves in and risks to others such as glass that could be broken. This tool enabled staff to mitigate risks, such as moving the patient to a more suitable area or removing items that presented a risk, such as access to chemicals where a patient was at risk of self-harm.
- Staff on Plashet ward had submitted a business case for resources to implement a specialised alcohol care pathway for patients with a dependency. This was submitted to address the issue of assaults on staff and to provide a 1:1 nurse to patient ratio of care.
- Shift handover documentation was detailed and included information on patients with specific risks, such as falls or pressure ulcers. The patient information board in each ward provided staff with a summary of the key risks on the ward, including patients with a Deprivation of Liberty Safeguards order in place.
- Staff in the discharge lounge used a safety checklist to ensure patients were only accepted in line with an established criteria that meant they could be cared for safely in the area. The nurse in charge worked to a standard operating procedure that ensured they could escalate any patients who became unwell.
- Staff in the observation ward had training that helped them to respond appropriately to deteriorating patients. This included basic and immediate life support, security, medical gas management and early warning systems.

Nursing staffing

- In June 2016, nurse vacancy rates in medical care services varied from 0% to 29% of the established staff level needed. At the same time, nurse turnover rates varied from 0% to 25%, with the HCA team in gastroenterology demonstrating the highest vacancy rate. However, on-going focus on recruitment had significantly reduced vacancy rates by August 2016, where the highest vacancy rate was 8% on Tayberry ward.
- Between July 2016 and October 2016, an average of 23% of planned nursing shifts were uncovered. This figure included critical care services as well as medical inpatient wards.
- Sickness rates varied considerably between wards including HCAs on care of the elderly wards who had an average sickness rate of 10%.

Medical care (including older people's care)

- Between March 2016 and June 2016, nurse turnover was lower than the trust target of 14%, at an average of 9%.
- Staff used the daily site safety huddle to review planned and actual nurse staffing levels and establish support plans for any wards that were short staffed or had patients with high levels of acuity. Although the safety huddle enabled staff to establish actual staffing levels and pressures on the service, there was not a process in place to include the concerns of senior nurses or ward managers. For example, we visited one ward before the safety huddle and the nurse in charge told us they were three nurses short for that shift, which had a significant impact on their plan for the day. However, at the safety huddle the ward was presented as fully staffed. The nurse in charge told us this was because there were discrepancies between what the hospital considered a safe staffing level and what the ward team felt was safe.
- Each ward established its planned nursing and HCA staffing levels based on occupancy and patient acuity. This varied between wards. For example, during the day the observation ward had a staffing requirement of five nurses and two healthcare assistants. Plashet ward had a requirement of four nurses, three HCAs and a ward manager during the day and four nurses and two HCAs overnight. On our weekend unannounced inspection the ward was short of one nurse and the nurse in charge had therefore had to take patients as well as their ward leadership duties. Due to the high levels of complexity seen on Plashet ward, staff shortages were covered by experienced bank staff rather than agency nurses.
- The respiratory ward had three nurses and three HCAs per shift, which equated to a staff to patient ratio of 1:3 or a nurse to patient ratio of 1:6. Stratford ward planned to operate with three nurses and three HCAs during the day and with three nurses and two HCAs overnight. Senior nurses and ward managers had access to bank and agency staff and told us they prioritised staff who had previously worked on the ward for continuity. Staff on Silvertown ward said they had never seen the same agency nurse more than once because it was difficult for agency nurses to understand the type of care offered there.
- The acute care unit (ACU) cared for patients with level two high dependency needs and the senior team used a safer staffing tool to ensure a nurse to patient ratio of 1:2 was maintained.
- Core nurse staffing for the Greenway Centre was a senior nurse coordinator, three nurse practitioners and a sexual health technician. This was increased and supplemented with specialist staff depending on the clinics running.
- A staff nurse and HCA led the discharge lounge and had access to more senior clinical staff in nearby medical wards if needed.
- Although staffing levels on the ACU were assessed using a safer staffing tool, only 12% of nurses were trained in providing high dependency care. This meant they could not always competently meet the needs of patients. We asked senior nurses about this who said they had stopped reporting the issue through the incident reporting system because they felt it made no difference and that a letter of concern sent to senior staff had been unanswered.

Medical staffing

- As of June 2016, the turnover rate for medical staff was 0% and the sickness rate was consistently low, at an average of 4%.
- Consultants on inpatient wards were typically available from 8am to 5pm Monday to Friday. Foundation level doctors in each ward or specialty, including endocrinology, gastroenterology and respiratory medicine joined ward rounds twice weekly. Where there were medical outliers being cared for outside of the specialist area they needed, consultants and foundation level doctors ensured they were included in the ward rounds. We found evidence of this by looking at patient records and speaking with staff.
- On the observation ward, consultant cover was from 8am to 8pm seven days a week with on-call cover available at other times. Weekend medical cover was provided by a specialist registrar from 9am to 10pm and from 10pm to 9am, two foundation doctors between 9am and 10pm, and three middle career doctors from 9am to 9pm. Between 9pm and 9am two middle career doctors were available.
- Site medical cover at weekends during the day was provided by two foundation level two doctors, two senior house officers and one specialist registrar. Overnight at weekends, medical cover was provided by one specialist registrar and two senior house officers. This was in addition to any specific ward-level medical cover.

Medical care (including older people's care)

- A lead consultant was in post for the Greenway Centre and led sexual health and HIV services. Typical daily medical staffing for the centre was a consultant, two senior doctors and a foundation level doctor. In addition the centre had recruited an extra middle career doctor to reduce waiting times for walk-in appointments.
- We asked all of the doctors we talked with about medical cover on their ward and in the hospital in general. A senior doctor in older peoples medicine told us they felt medical staffing was stable and consistent and each specialty had enough medical cover to respond to referrals. The trust had taken steps to ensure long-term consultant sickness in neurology was covered by a locum consultant. We saw further evidence of this in a multidisciplinary meeting for patients in older people's medicine where staff discussed strategies to overcome delays in obtaining decisions from the neurosciences team.
- Three cardiologists led care and treatment on the coronary care unit and a consultant was available at all times on call overnight and at weekends.

Major incident awareness and training

- An overall major incident plan was in place for the hospital but knowledge of this on the medical wards was variable. For example, most wards did not have a locally maintained directory of staff availability in the event of a major incident and staff we spoke with did not have consistent knowledge of evacuation plans.
- A fire risk assessment in June 2016 in the observation ward found although staff demonstrated knowledge of how to safely evacuation the unit in response to a major incident, there was no written or structured formal evacuation plan.
- Staff did not routinely complete major incident training.

Are medical care services effective?

Good

We rated medical care services as good for effective because:

- A comprehensive programme of 73 audits, pilot programmes and benchmarking exercises took place in 2015/16, which staff used to establish compliance with national best practice guidance. Audits took place against the standards set by organisations such as the National Institute for Health and Care Excellence, the British Thoracic Society, the British Association for Sexual Health and HIV and the British Society of Gastroenterology. Learning from audits was evident and staff demonstrated a commitment to on-going improvements.
- Clinical staff took part in 21 different pilot projects or benchmarking exercises to monitor patient outcomes against national trends and standards, including in long term condition care and condition management.
- Foundation level doctors were actively engaged in audit cycles that helped them build their skills and competencies in clinical assessments and benchmarking. Doctors in the Greenway Centre had protected study time for teaching and learning delivered by consultants.
- Performance in the 2015 Heart Failure Audit was better than the national average for all four standards relating to inpatient care and in three of the seven standards relating to discharge. This included higher performance than the national average in multidisciplinary working, including in referrals to cardiology follow up and the heart failure liaison service.
- There was evidence of regular multidisciplinary meetings in medical inpatient areas to review patients with complex needs and comorbidities. Multidisciplinary services in the Greenway Centre were tailored to the needs of patients, including specialist-led sexual dysfunction and sex worker clinics.
- The dementia and delirium team had introduced improved monitoring of food and fluids for patients living with dementia as well as improvements to staff competencies, training and resources.
- The hospital performed higher than the national average in the national British Thoracic Society Smoking Cessation Audit, with smoking status documented in 90% of records compared with 80% nationally.
- The hospital achieved a B rating in the Sentinel Stroke National Programme 2016 results. Although this represented a downgrade from the previous A rating due to the removal of some aspects of multidisciplinary working as a result of another provider's provision, the final rating reflects effective practice.

However, we also found:

Medical care (including older people's care)

- Between March 2015 and February 2016, patients had a higher than expected risk of readmission than the national averages for both elective and non-elective medical admissions.
- In the 2015 National Lung Cancer Audit, 64% of patients were seen by a cancer nurse specialist. This was lower than the audit minimum standard of 80% and all measurements in the audit were below national targets. General hospital performance had deteriorated since 2014.
- Resources had been reduced for some teams that meant they could not provide a full service or that they had reduced their clinical competencies. This included a change in role for healthcare assistants and a change in leadership and capacity for the pain management team.
- Staff documented observations in relation to mental capacity inconsistently and it was not always clear that established tools had been used to assess this.
- In the national diabetes inpatient audit, the hospital performed significantly worse than the national average in relation to the choice of food available.
- Results from the patient-led assessment of the clinical environment indicated significant deficiencies in the provision of appropriate nutrition for patients living with dementia.

Evidence-based care and treatment

- In 2015/16, the hospital took part in 27 national and local audits to benchmark standards of care and to assess quality against national best practice guidance, including for pulmonary rehabilitation, diabetes care and the use of opioids.
- Foundation level doctors took part in local and national audits, including in the national diabetes audit and a local audit of the management of hypoglycaemia. Doctors spoke positively about the opportunities for auditing and said they had protected time every five weeks to discuss audits as a staff group. Audits were designed to address the unique challenges of the hospital and the needs of the local population. For example, junior doctors often managed emergency diabetes cases out of hours and an audit took place to assess the usefulness of simulation training. The audit found improved response and understanding by doctors in training, which resulted in continuation of a practical training programme.
- The pain management team had completed an audit that found their workload had increased by 45% between 2012 and 2016 with a 50% decrease in staffing. The pain management team lead had updated the patient-controlled analgesia policy and epidural policy in 2016 to maintain them with national guidance.
- Staff in the Greenway Centre delivered care and treatment in line with national standards set by the British Association for Sexual Health and HIV (BASHH) and The STI Foundation. Standards formed part of a comprehensive audit programme that included 25 local or networked audits between 2014 and 2016. This included audits of the location of new diagnoses of HIV and tracking of prevalence and population risks for specific sexually transmitted infections. Staff also developed audits that aimed to identify how services met the needs of specific population groups with complex behaviour and vulnerabilities.
- A flexible endoscopy decontamination audit had taken place in November 2016 using the guidance of the British Society of Gastroenterology. Although the audit was fully completed there was no documented learning or outcomes and some information was contradictory, including records of the use of air drying for endoscopes. The audit found staff were not regularly screened by occupational health but did not note if this was acceptable within trust policy.

Pain relief

- A pain management team was available Monday to Friday during the day. A full time band seven nurse and part time band six nurse formed this team, which represented a reduction from three full time senior nurses. There was also no junior anaesthetist on the team, which meant they could not always provide ward round cover.Overnight and at weekends, an anaesthetist held the pain team bleep for urgent assessments but staff raised concerns this meant there was no specialist pain management input available out of hours.
- Staff used a pain assessment and management nursing care plan to establish pain and analgesia needs. The plan included three key goals, including the achievement of a level of pain acceptable to the patient and a multidisciplinary approach to pain management. In addition, the pain management team provided inpatient areas with reference tools and care pathways for the management of pain, such as an analgesia regime for use after knee replacement.

- The pain management team provided patient controlled analgesia services, such as morphine pumps, and managed these with ward staff.
- The pain management team had participated in the National Pain Audit in 2016. The audit included all 1692 patients referred to the service in the previous 12 months and highlighted three recommendations. These were that constipation be prevented through improved prescribing of laxatives; that the pharmacy team supply guidance on the use of opioids to prescribers and that anti-sickness medicine be more readily prescribed.
- Pain relief processes were based on national and international best practice guidance. Staff used pain documentation that was based on the guidance of the World Health Organisation. However, the hospital had not fully implemented the Faculty of Pain Medicine's Core Standards for Pain Management (2015). This was because pain scores were not consistently recorded for all patients. For example, one patient in the respiratory ward had no documented pain scores in the 19 days since they were admitted. This patient was a medical 'outlier', which meant they were being cared for in a ward not related to their specialist needs whilst they awaited appropriate placement. Nurses had noted that pain relief had been given overnight when the patient complained of a headache but there was no evidence of a follow-up by staff during the day.

Equipment

- In May 2016 the hospital introduced new hybrid mattresses that could be used by every patient and included air flow controls to reduce the risk of pressure ulcers. This meant patients did not need to be transferred to another bed if their skin deteriorated and meant staff could more readily manage pressure ulcer risk. The mattress manufacturer had provided a clinical nurse advisor to provide on-site support to staff in assessing patient risk and managing the equipment. However, management of pumps that staff could order to control the air flow was problematic and the manufacturer noted in October 2016 that 10 pumps were missing, which had caused a waiting list for patients. This issue was resolved in seven days through the provision of additional pumps but staff on wards did not follow a process to ensure pumps were tracked and ready for use as soon as they were needed.

Nutrition and hydration

- From looking at patient notes we found staff encouraged patients to maintain food and fluid levels. For example, a mental health nurse worked with a patient's family to improve their diet after they started to refuse food.
- In the National Diabetes Inpatient Audit, 26% of patients rated their food choice as positive compared with the national average of 54%.
- Staff used the malnutrition universal scoring tool (MUST) for each patient on admission to assess their nutrition and hydration needs. This was updated weekly or more frequently if the patient was at increased risk.
- Nutrition and hydration was one of the 'activities of daily living' care plans in the nursing documentation bundle and prompted staff to offer assistance to patients to eat and manage their oral hygiene appropriately. We looked at 26 care plans and found in all cases staff were using the nutrition and hydration care plan.
- A pressure ulcer care plan audit in October 2016 found staff did not always correctly identify patients at risk of malnutrition, referrals were not always made in a timely manner to a dietician and MUST scores were not always acted on.
- The catering team had introduced electronic ordering that enabled ward staff to show patients food options using a digital tablet and transmit these to the chef team. This meant the team could accommodate changes more responsively and more readily involved patients in the process.
- Dieticians and staff caring for gastroenterology patients conducted a daily nutrition round to review each patient's nutrition and hydration intake and to ensure their planned care was still appropriate.
- We asked five patients about their experience of food in wards. All patients said the quality of food was good but also said hot meals were served only lukewarm. Patients also said they felt there was a lack of choice and staff had not been able to supply alternatives to the menu.
- The dementia and delirium team had introduced workstreams to improve monitoring of food and fluid intake for patients with dementia or delirium.
- As part of the annual patient-led assessment of the care environment (PLACE) audit, patients and visitors assessed the quality of food in Heather and Silvertown wards. Provisional scores for 2016 indicated 87% satisfaction with food on Silvertown ward and 98% satisfaction with food on Heather ward. The overall average score of 89% was comparable to the national

average. The PLACE audit also considered appropriate food and food services for patients living with dementia. In 2016, patient assessors scored Silvertown ward 38% for dementia-friendly food service and Heather ward 88% for the same measure.

Patient outcomes

- Between March 2015 and February 2016, patients had a higher than expected risk of readmission than the national averages for both elective and non-elective medical admissions. The readmission rate for elective rehabilitation services was more than double the expected rate. This coincided with a significantly lower length of stay for rehabilitation patients than the national average, at 16 days compared with 24 days nationally. Respiratory medicine and gastroenterology were the specialties with the next highest readmission rates for elective patients. For non-elective patients, general medicine, geriatric medicine and cardiology were the specialties with the highest rate of readmissions.
- Staff used a programme of 21 pilot projects, benchmarking exercises and outcome measure assessments to establish patient outcomes and how these could be improved through innovative service developments. This included a new end of life care pathway and the use of remote video technology to improve chronic diabetes management. Outcomes for patients who needed medical assistance for alcohol withdrawal were variable, with a 33% readmission rate within six months. This audit found variable compliance with trust guidelines, including an alcohol liaison team referral rate of 67% and clinically indicated average prescribing compliance of 77%.
- The hospital took part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the hospital achieved grade B in the latest audit between January 2016 and March 2016. This represented a downgrade from the previous quarter. Within the latest audit, standards of discharge with hypertension medicine and multidisciplinary working decreased in rating and standards of scanning improved. The hospital achieved eight of the 10 required indicators for optimal stroke care. The two indicators not met were the presence of a clinical psychologist and the availability of two types of therapies seven days a week. The provision of a psychologist was the responsibility of another trust, which also provided community stroke team reviews.
- Results from the 2015 National Diabetes Inpatient Audit showed a need for improved foot inspections and increased access to podiatrists. The audit also highlighted cases of avoidable hypoglycaemia in the hospital. In response, a team of healthcare assistants (HCAs) undertook specialist training to become 'foot champions' on the wards, nurses received intensive specialist training and podiatrists were made available three days per week.
- The hospital's results in the 2015 Heart Failure Audit were better than the national average for all standards relating to in-hospital care. Results were also better than the national average in three of the seven standards relating to discharge. The hospital performed significantly better than the national average for cardiology inpatients, with 86% compliance compared to 48% nationally. In the same audit, input from a cardiologist was noted in 93% of patients, compared with 59% nationally.
- In the 2016 British Thoracic Society Smoking Cessation audit, the hospital scored higher than the national average in documenting patient smoking status, at 90% compared with 80% nationally. The audit also highlighted the need for more structured guidance for patients to reduce smoking after discharge.
- In the 2016 National Clinical Audit of Biological Therapies, clinical staff highlighted the need for improved screening of patients for hepatitis B and C and HIV prior to the commencement of biological therapies by mandatory inclusion in care pathways. An action plan from this audit had been implemented and was underway at the time of our inspection.
- The hospital performed variably in the 2016 National Emergency Oxygen Audit. For example, the percentage of prescriptions filled increased from 54% in the previous audit to 74% but the percentage of drug charts signed decreased from 18% to 0%. In response the pharmacy department initiated a new training and education programme for nurses.
- In the 2015 National Diabetes Inpatient Audit, the hospital performed better than the national average in

11 out of 17 metrics. Performance in foot risk assessments during an inpatient stay and after 24 hours; insulin and prescription errors and management errors were significantly better than the national average.

- In the 2015 National Lung Cancer Audit, 64% of patients were seen by a cancer nurse specialist. This was lower than the audit minimum standard of 80% and 26% lower than the result in the 2014 audit. All measurements in the audit were below national targets and general hospital performance had deteriorated since 2014.
- Staff used an intentional rounding daily care record as part of the nurse risk assessment and care pathway notes. The intentional rounding tool prompted staff to ensure patients were comfortable, had been offered hydration and had their general wellbeing checked. This tool also helped staff to continually monitor the patient's environment; such as if they had a call bell in reach.

Competent staff

- We highlighted nursing staff competencies as an area of concern in May 2015. This was because not all nursing staff on medical wards had the necessary clinical competencies to provide safe and effective care for patients. In response the hospital had begun an assessment of all staff against a competency framework and an improvement in mandatory training. At the time of our inspection this assessment was still being compiled. Nurses and HCAs we spoke with had varying experiences of continued development and opportunities for training in addition to standard mandatory training. One nurse told us that in four years of employment, they were disappointed to only have one training request approved. Another nurse said they felt unsupported by the senior team in building their professional development and said if they did undertake training this was unpaid and in their own time. Staff in other areas were more positive about their experiences. One nurse said they had regular one-to-one meetings with the ward manager and that most of the training they had asked for had been approved.
- HCAs told us their training programme had been simplified and no longer included cannulation, catheter care or wound care. HCAs we spoke with said this was a disappointing transition and they felt their clinical competencies had significantly reduced as a result, which was corroborated in our discussions with nurses. However, after our inspection However, after our inspection the trust said they had not reduced HCA opportunities for training. We were not able to identify why there was a difference in information.
- Staff in the Greenway Centre worked within specific competency criteria. For example, sexual health advisers had to demonstrate compliance with the Society of Sexual Health Advisers Professional Code of Conduct before they were able to see patients alone. In addition this staff group had to complete a practice-based competency assessment based on 11 areas of clinical practice and a period of reflection on their performance and skills. Nurse practitioners developed clinical competencies in line with national BASHH standards of practice and sexual health technicians completed clinical and patient competencies based on the needs of the department.
- Consultants and senior doctors used ward rounds as teaching opportunities for doctors in training. For example, when one patient became angry, confused and aggressive the consultant first worked with the patient to calm them down and then discussed the situation with the other doctors to explain different care pathway and assessment options available that could best help the patient.
- Each member of staff was due to undergo an appraisal annually. These had been completed to varying degrees. Staff in Stratford ward had not undergone an appraisal in the previous 12 months but all staff in the Greenway Centre had an up to date appraisal.
- The hospital's quality improvement plan (QIP) highlighted the need for improved staff competency training in mental health and the Deprivation of Liberty Safeguards (DoLS). This was implemented through targeted training in staff meetings in August 2016. The QIP highlighted short staffing and the associated lack of capacity as a key risk to improving competencies. Although this was partially mitigated with the use of temporary staff, it meant the competencies of substantive staff were not consistently improved.
- Foundation level doctors and GP trainees had protected time for training, research and audits. This helped to build core clinical competencies and contributed to the unit's track record of developing medical staff from foundation level doctors to consultants.

- The dementia and delirium team delivered training to all clinical and non-clinical staff to improve communication and person centred care to patients with dementia and delirium.
- An infection prevention and control practitioner supplemented basic mandatory training with more comprehensive competency checks and education sessions for clinical staff, including processes for isolation. The practitioner led bi-monthly infection control link nurse study days to ensure each ward had a point of contact who was up to date with latest advice and guidance.

Multidisciplinary working

- Nurses and specialists from a range of disciplines were readily available for ward staff. This included a tissue viability nurse, alcohol liaison team, sickle-cell community nurse, registered mental health nurses, psychiatric liaison team and a learning disability nurse. A podiatrist was on site three days per week and also provided a targeted diabetes foot service.
- Multidisciplinary (MDT) working with the pain management team had been reduced. For example, until recently a junior anaesthetist joined ward rounds, including on Saturdays, as part of an MDT approach to pain management. However, the trust stopped this practice as part of a reduction of the pain team overall.
- National audits indicated staff facilitated MDT specialist care for patients. For example, in the Heart Failure Audit, 62% of patients were referred to cardiology follow up compared with the national average of 54%, and 70% of patients were referred to the heart failure liaison service, compared with the national average of 54%. However, in patients with left ventricular systolic dysfunction, 9% fewer patients were referred to the heart failure liaison service than the national average of 60%.
- MDT staff provided coordinated services in the Greenway Centre, including a weekly specialist nurse providing screening services to sex workers and a doctor specialising in erectile dysfunction for a weekly men's clinic.
- Psychological services were available as part of the Greenway Centre's sexual health network, including an HIV psychology liaison service.
- An HIV consultant in the Greenway Centre provided an on-call referral service for medical inpatient areas in the hospital. This meant if a patient with previously undiagnosed or uncontrolled HIV was identified through the medical ward round in the main hospital, the HIV consultant could attend to support the medical and pharmacy teams in the specialty in which they were being treated.
- A weekly multidisciplinary meeting took place in Thistle ward to review all patients cared for in the older people's service. We attended a meeting during our inspection, which had representation from multiple specialties and services including social services, dietetics, allied health professionals and community nurses. Staff used this meeting to liaise with other hospital and community services, including a tissue viability nurse, palliative care team, microbiology, gynaecology and community physiotherapist. This team liaised with providers outside of the hospital as part of care and treatment planning. For example, when a patient who experienced multiple falls in an assisted living facility demonstrated much better mobility in the hospital, the Thistle ward team liaised with the warden of the living facility to identify how and why the patient was falling. This meant a package of care could be put in place to facilitate a safe discharge.
- A weekly MDT team meeting took place on Plashet ward to review the complex medical and social needs of patients. We attended a meeting and saw there was a consistent focus on ensuring patients' care was well coordinated and involved community social care specialists, including drug and alcohol teams and social services. For example, hospital staff had liaised with a housing authority to ensure a patient had suitable housing on discharge and staff had implemented an immediate specialist care package for a patient with safeguarding needs who developed sepsis.
- Consultant-led alcohol withdrawal support was available through the borough rapid assessment, interface and discharge team. Staff additionally had access to social services and a rapid response security team to help protect them from harm and to ensure patients with complex needs could be safely cared for.
- Staff on Heather ward had implemented a monthly MDT meeting to discuss the hospital's 'Listening into Action' improvement strategy. This helped staff to review improvements in the service provided and in working policies to identify where they would like to make changes.

Seven-day services

Medical care (including older people's care)

- Seven day consultant cover was provided in all areas through an on-call system, with the exception of the acute medical unit, the coronary care unit and observation ward. In these units there was consultant presence seven days a week.
- Routine pharmacy services were available Monday to Saturday and on a Sunday between 10am and 2pm, with an on-call service at all other times.
- Physiotherapists provided a seven day service, including an on-call service from 6pm to 8am. Occupational therapists were available daytimes Monday to Friday.

Access to information

- Staff had access to safeguarding and child protection information in advance of elective admissions and worked with on-call social workers to ensure social information was available on an as-needed basis.
- Doctors began the discharge planning process on admission and this included contact with each patient's GP as soon as they left the hospital. GP trainees in the hospital facilitated contact between consultants and GP practices.
- Staff working in networked services, such as endoscopy and sexual health, had access to health records from all satellite centres. This meant if a patient was seen at Newham Hospital, staff could access their previous medical records regardless of where they had previously been seen.
- Sexual health advisers and technicians in the Greenway Centre were trained in partner notification for positive HIV and sexually transmitted infection results.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- A doctor or other qualified clinician completed a capacity and consent to admission for medical care form for each patient on admission. This took into account whether the patient had delirium, a diagnosed condition such as dementia or a learning disability as well as other temporary influences on their mental capacity, such as alcohol or substance use. This assessment also helped staff to identify when they needed to make a safeguarding referral.
- The quality of patient records in relation to mental capacity and cognition was variable. For example, staff noted 'confused on and off' in one patient's notes but there was no detail to explain this further or to indicate additional care had been provided.
- Awareness of mental capacity was embedded in care plan and risk assessment processes. This included prompts in the enhanced care bundle to establish whether patients had the capacity to consent to care or whether a best interests meeting was needed.
- In an endoscopy unit survey from June 2016, 98% of patients said they were satisfied with the consent process.
- The trust safeguarding team had implemented the most guidance from the Department of Health with regards to DoLS authorisations for patients who were cared for on an end of life care pathway. This provided staff with more structured support and enabled them to assess patients who needed palliative care and who had cognitive impairment.

Are medical care services caring?

Good

We rated medical care services as good for caring because:

- Staff demonstrated compassion and kindness in all of our observations, including during transfers and when discussing difficult situations.
- The hospital consistently met or exceeded the recommendation rate target of 95% in the NHS Friends and Family Test (FFT).
- Nursing documentation helped staff to involve relatives when planning personalised care, such as when establishing a person's daily routine, interests to talk about and in identifying factors that might cause a patient distress.
- Emotional support in the Greenway Centre was provided by a range of staff including health advisers and HIV liaison doctors. This ensured patients could access immediate counselling and psychological support on-site.
- The dementia and delirium team and teams in the Greenway Centre and endoscopy unit had conducted their own unit-specific patient surveys to gather detailed information on their experiences. The results indicated patients cared for in each area largely felt involved in their care planning and most patients said they were given enough information.

However we also found:

Medical care (including older people's care)

- Scores relating to privacy, dignity and wellbeing assessed in the patient-led assessment of the care environment audit indicated a sustained decline of 25% in scores between 2013 and 2016, with 2016 results ranging from 45% to 80% for individual wards.
- Although recommendation rates from the NHS FFT were high, response rates were variable and between March 2016 and June 2016, the hospital met the minimum target of a 30% response rate in only one month.

Compassionate care

- Typical response rates to the NHS Friends and Family Test (FFT) could be low. For example, in September 2016 only six responses were received in Thistle ward, although all six respondents said they would recommend the ward. This was indicative of on-going low response rates against the hospital's minimum target of 30%. For example, between March 2016 and June 2016, the average response rate was 16%. This reflected monthly response rates of between 5% in May 2016 and 32% in June 2016. The quality improvement programme included improved response rates and recommendation rates in the NHS FFT as key performance improvement indicators. In the same period, an average of 97% of respondents said they would recommend medical services. This was better than the hospital minimum target of 95% and included some maximum rating achievements. For example, in August 2016, 100% of respondents said they would recommend the respiratory ward and in October 2016 100% of respondents said they would recommend Jasmine ward.
- We observed staff maintained patient dignity and privacy during transfers and handovers, including when transferring between the emergency department and observation ward.
- Patients, their relatives and friends we spoke with described an improvement in their experience over preceding years. One friend of a patient said, "Everyone is more respectful than they used to be. The doctors, nurses, volunteers…everyone seems happier."
- We spoke with a total of 13 patients in Stratford, Silvertown and Tayberry wards and in the discharge lounge.
- One patient in the discharge lounge said, "Everything's fine. They've [staff] all been very nice and I think I've been well looked after." One patient in Stratford ward told us, "Staff are brilliant, they are just like family. I feel safe and well looked after."
- Three patients and relatives we spoke with in the endoscopy unit said they felt there was room for improvement in privacy around the reception desk. One individual said, "I wish the reception staff would be a bit more discreet when speaking to each other about our personal health matters."
- Staff in the endoscopy unit conducted a patient satisfaction survey between April 2016 and June 2016. Overall 93% of patients said they were treated with respect and dignity in the unit and 91% said their privacy had been respected.
- We saw during breakfast time on Tayberry ward healthcare assistants (HCAs) helped each person in a relaxed and compassionate manner. HCAs provided gentle encouragement and assistance, made each patient feel comfortable and acknowledged their effort when they did not feel like eating.
- Results from a May 2016 patient survey in the Greenway Centre showed 94% of patients felt they were treated with dignity and respect and 89% rated their care as excellent or good. Patients commented that they felt welcomed by staff without judgement.
- As part of the annual patient-led assessment of the care environment (PLACE) audit, patients and visitors assessed the level of privacy, dignity and wellbeing promoted by staff in Silvertown ward, Plashet ward and the coronary care unit. Provisional results for 2016 indicated an overall score of 63%, which was significantly lower than the national average of 85%. This was an average figure and reflected individual scores ranging from a low of 45% in Plashet ward to 80% in Heather ward. The overall hospital score of 74% reflected a sustained decline in results between 2013 and 2016, of 25%.

Understanding and involvement of patients and those close to them

- The enhanced care bundle included involvement of patient's relatives and carers, such as to help staff establish their normal daily routine and identify strategies that might help them to relax and improve their experience.

Medical care (including older people's care)

- During a medicine round on Thistle ward we saw the nurse in charge explained to each patient what their medicine was for and provided reassurance when they needed it.
- We spoke with patients and relatives in the endoscopy unit, observation ward and discharge unit. Each individual spoke positively about how they had been involved in their care. One patient said, "I can't fault the medical team, they've been very thorough." One relative told us, "I felt I got all the information I wanted from the doctor." People we spoke with said they would have liked more information about the waiting times and information on what was planned when they had to move between departments. Another patient said, "The procedure I had didn't go well the first time and they had to re-do it. The doctors and nurses kept me informed at every step and I really appreciated knowing what they were doing. I'm not from this area and the care I've had doesn't compare to what I'm used to, they are doing a great job." One patient in Stratford ward said, "I didn't want to know much about what's happening to me; just the essentials. I told the doctor this and he listened and respected that."
- The dementia and delirium team asked carers about their involvement with staff and care planning in a survey between January 2016 and March 2016. In all but one case carers said staff had involved them in the care of the patient they were responsible for. In addition, 84% of carers said staff had explained that patients were at risk of developing delirium and provided them with information and guidance.
- Staff in the endoscopy unit conducted a patient satisfaction survey between April 2016 and June 2016. Overall 91% of patients said they were given the chance to ask questions about their procedure beforehand and 83% said they received printed information about what to expect at their appointment. In addition, 74% of patients said they were told what to expect after their procedure and 75% of patients said a clinician explained their results to them after the procedure.
- Clinical staff worked with patients with complex and challenging needs to involve them in care planning as far as possible. For example, one consultant asked a patient, "What do you really want?" when they had disengaged with their treatment plan. As a result the consultant initiated a compassionate care pathway to gain a better understanding of the patient's needs and wants.
- In a May 2016 patient survey in the Greenway Centre, 88% of patients said they were given enough information about their medicine in the unit.

Emotional support

- Although counsellors were not based in the hospital, staff who worked most often with patients with complex social and psychological needs could refer patients to community psychotherapy support. This also included access to independent mental capacity advocates and counsellors specialising alcohol and drug withdrawal.
- Health advisers in the Greenway Centre offered basic counselling and psychological support in relation to HIV or sexual health needs and referred patients with more complex psychosexual needs to another site within the network that had access to psychologists.
- An HIV specialist counsellor was available in the Greenway Centre to provide emotional support for patients with trauma or depression.
- The hospital chaplaincy was available 24 hours a day, seven days a week and could provide a priest or imam on request.

Are medical care services responsive?

Good

We rated medical care services as good for responsive because:

- Between April 2015 and March 2016 the average length of stay for non-elective medical patients was 3 days, which was lower than the national average of four days.
- The hospital had implemented a patient flow coordinator role that worked proactively with a dedicated discharge consultant to prioritise medical discharges at weekends. This team worked with local social services that provided a 24-hour, seven day service to reduce discharge delays at the weekend.
- Day services demonstrated flexibility in access. For example, the Greenway Centre provided daily walk-in appointments with a 60-minute target for each patient to be seen. Staff in the endoscopy unit were able to see patients who urgently needed a procedure but who had mixed up their appointment time.
- In response to the needs of the local population, a dedicated overseas team provided support and liaison for patients with complex needs around immigration,

refugee or asylum status. In addition, the Greenway Centre provided advocates who could speak Romanian and Portuguese, in response to an increase in demand from the local population.
- An enhanced care bundle had been introduced to each inpatient ward area that provided staff with a care pathway and contacts to help those with complex social needs. This included support for staff in establishing communication with patients who had cognitive impairment or a language barrier.
- A learning disability passport and 'forget me not' system helped staff to provide more individualised care to patients living with those conditions.
- There had been a 76% reduction in the number of six week wait breaches in the endoscopy unit between July 2016 and August 2016.
- Complaints were dealt with effectively, with learning identified, implemented and shared. Staff apologised to patients where a mistake had been made and offered a resolution to the problem.

However we also found:

- The average length of stay for elective medical patients was 13 days, although this patient group reflected only 1% of medical admissions.
- The number of overnight bed moves remained high.
- Although 140 additional bed days had been provided in September 2016 and October 2016 to meet winter pressure demand, the hospital could not fully staff these.

Service planning and delivery to meet the needs of local people

- The hospital had established an innovative relationship with the local authority social services team to provide 24-hours, seven day a week liaison cover for discharge support. This meant staff had access at all times to social services to provide patients with social or complex community needs a package of care in order to reduce discharge delays.
- An on-site overseas team provided specialist support to non-UK citizens who had been treated as inpatients and had needs relating to homelessness or asylum or refugee status. The team was available five days a week and liaised with immigration authorities, police and social services to ensure patients received the care they needed and were not discharged without an address to go to.
- Staff in the Greenway Centre worked with other services in the network, non-profit agencies and NHS England to ensure health promotion material targeted people at risk of emerging health patterns and infections. For example, following an increase in rates of shigella infections in London, specific prevention information was provided for patients.
- Plashet ward provided patients with an acute medical service in gastrointestinal medicine, haematology, sickle cell and oncology. The ward also provided care for patients with alcohol dependency and post-procedure care after an endoscopy.
- All clinical staff in the Greenway Centre undertook clinical competency training and assessments based on the needs of the local population, including health promotion strategies and motivational interviewing. The senior team used this as a service planning strategy to ensure they could meet demand on the service and be responsive to trends in local population behaviour and risk.

Access and flow

- In August 2016, 98% of patients were seen within established referral to treatment (RTT) times for their speciality. This included 100% compliance with RTT times for diabetic medicine, clinical oncology, medical oncology and geriatric medicine and 92% for general medicine and 96% for endocrinology.
- Between May 2016 and October 2016, 33 patients experienced a transfer between wards after 10pm at night. In the same period, 41% of all patients (3077 individuals) experienced at least one bed move. This amounted to 25% of patients experiencing one bed move, 25% of patients experiencing two bed moves, 5% of patients experienced three bed moves and 3% of patients experienced four or more bed moves. This was a slight improvement on the previous year, during which time 43% of all patients experienced a bed move, including 34% who experienced two or more bed moves..
- A discharge consultant led a daily morning ward round to identify medical patients who were fit for discharge. The consultant liaised with the site manager and the dedicated patient flow coordinator (PFC) afterwards to review each patient together and prioritise individual discharges. We joined a handover meeting during our weekend unannounced inspection and saw staff used an effective and holistic approach to planning

discharges. For example, the PFC was aware of each patient's social circumstances and ensured that a package of care was in place before a discharge was agreed.

- A discharge lounge was available from Monday to Friday between 10am and 6pm. A consultant-led ambulatory care service was available on Mondays and Tuesdays that meant patients with minor intervention needs could be discharged from the emergency department or observation ward without the need for an inpatient bed.
- In response to an increase in demand on services in September 2016 and October 2016, an additional 140 bed days for medical care were provided. Although this improved capacity and access to inpatient care, the service could not fully staff the additional nurse shifts needed, with 89 shifts uncovered.
- The endoscopy unit had a weekly capacity of 125 procedures. A backlog of procedures, equipment failures and a lack of staff meant that at the end of August 2016 there were 323 referrals backlogged. The hospital was able to outsource up to 120 procedures per month to another provider and along with improved equipment maintenance and staffing, the number of appointments that breached the maximum six week referral-to-treatment wait reduced from 115 in July 2016 to 28 in August 2016.
- Between April 2015 and March 2016 the average length of stay for non-elective medical patients was 3 days, which was lower than the national average of four days. The average length of stay for elective medical patients was 13 days although this represented only 1% of admissions.
- The Greenway Centre offered daily walk-in appointments for sexual health screening as well as pre-bookable appointments in 30 minute and one hour slots. The centre had a target of seeing each patient within 60 minutes of arrival and there were a range of options available to meet patient needs. This included contraception services and a consultant review clinic. To reduce waiting times, receptionists were trained to give out condoms and sexual health home testing kits to walk-in patients who had registered with the service and did not have symptoms of an infection. Receptionists followed a standard operating procedure for this service and ensured basic contact details were captured so a clinical member of staff could follow up with each patient.
- Specialist services in the Greenway Centre, including a sexual dysfunction clinic and sex worker service, accepted self-referral from patients as well as GP referrals. This provided patients with direct access when they needed it.
- A chaperone policy was in place in the Greenway Centre and staff had been trained to act in this capacity. This meant patients could request a chaperone of the same gender when undergoing an intimate examination.

Meeting people's individual needs

- An older person's liaison service and a dementia and delirium team provided ad-hoc specialist support in wards on request. We saw this team were effectively used by ward staff when a patient's mental state deteriorated and nurses could not meet their personal care or behavioural needs.
- Each ward had an enhanced care bundle pack that enabled staff to provide individualised care to patients with social or complex needs. This included an easily-identifiable lanyard for the member of staff with responsibility for the patient to wear. The enhanced care bundle included a holistic approach to patient care and wellbeing. This included prompts for staff to identify barriers to communication such as language differences and sensory impairment. The care bundle also supported staff to establish the patient's psychological state in addition to their mental cognition and capacity, such as their mood and feelings. Where a patient was in distress or anxious, the care bundle enabled staff to try a series of strategies to help them relax, such as playing music, talking about a topic important to them or going for a walk.
- The enhanced care bundle could be used in addition to tools developed to meet specific patient needs, including a learning disability passport and 'forget me not' documentation for patients living with dementia. The hospital passport was a highly visual colour-coded, easy-read document that used a 'red amber green' system to identify key risks and important facts about the patient. Staff used this tool when patients were unable to communicate or had problems communicating verbally. It included information that was essential to for staff providing care as well as other information that could be used to improve the patient's experience, such as their likes and dislikes. The passport outlined reasonable adjustments that could be made

such as modifying speech so staff could be more easily understood or facilitating overnight stays for carers. Staff could support this with the use of sleeper chairs in inpatient wards.

- In addition to the enhanced care bundle, a care pathway for learning disabilities was in place that enabled staff to assess level of need, including whether the patient needed a private side room. Doctors ensured patients cared for on this pathway were seen first on ward rounds to ensure any additional support needed could be arranged by the nurse in charge.
- New nursing documentation introduced included monitoring of each patient's moods. Staff used this to assess when patients may need social or mental health support.
- The nursing documentation bundle included nine 'activities of daily living' care plans to help staff provide individualised care. Care plans included communication, personal hygiene and mouth care, each of which was reviewed by a nurse every 12 hours.
- Staff made service and risk assessment adaptations to ensure they could provide care for patients living with dementia. For example, the pain assessment and management nursing tool was adapted to include the Abbey Pain Score to help staff assess pain in patients who could not speak to them.
- The tissue viability team produced a pressure area care leaflet for patients and their relatives to help them take steps to prevent pressure ulcers while in the hospital and when they were discharged.
- Although staff told us they had access to translators or interpreters 24-hours seven days a week, we did not find this was routinely used to support patients. For example, we spoke with the friend of a patient who did not speak English. They told us they came in every day and helped the patient to communicate with staff because they did not have a translator. They said, "They have explained they're finding it difficult to get a translator but I don't know why it's an on-going problem, they need to prioritise this." The relative of a patient who could not speak English said, "This is a struggle; the hospital hasn't provided a translator so I have to come in every day around work, I don't know if [staff] are trying to find one."
- The Greenway Centre team had implemented advocacy posts in response to the language and cultural needs of the local population. A Romanian advocate and a Portuguese advocate provided targeted support in the clinic and helped patients to communicate through interpreting services and helped them to understand the different services available. Staff also had access to other specialist advocates on demand.
- Staff demonstrated an understanding of individual needs in addition to clinical and medical care. For example, one patient on Thistle ward found it difficult to manage without smoking. In response the nurse in charge had ordered nicotine patches for them. When the patches arrived the nurse spent time with the patient, explained how they worked and showed them how to fit them.
- A multidisciplinary team used a weekly meeting to ensure patients with complex needs received the individualised care they needed. This included a holistic approach between medical, psychology and community specialists. For example, the team planned a presentation to the neurosurgery team to help coordinate the care of one patient with complex comorbidities. In another case review, staff demonstrated a dedication to coordinating a discharge with a patient's family who were travelling from overseas. Staff identified the patient had elevated anxiety because of their family situation and had worked closely with them and their family to provide a viable discharge plan. The team also ensured patients had appropriate equipment at home by coordinating care with community matrons. In each case the team demonstrated a highly detailed understanding of each patient's immediate needs and worked to identify the priorities that would make the patients most comfortable. For example, one patient's priority was to get home despite their elevated medical needs. The senior doctor and nurses worked with social services to plan this and ensure they would be as safe as possible at home.
- A care pathway for patients with alcohol dependency was awaiting formal funding and ratification but staff used it informally to include community and social services and security staff. Nurses spoke positively about the support they received from the security team and said security officers could maintain a presence on the ward on request.
- Social workers and a non-profit community organisation were available on-call to support homeless patients.
- Staff in the endoscopy day unit tried to see patients who missed their appointments or who attended on the

wrong date. For example, during our inspection a patient who needed to fast had arrived the day after their planned appointment but staff were working together to enable the patient to still have their procedure.

- Thistle ward had been decorated to provide a more welcoming environment for patients living with dementia. This included doors to side rooms painted in bright colours and decorated to have the appearance of typical home doors and 'street' names to help patients orientate themselves. In addition the hospital's dementia team provided volunteers on a weekly basis who visited the ward and provided one-to-one care including Namaste hand massage conversation sessions to help reduce anxiety and improve mood. Resources were available on the ward to help communication with patients, including reminiscence photos of the local area and a colouring book designed for adults with dementia.
- The dementia and delirium team asked carers about their experiences in the hospital between January 2016 and March 2016. An average of 77% of carers said staff had asked them for information on patients that could be used to personalise care, such as their routine, likes and dislikes. In addition, 54% of carers said they had been given information on community support organisations that could help them. As a result of this the team implemented increased use of the nostalgia and activities room and sourced a sound amplifier to enable them to play music to patients with reduced hearing.
- We observed a ward round on Thistle ward with the specialist trainee doctor who was deputising for the consultant and two other doctors. Each member of the team demonstrated a detailed understanding of each patient, including of their social needs. In each case the doctor in charge knelt by the patient so they could talk to them at the same eye level, which had a demonstrably positive calming and positive affect on them. Doctors also told patients when their family were due to visit and used their understanding of each individual's social circumstances to plan the next stage of care and their discharge.
- We observed a consultant-led ward round on Tayberry ward. The consultant and doctor in training demonstrated a detailed understanding of each patient's needs and adapted their approach for patients living with dementia. This included a change in eye contact, tone of voice and body language to help the patient to understand what was being said.
- Staff had developed more responsive communication strategies for young adults with long-term care needs. For example, video chat software was in place that enabled clinicians to speak with patients remotely without the need for them to attend the hospital. This reduced the number of missed appointments and increased compliance with condition monitoring and management. The facility had recently been implemented and the hospital had sought feedback from patients and carers. Patients gave positive feedback about digital remote appointments and one patient said it made managing their condition much easier as they travelled a lot and this meant they could attend appointments even when out of the UK. Students who used this service gave feedback that it meant they no longer needed to miss lectures to attend reviews because they could do this from university. Patients also said it offered an enhanced method of managing their condition because they could contact a clinician remotely without the need for an advance appointment.
- A volunteer-led hairdressing service was available on Tayberry ward, which helped to ensure patients admitted for long periods had some control over their personal care.
- The hospital had a sensory garden and therapy courtyard that was in place to help patients with sensory needs, such as dementia or autism.
- All wards had access to bariatric chairs and beds that could be ordered in advance for patients.
- As part of the annual patient-led assessment of the care environment (PLACE) audit, patients and visitors assessed the environment for dementia-friendly features and adaptations. The provisional 2016 hospital score of 56% was 25% lower than the national average and represented a 35% decline from the 2015 survey. This figure was a hospital average and included scores of 50% for Plashet ward, 52% for Silvertown ward, 69% for Heather ward and 75% for the CCU.

Learning from complaints and concerns

- In August 2016 there were two unresolved patient complaints in medical care services, both of which

related to older people's services. In addition four complaints were received about patient transport services. All of the complaints were within the trust's target of a 25-day resolution.

- The medical director, director of nursing and managing director was responsible for addressing re-opened complaints where the original complainant was unhappy with the resolution. As at July 2016 medical care services had one re-opened complaint. This related to an original complaint in September 2015 and reflected the approach of the quality improvement programme to ensure all patient concerns were addressed. The hospital had contacted the complainant and offered them the opportunity to meet.
- Between May 2016 and September 2016, the Greenway Centre received two complaints. There was evidence staff investigated complaints, apologised to patients and implemented changes to the service as a result. For example, one patient was turned away from a walk-in clinic without being offered a next day appointment as per clinic policy. In this instance the patient received an apology and resolution, and staff responsible for triage were given additional training.

Are medical care services well-led?

Good

We rated medical care services as good for well-led because

- The trust had introduced a ward manager role that meant staff had a single point of contact in each ward for management and leadership. All of the staff we spoke with spoke positively about this and said ward managers had helped to stabilise their teams during staff shortages. Ward managers had increased their clinical presence to 40% of their workload, which meant they were more visible and readily available to clinical staff.
- A medical director, site improvement lead and project manager led a quality improvement programme that included monthly monitoring of staff engagement, safety improvements, patient feedback and access and flow performance. This team demonstrated on-going improvements, including an increase in staff engaged through social media, over 1000 staff engaged through face-to-face meetings and a 6% increase in compliance with staff training between March 2016 and June 2016.
- Individual specialist teams were empowered to establish new policies and improve existing policies as a result of patient engagement. For example, a carers survey led by the dementia and delirium team led to a new carers policy to provide a framework for staff to provide support as well as broader support for carers and patients living with dementia.
- Medical care wards that provided placements for pre-registration student nurses took part in an annual Practice Learning Collaboration Group Enhancement of the Practice Learning Environment audit that monitored the quality of practice learning environments. Audit outcomes were positive and seven out of nine wards scored 100% against pre-set quality criteria.
- Individual teams had developed programmes of public engagement and implemented service improvements as a result. For example, staff in the endoscopy unit improved the way information was given to patients whilst they were waiting.

However, we also found:

- Staff did not always feel they were recognised for their skills, supported to develop or had access to appropriate management support. This included healthcare assistants who felt unsafe in caring for some patients because they did not have restraint or conflict management training and specialist teams that had been reduced in size and had no access to a manager with experience in their dedicated area.
- Staff spoke variably of morale and working culture, including individuals who said they were concerned about the long-term impact of morale because of high levels of sickness and vacancies in nursing teams.
- Although some services such as the endoscopy unit and Greenway Centre conducted their own patient engagement programmes, there was limited evidence information from engagement was used at a hospital-wide level.
- There was limited evidence of consistent and structured leadership on some wards, including on Silvertown ward. On Tayberry ward there was evidence staff did not always feel safe because of short-staffing and the volume of work. However, the trust had recognised the

need for more structured leadership and support on this ward and had appointed a new ward manager who had a track record of improving standards and building effective, coherent teams.

Leadership and culture within the service

- All of the staff we spoke with were positive about the expansion of the ward manager role to include 40% clinical time. A nurse on the respiratory ward said, "The ward manager is very supportive and holds the team together." A member of staff on Plashet ward said, "The service is growing and developing now because we have a ward manager in charge. Now that we feel listened to and supported I think this is a better place to work." Although the ward manager role had contributed to staff cohesion and feelings of support, the implementation of this was inconsistent. For example, during a weekday daily safety huddle we observed, five inpatient wards did not have a ward manager on duty and the most senior nurse had to cover this role. In addition, Silvertown ward had been without a ward manager for four months and staff said the hospital had not provided any additional support. A nurse said, "This is a high pressure ward. We have lots of discharges but just have to get on with it. We support each other because we don't have anyone else to go to. We rarely get breaks or relief."
- The pain management team were led by a theatre matron. Although this provided the team with an accountable line of management, it meant they did not have access to leadership with a specialisation in their area of work.
- Staff in some areas talked to us about concerns with workload and morale. One nurse said, "Staff are tired, sickness is high and morale is low. We really struggled last week because three nurses were off sick and we had no replacements. We asked the matron to get agency nurses and [they] told us 'no' and said we just had to manage." Another nurse said, "I can see a difference in most of the hospital in how managers are more supportive and open but on my ward there is not a positive culture. It's very stressful and I do not feel comfortable approaching the matron." Staff in other areas felt more positively about their experience. One nurse said, "The matron is visible and approachable and everyone seems to have a good rapport. I think we've built a great team here."
- Most staff we spoke with said they worked in a culture free from bullying, harassment and intimidation. One member of staff said they felt racial discrimination was common in their department and they felt individuals were victimised for speaking up. We did not find this was a common theme.
- Senior staff had undertaken training in the principles of the duty of candour and their responsibilities within this. All of the staff we spoke with had an understanding of this and junior staff knew who to refer to when they needed to use the duty of candour. Staff documented in clinical governance meetings, incident reports and complaint analyses when they used the duty of candour to speak openly with people when things went wrong.

Vision and strategy for this service

- Following a period of leadership and governance restructure, the division of medicine business plan for 2017/18 was in draft form at the time of our inspection. The draft plan included seven potential aspirational strategies such as improved seven day services and an expansion of elderly care services.
- Staff in each area we visited as part of the inspection demonstrated knowledge of the immediate vision and strategy for their usual area of work, including improving dementia-friendly environments and opportunities for specialist training. Staff also understood where there was room for improvement in ward-level practice such as in infection control results and patient feedback.

Governance, risk management and quality measurement

- In September 2015 the trust implemented a new leadership operating model that implemented a new directorate structure. Medical care inpatient services came under the remit of the acute medicine and older people's services directorate. The hospital operated cardiology services centrally with clinical leadership independent from other medical inpatient services. A consultant clinical lead, clinical director, service manager and senior nurse for older people and stroke led clinical provision in the directorate. Senior staff we spoke with said the new directorate structure had enabled them to develop new governance and quality frameworks that led to an improvement in service

development and both patient and staff experience. The directorate was within the acute medicine clinical academic group and included seven specialties and 10 wards and units.

- A triumvirate leadership team of a medical director, site improvement lead and project manager led a quality improvement programme. This team met monthly to review progress in key improvement areas. For example, in July 2016 the team reviewed progress in the planned improvement of mental health care and the use of Deprivation of Liberty Safeguards. Improvements were tracked and where there had been no or little progress, this was addressed with further action.
- A site quality and safety committee, hospital board and executive performance review had oversight of risk management and clinical governance in addition to local leadership structures. This framework for monitoring risk demonstrated a responsive approach to trends, such as in a risk summit convened to respond to on-going instances of hospital-acquired pressure ulcers (HAPUs).
- A multidisciplinary clinical quality review meeting took place monthly and was used to review incidents using a thematic analysis, stakeholder engagement feedback and updates on the hospital's improvement plan.
- Healthcare assistants (HCAs) worked on each medical ward and provided support to the nursing team depending on their skill set, training and experience. Due to on-going staff shortages in the nursing team, two HCAs told us they felt under additional pressure. One HCA told us, "There is not enough teamwork here and we're [HCAs] often left to provide the care nurses should be doing. Not everyone has an understanding of what we're here for and it means we really struggle." This team also told us they did not feel risks to them were well managed. For example, one HCA told us they sometimes looked after patients recovering from alcohol abuse who were violent. They said, "There have been a few assaults on staff but we're not trained to handle that, we have had no conflict management or restraint training." Security staff were available on-site 24-hours, seven days a week but we did not see that there were processes in place for staff to protect themselves immediately if they were threatened. We checked training records and found only 40% of staff on this ward had completed conflict management training. Service managers in other areas had been more responsive when a security risk had been identified. For example, staff in the Greenway Centre carried a personal alarm on them at all times. In addition, staff proactively submitted an incident report for instances of patient threatening behaviour. The senior team acted on this and the unit used a card system to warn patients of unacceptable behaviour.
- A ward manager's forum met monthly to discuss risk and incident trends. In October 2016 this included a review of pressure ulcers and each root cause analysis.
- Sexual health and HIV services had an information governance system that protected patient's confidentiality, including a stand-alone patient records system and dedicated data teams. The Greenway Centre provided networked sexual health services along with other hospital and satellite services across Newham. This meant the services shared one clinical governance structure that included clinical leadership and management teams. This also meant staff had ready access to learning from colleagues at all sites. Local service leads in sexual health and HIV provided local leadership and worked with their counterparts at other sites to ensure each service provided care options to meet local needs. We looked at the minutes of governance meetings for the six months prior to our inspection. Staff documented how they improved safety and effectively managed risk by learning from incidents, complaints and feedback from each site.
- Staff in Heather ward met consistently every month and said they found this an important way to discuss incidents, staffing and training. Staff in some other wards, such as Tayberry and Thistle wards, said they met on a more ad-hoc basis because it was difficult to get permanent staff together. Tayberry ward was consistently short of staff during our inspection, to the extent it was not possible to speak with any members of staff on one day. Staff were visibly very rushed and under pressure and it was not clear the senior nurse had access to support from a more senior level. After our inspection we received information from a person who wished to remain anonymous about the standard of care and safety on this ward. The person felt patients were not always protected from avoidable harm because of low staffing levels and the lack of time staff had to spend with patients. We asked the trust about this. The senior team demonstrated an awareness of previous challenges on Tayberry ward and provided evidence of their progress in establishing significant

improvements. This included the appointment of a new ward manager and the use of an external specialist organisation to help improve staff psychological wellbeing.

Public engagement

- Some clinical areas had 'you said we did' boards on display. The boards allowed staff to demonstrate how patients, relatives and visitors were included in improvements to the service. However, not all units used the boards effectively. For example, the boards on the observation ward, Thistle ward and in the Greenway Centre were blank. In Tayberry ward the board was in use but only displayed results of the NHS Friends and Family Survey.
- Staff had initiated a Newham Diabetes Champion focus group patients living with the condition. Twenty-five people attended the focus group, ranging in age from 17 to 69 and including patients, family members and carers. Feedback from the focus group was very positive and people noted the opportunity to meet others living with the same condition as particularly useful.
- The dementia strategy group had implemented an action plan following the results of a dementia carers' survey by the dementia and delirium team between January 2016 and March 2016. This included the publication of a dementia carers information leaflet that helped people to access carers' health assessments and local support services. A new carers policy had been implemented that enabled ward staff to provide structured support for carers whilst the person they cared for with dementia was an inpatient.
- Staff in endoscopy used results from a patient survey to improve the information given to them whilst waiting, provide more reassurance to nervous patients and consider increased sedation for anxious patients.
- In May 2016 staff in the Greenway Centre used an online survey sent by text message to engage patients and collect more detailed information about their experience in the sexual health and HIV clinics. The unit carried this out in addition to the trust's standard patient experience questionnaire to improve feedback specific to the service.

Staff engagement

- The trust implemented a programme called 'Listening into Action' (LiA) to engage staff through regular 'pulse checks', wider team conversations and team meetings. The QIP team monitored this monthly, including staff engagement through social media. For example, between March 2016 and June 2016 the QIP recorded a 1% increase in the number of staff engaged with the LiA through social media and a total of 1,115 staff individual engagement interactions through on-site activities.
- A quarterly HCA forum was available to all hospital HCAs as an opportunity to discuss their work with senior staff and to share experiences with each other.
- Some staff said they felt their views and concerns were not always valued. For example, staff on Tayberry ward said a flexible working policy had been removed without consultation, which led to an increase in staff turnover. Other staff felt more listened to. All of the staff we spoke with in the Greenway Centre said they felt their contribution was valued and recognised and described the unit as an "inclusive and welcoming" place to work.

Innovation, improvement and sustainability

- The trust operated a 'hero award' scheme for staff. Patients, visitors and colleagues could nominate individuals for a hero award in recognition of their work practices or achievements. HCAs on Plashet ward had been recognised with a hero award for their work. In addition, awards were given to wards or units with a track record of harm free care, including Thistle ward that achieved a Gold Award for 100 days of care free from pressure ulcers.
- Senior teams recognised the need for sustained improvement in the reduction of hospital-acquired pressure ulcers. In response, a number of improvement strategies were implemented in late 2016. This included a plan to rapidly increase ward staff compliance with mandatory training of pressure ulcer awareness, planned provision of drop-in education sessions and practical simulation sessions, a tissue viability audit supported by tissue viability nurses and a mock coroner's court to identify the role of pressure ulcers in mortality rates.
- The hospital provided opportunities for student nurses including a key mentor on each ward and quality assurance of training opportunities provided through an annual education audit.
- All medical care wards or units that provided placements for pre-registration student nurses took part in an annual Practice Learning Collaboration Group

Medical care (including older people's care)

Enhancement of the Practice Learning Environment audit that monitored the quality of practice learning environments. The audit assessed the learning environment and supervision of students against 19 criteria that included safety risk, clinical competency of nurse supervisors and opportunities for development. We looked at the audit results for eight medical wards between June 2016 and August 2016. In all cases audit results were positive. All wards except Stratford ward and Thistle ward met 100% of the quality criteria. Auditor comments noted the quality of mentorship and the dedication and passion of mentors as notable features. Student nurses on Heather ward had access to nurse teaching and research opportunities and support from a practice development nurse in the observation ward, both of which were noted as good practice in the ward's audit. Auditors noted the positive involvement of the ward manager in Silvertown ward on the student experience and the overall exposure to multidisciplinary teams and clinical nurse specialists. Areas for improvement included an improved mentor handbook in the CCU and the need for more sign-off mentors in the observation ward. Overall auditors noted mentors must undertake triennial reviews to remain in this role.

Surgery

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

Information about the service

There are five main theatres on the main hospital site, one of which is a designated emergency theatre which runs for 24 hours a day, seven days per week. There are a further three main theatres at the Gateway Surgical Centre – a designated elective surgical site in the hospital grounds.

The surgery service is part of the surgery and cancer clinical academic group (CAG) that operates across the trust. There are four wards - Clove Ward (12-bed, elective assessment) and Maple Ward (18-bed, elective surgery, inpatient), which are based at the Gateway Surgical Centre on the hospital site, and East Ham Ward (25-bed, elective and non-elective inpatient surgery) and Forest ward.

Newham University Hospital (NUH) had 10,157 surgical spells between April 2015 and March 2016. Emergency admissions accounted for 3,500 (34%), 5,135 (51%) were day case spells, and the remaining 1,522 (15%) were elective.

We spoke with six patients, observed care and treatment and looked at 10 care records. We also spoke with 14 staff members at different grades, including allied healthcare professionals, nurses, doctors, consultants, ward managers, matrons and members of the senior management team.

Summary of findings

We found that there was much improvement made in the hospital's surgical services from the time of our last inspection in January 2015, when four domains were rated as requires improvement and one as inadequate. During this inspection, we found that four domains were good and one required improvement.

There was a new site based management team and a more robust clinical governance structure which meant there was better oversight of risk. Staff expressed a greater level of confidence in management and general morale was high. We found that there were reduced numbers of staff vacancies and better planning of skill mix. Staff reported on a supportive learning environment with good continuous professional development opportunities.

Patient flow was well-managed and there were no surgical site infections for knee and hip replacements and length of stay for elective and non-elective surgical patients was better than the England average.

The majority of patients we spoke with were happy with the care and treatment they received and we observed kind and compassionate care being given.

There were low levels of training amongst certain groups of staff in Level 2 safeguarding adults and safeguarding children.

Surgery

Are surgery services safe?

Requires improvement

We rated safe as requires improvement because:

- We were told that staff were not always given feedback on incidents raised.
- Compliance levels with the World Health Organisation (WHO) safety checklist were inconsistent, especially in The Gateway Centre.
- There was one shared adult and paediatric resuscitation trolley held in the recovery ward which staff told us was confusing. Equipment on the shared adult and paediatric resuscitation trolley in recovery area was not clearly differentiated.
- Training in Safeguarding adults and children level 2 was 77.38% and 84.9% respectively which was below the Trust target of 90%.
- Inadequate numbers of staff grade anaesthetists were identified as a high risk on the hospital wide risk register.
- Sluice rooms were not always locked and chemicals were easily accessible.

However,

- Staff were familiar with the procedure for reporting incidents.
- There were no surgical site infections for knee and hip replacements between October 2015 and June 2016.
- There was good compliance with infection control training on surgical wards.
- Venous thromboembolism (VTE) data was routinely recorded.
- There was a practice development nurse specifically for the surgery service.
- There was a high compliance with cleaning in most areas.
- Medicines were well managed.
- There was high compliance with mandatory training.
- Staffing levels and skill mix had improved since the last CQC inspection in January 2015.

Incidents

- In accordance with the Serious Incident (SI) Framework 2015, NUH reported five serious incidents in surgery which met the reporting criteria set by NHS England between October 2015 and September 2016. The most common type of incident reported was 'sub-optimal care of the deteriorating patient meeting SI criteria' of which there were three.
- Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- There were no recorded never events since the last inspection in January 2015.
- During the last CQC inspection in 2015, we found there were inconsistencies in incident investigation throughout the service, and opportunities for learning were not shared with staff. During the current inspection, we found there were improvements in this area and staff were able to tell us learning from certain incidents. Ward managers liaised with relevant members of staff and conducted root cause analysis investigations. There was a standard reporting template for all investigations and those root cause analysis (RCA) reports we looked at followed the same consistent investigatory and reporting process. We saw from the training matrix that matrons and ward managers received training in investigation of incidents.
- A member of staff told us how all staff were encouraged and reminded to record incidents on the electronic incident record. These then went to the band 7 nurses or matron, depending on the severity. The theatres matron attended the weekly cross site governance meeting where all theatres risks were discussed.
- However, we found that not all staff were aware of the current departmental top three risks which were: inadequate numbers of staff grade anaesthetists; monitors in recovery which could not monitor ETCO2 levels and emergency care of critically ill children.

- Staff used an online electronic incident reporting system and all surgery staff had individual user login details to access this system.
- A nurse told us they were informed of serious incidents and could tell us about shared learning. For example, there have been new insulin 0.5mls syringes introduced as a result of a previous 'never event' and those involved were able to share their experiences and learning from this as part of training sessions.
- However, feedback from other incidents was poor and staff were not always informed of any follow-up to a reported incident. One member of staff told us this led to some under-reporting since staff questioned whether it was worth their time to report if they do not always hear the outcome. We saw this was raised as an issue in minutes from the peri-operative, pain management and theatres governance meeting April 2016.
- A senior manager told us there was a new governance lead who would be working with staff to ensure they were able to properly identify and report a risk since there was a concern that not all risks were being properly identified at the time of our inspection.
- We were told that risks were discussed at team briefings, something we observed earlier in the day when we attended one such briefing. The lead nurse referred to an incident with the mislabelling of a patient specimen and reminded staff about the correct procedure. We later spoke with a nurse who was able to explain what they had heard in the morning brief.
- Sharing of learning from incidents on a departmental level was through morbidity and mortality meetings (M&M meetings). The surgery service held monthly M&M meetings where difficult surgical cases were discussed by consultants and doctors in training. All patient deaths and surgical complications were also discussed. We saw a sample of meeting minutes and presentations which were comprehensive, with action points and lessons learnt clearly identified.
- In addition the surgical directorate sent representation to the site safety huddle each morning at which there was feedback on incidents and immediate risk management issues. Trust wide sharing of information was circulated across hospitals with vignettes produced by the hospital involved, circulated by e-mail and paper copies and distributed to wards. Follow-up discussions took place at safety huddle and monthly grand rounds.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- We found senior staff within the surgery service understood their responsibilities for duty of candour, and were able to describe giving feedback in an honest and timely way when things have gone wrong.
- A nurse we spoke with was fully able to articulate how they would respond should a mistake happen. They appreciated the need for openness and honesty in the investigation of incidents. They told us it was imperative that patients trusted staff to acknowledge any mistake which may have occurred as quickly as possible.
- A senior nurse told us they offered to meet with patients and families when incident investigations were completed.

Safety thermometer

- The NHS Safety Thermometer is an improvement tool to measure patient harm and harm free care. It provides a monthly snapshot audit of the prevalence of avoidable harm in relation to new pressure ulcers, patient falls, venous thromboembolism (VTE) and catheters and associated urinary tract infections (UTIs). It was noted during the CQC inspection in January 2015 that VTE screening activity was not being recorded. This situation had been addressed and the surgery service collected safety thermometer data on a monthly basis and made the results available to wards managers.
- We looked at safety thermometer data between October 2015 and October 2016 and noted that the majority of months were 100% harm free on most wards. East Ham ward recorded five months harm free with the remainder varying between 88% and 96%, of which falls with harm and new VTEs accounted for recorded harm.

Surgery

- Data submitted by the trust's surgery & cancer divisional board performance review for July and September 2016 showed that the surgery service reported one grade 3 pressure ulcer between May and September 2016 and one fall with harm for the same reporting period.
- The surgery wards identified patients at high risk of falls and this information was highlighted on the patient information board (cross board). We also heard information about at-risk patients discussed at the daily safety briefing and at handover.
- However, safety thermometer results were not consistently displayed outside all wards for patients and relatives to see. There was some safety data displayed on the cross boards and we saw that there was recent information on hospital acquired pressure ulcers and acquired infections. The level of falls was also recorded, as were staff shortages.

Cleanliness, infection control and hygiene

- Infection prevention and control was generally well managed and all of the clinical areas we visited were visibly clean. The environment across the surgery wards and theatres was clean, tidy, well organised and clutter-free. All floors in corridors were clean and there was no evidence of dust.
- We saw a cleaning audit which showed that there was high compliance for theatres and most wards of 98%.
- However, we saw a recent quarterly audit of infection prevention and control (IPC) on East Ham ward which returned a poor result of 78%. Some of the issues picked up in this audit included the lack of green stickers to indicate when an item had been cleaned, particularly on commodes; the sharps bin was full and still in use in the treatment room and there was no cleaning schedule or checklist on display.
- Most equipment we looked at was visibly clean, but not all of it was consistently labelled as clean and ready for use across all clinical areas. For example, there were no green stickers on any physiotherapy equipment on Forest ward. In other areas, we saw these stickers were used on resuscitation trolleys, IV trolleys, electrocardiograph machines, hoists and weighing scales.
- There was easily accessible personal protective clothing such as latex gloves and plastic gowns and we saw staff using this appropriately when delivering care. We noted all staff adhered to bare below the elbows guidance in clinical areas. We spoke with a cleaner who told us personal protective equipment (PPE) was in plentiful supply. PPE refers to protective clothing, helmets, goggles, or other garments or equipment designed to protect the wearer's body from injury or infection. A nurse told us that staff reminded each other to remove their PPE when interacting with patients if it was not necessary to wear it.
- However, we noted that patient records still had old string tags on them which could present an infection control risk.
- We also found that there were occasions when patient checks were poor. For example, one patient record showed their venous cannula, which was meant to be checked twice a day, had been checked twice on two out of five days, with just one check on the remaining three days.
- Side rooms were used to care for patients where a potential infection risk was identified. This was to protect other patients from the risk of infection. Signs were in place at the entrance to side rooms which were being used for isolating patients, giving clear information on the precautions to be taken when entering the room.
- There were no reported incidents of Methicillin-resistant staphylococcus aureus (MRSA) and two incidents of Clostridium difficile (C Diff) between April and November 2016.
- The surgery service conducted monthly formal hand hygiene compliance audits. A hand washing audit between April and October 2016 showed compliance rates at 97% for all staff.
- All staff were given hand washing instruction during their induction and orientation to the wards and theatres. Hand cleaning instructions were visible on wards and in theatres, with posters displaying information on the importance of hand washing. We observed clinicians, nurses and allied health professionals cleaning their hands and following hand hygiene procedures.

- There was easily accessible handwashing gel facilities located at the entrance to each ward, throughout wards, theatres and the day surgery unit.
- We checked sluices on wards and in theatres and most were clean, tidy and well organised. However, the sluice room door on East Ham ward was open and it contained bins which were not labelled for different rubbish types. In addition, we saw there were active chlorine tablets in the sluice and the door to the cleaner's cupboard was open where there was a bottle of bleach contained in it. There were traditional wet mop heads in use for cleaning floors as well as plastic bowls for assisting patients with washing. Both of these had the potential to increase the risk of cross infection.
- The surgery service undertook surgical site infection surveillance of selected procedures, which was coordinated by the Centre for Infections at Public Health England. The trust contributed to data for knee and hip replacement and recorded no SSIs for knee or hip replacement between October 2015 and June 2016.

Environment and equipment

- We saw resuscitation equipment was available in all clinical areas with security tabs present and intact on each. All equipment was sealed as appropriate. Systems were followed for checking resuscitation equipment.
- We saw that there was one crash trolley held in the recovery ward. This was a shared adult and paediatric trolley, with each drawer given over to half adult equipment and half paediatric equipment, with no physical barrier in between. The differentiation was written on a plaster strip on each drawer. A nurse told us that this was confusing and they had placed this as a concern on the electronic incident recording system.
- When we checked the contents of this trolley with a nurse, it was evident that the differentiation between adult and paediatric equipment was not clear enough. For example, we struggled to find the paediatric glucose. It was eventually located under a piece of adult equipment.
- The resuscitation trolley on East Ham ward was checked as complete in most cases, with one day missing in September and one day missing in October. However, we noted that the anaesthetic breathing system had an expiry date of June 2016.
- All of the clinical areas such as theatres and wards we visited were calm, well organised and quiet. Wards were well laid out with adequate space to move and no clutter or trip hazards blocking walk ways. Patients on the wards looked comfortable. Theatres were small but the infrastructure was organised and well maintained.
- There were stickers on portable equipment to indicate they had been recently tested.
- We checked the storeroom on East Ham ward and found it to be relatively well maintained. However there were some issues, for example, an airways mask was unwrapped, a tracheal tube was out of date and had a use by date of 16/06/2016. We were told that there is a new housekeeper coming into post whose job it will be to organise the store room and identify out of date supplies.
- Theatre equipment was neatly stored in labelled in drawers. The theatre equipment storeroom was segregated and contained large pieces of equipment that were cleaned and stored away from theatres. Part of the room had racked shelving containing all disposable supplies.
- Staff in theatres told us that there was no shortage of sterile equipment. However they reported there were occasions when there were incomplete sterile equipment sets returned from the trust's sterilisation service such as those used in hip replacement procedures. An operating department practitioner told us they had to pay particular attention when they prepared all the necessary instruments for surgical procedures as they needed to be sure that there was a full equipment set before the operation began.

Medicines

- Evidence seen during our inspection showed medicines including controlled drugs (CDs) were stored and managed appropriately across the surgery service. Treatment rooms were clean and tidy, with cupboards labelled detailing contents within.
- Controlled drugs were audited on a twice daily basis by two nurses, with a separate signing sheet seen and were correctly documented in the CD register. Patients own CDs were stored in the ward CD cupboard and recorded in a separate book in accordance with regulations.

- There was a monthly audit carried out by a pharmacy representative and a nurse from the ward or theatre being audited. We looked at audits of theatres and wards and noted appropriate actions were taken in response to points raised. For example, an audit done in April in a theatre area picked up that keys for the CD cupboard were not kept separately from other keys. The next audit noted that CD keys were now on a separate bunch. A quarterly audit of all controlled drugs for April to June 2016 identified common themes to be transfers of CDs within registers not documented appropriately, entries in CD registers being crossed out, obliterated or altered and guidance from Trust CD policy for altering entries not being followed.
- Patient's own drugs were kept in a lockable cupboard mounted on the wall next to each patient.
- We observed two members of staff distributing medicines to patients. Nurses enquired about any allergies and confirmed the patient's name. We subsequently spoke with patients who demonstrated a good understanding of what medication they were given.
- One patient told us there had initially been some confusion as to what was the most appropriate time for them to take their medication. The nurse consulted with the pharmacist and sorted out any confusion around this.
- In theatres, local anaesthetic drugs were stored in a separate trolley to medicines for general anaesthesia, in accordance with guidelines. Theatre staff had access to emergency drugs, which were stored securely in a separate cabinet.
- Staff had access to a virtual British National Formulary (BNF) through the trust intranet, as well as all policies/ information relating to medicines management.
- We saw that drug fridge temperatures on Forest ward were regularly checked, with just four omissions in the previous 12 weeks. We checked the drug fridges in each theatre and saw that they had been checked on a daily basis every day for the previous three months.
- However, the theatre specimen fridge had eight gaps in August and eight gaps in October, with no gaps in September. A nurse told us that responsibility for checking this was less clear, hence the omissions.
- NUH had a pharmacy dispensary, distribution and ward pharmacy service. It provided a service on 7 days of the week, with a reduced level of service evenings and weekends. There was an out of hours on-call pharmacist from 5-8pm weekdays provided out of the Royal London Hospital site, which had a 24/7 service with an on-site pharmacist and provided on call services for Newham.There was a small pharmacy outpatient service which operated six days a week at NUH. All prescriptions were handwritten.

Records

- Patients' records were kept in two separate folders. Medical staff recorded in one, which also included any multidisciplinary team notes. Nursing notes contained care plans and nurse-led risk assessments, such as of pressure area care and nutrition and hydration. Medical and therapy staff used a hip fracture pathway document on Tayberry ward.
- We reviewed six patient records on the wards and found patient notes were completed in a logical and comprehensive way. In most cases, the clinical notes provided a good description of care plans, observations and patient progress. However, we saw on one record where a patient had surgery, but the type was not documented and it was not handed over in the ward handover.
- Nursing assessments were completed, including vital observations and early warning scores, falls assessments, assessment for pressure areas (Waterlow score), venous thromboembolism (VTE) assessment and nutritional status (Malnutrition Universal Screening Tool - MUST), drug charts, and safeguarding status. Care plans included all identified care needs.
- We also reviewed four patient records in the recovery room and found them to be well documented. Details included regular pain assessments, whether the patient had loose or false teeth and when they last ate.

Safeguarding

- There was a trust wide policy for safeguarding vulnerable adults and children. The policy and protocol for safeguarding referrals was available for staff to access via the trust's intranet. The trust's Deprivation of Liberties Safeguards policy and process was also available for staff to access on the trust intranet.

- Staff were provided with safeguarding vulnerable adults training levels 1 and 2 and safeguarding children levels 1 and 2, with an expected completion target level of 90%, a level which was not reached by certain groups of staff. For example the staff training matrix showed that the acquired level for staff on East Ham ward was 55% for level 2 training in safeguarding adults and 66% for safeguarding children. Percentage completion levels for theatre nursing staff was 50% level 2 safeguarding adults and 75% level 2 safeguarding children. It was not evident from the training matrix that any staff within surgical services had level 3 safeguarding children training.
- Staff told us that they could access information about safeguarding by using the intranet and showed us how this was done. The safeguarding page included information on bereavement counselling referral, paediatric trauma, child sexual exploitation, domestic violence referral pathway and contacts for support to rough sleepers.
- All staff whom we spoke with demonstrated a good understanding of safeguarding and the principles of safeguarding for children and adults. They were clear about the trust's safeguarding escalation process and knew how and to whom to report concerns about abuse, domestic violence and neglect. People told us they felt confident to seek safeguarding advice from their line managers.
- We observed that safeguarding concerns were raised at the daily safety huddle. There was a discussion about a particular patient where it was agreed that advice would be requested from the safeguarding lead, and we subsequently heard a nurse make a telephone request for this.

Mandatory training

- The last CQC inspection in January 2015 identified that the responsibility for managing training and development rested with the theatre matron. We found during this inspection that the trust had appointed a practice development nurse (PDN) for theatre and ward staff. Staff told us that training had improved as a result of support from the PDN.
- The mandatory and statutory training programme amongst which was included basic life support, infection control, VTE, catheter acquired infections, early warning systems, manual handling, consent, dementia awareness and fire safety. Data submitted showed that overall compliance with mandatory training for all staff in the surgery service varied between 94% and 100%, where the target level was 90%.
- The last CQC inspection noted that no specific infection control training had been offered to staff on surgical wards. Data submitted for this inspection showed that there was 100% compliance for completed level 1 and 2 infection control training on surgical wards.
- Newly appointed staff were required to complete a corporate induction and a subsequent ward or theatre based induction.
- The PDN managed peoples' training requirements and sent reminders when a refresher was due. Staff were released to do their training and this was made clear on the rota, which we subsequently saw.
- Mandatory training records were kept by the ward manager. We looked at a nurse's personal development plan which included completed mandatory training and their competency assessments which included nutrition and patient controlled analgesia.

Assessing and responding to patient risk

- Patients' clinical observations were recorded and monitored in line with NICE guidance CG50 'Acutely Ill-Patients in Hospital.' A scoring system known as a national early warning score (NEWS) system was used to measure patients' vital signs and identify patients whose condition was at risk of deteriorating.
- We looked at an audit of NEWS recording from one ward for the period between October 2015 and October 2016. This showed that there was between 95% and 100% compliance consistently in almost all areas except for medical team contact details recorded on front of observation chart which was below 70% for the whole of this audit period.
- We saw staff in surgical wards recorded the observations of patient safety parameters such as heart rate, respirations, blood pressure, temperature and pain. These were recorded in patients' notes.
- Patients were assessed for actual and potential risks related to their health and well-being and we saw evidence of these in notes.

- Nurses assessed patients' fluid intake and output and recorded this in their charts. We observed a discussion between a doctor and a nurse about the most effective way in which to monitor a particular patient's fluid intake and output.
- There was no written escalation protocol for unwell patients. We were told that the anaesthetist, surgeons and nurse in charge of theatres met to agree a priority list of elective and emergency patients**.**
- Nursing staff told us they would call a doctor if they were concerned about a patient and said their response was always prompt.

Use of the 'five steps to safer surgery' procedure

- Surgery services are obliged to complete safety checks before, during and after surgery as required by the 'five steps to safer surgery' – the NHS Patient Safety First campaign adaptation of the World Health Organisation (WHO) surgical safety checklist. The five steps included briefing, sign in, time out, sign out and debriefing. The last CQC inspection identified areas of weakness, most of which had been addressed by the time of this inspection.
- A perioperative safety checklist codified the actions needed to be taken by theatre staff before the list started, before induction of anaesthesia, before skin incision and before the patient leaves the operating theatre. We later saw that the completed checklist was filed in the patient's notes.
- We observed a surgical procedure and noted that the first four stages were carried out. We did not remain until the end of the procedure in order to verify whether the fifth stage was completed.
- We were told that the theatre lead nurse was required to submit a report to the deputy head of nursing on compliance with the five steps to safer surgery for the first surgical case each morning from each theatre. This information formed the basis of the monthly compliance audit.
- In addition, we were told that the lead nurse did observational checks in each theatre to ensure that the five steps were being followed. However, we were told that there were no records kept of these observational checks.
- The surgery service audited WHO checklist compliance on a monthly basis which covered main theatres, observation ward and The Gateway Centre. We looked at a recent audit between October 2015 and October 2016 and saw that for the main theatres, there was 100% compliance in almost all briefing and time out steps. Sign-in dropped to 79% and 70% for May and August respectively whilst the debrief varied between 63% and 93% between June and October. We were told that in many cases, the debrief did not happen because staff left the theatre at slightly different stages in order to attend to other patients.
- However, the audit revealed inconsistencies with WHO checklist compliance in The Gateway Centre. The reporting period was between February and October 2016 since the site began to report separately from February 2016. For example, the team brief was 100% compliant for just two months with a variation of between 47% and 93% for all other months. Sign-in was 100% compliant for three months with a variation of between 44% and 95% for the remaining months and time-out was 100% compliant for two months with variations of between 70% and 98% for the remainder.

Nursing staffing

- As of June 2016, The vacancy rate in general surgery was 6% and in theatres was 12%.The last CQC inspection in January 2015 reported gaps in staffing and poor skill mix. Since then, the Trust had applied an evidence-based approach to setting establishment. This involved applying the Shelford Safer Care Nursing Tool (as set out in NICE 2014) to shape the numbers of nurses required. Agreeing nurse ratios was an integral part of establishing safe rotas, which the Trust routinely reviewed on a shift by shift basis through safety huddles. The nurse ratios were also reported on the quality and safety boards of every ward every day. As part of the annual review, nurse ratios were reported to the Board and benchmarked internally and externally.
- Each ward area presented their staffing data and acuity scores on a daily basis at the safety huddle. This informed a site wide picture of staffing and acuity to assist with redeployment of staff as needed. We observed a safety huddle which included a review of current staffing measured against patient needs. Whilst

no staffing issues were noted at that time, we were told that if additional staffing were required, this would be initially discussed with other wards as to whether they could provide staff.

- A weekly staffing report was sent to the assistant director of nursing. A senior nurse told us staffing problems were under control and they attributed this to good levels of recruitment, a low vacancy rate and good staff retention.
- A nurse told us that staffing had improved dramatically since the last CQC inspection. They said the skill mix was better, with active recruitment on-going.
- However, they told us there were occasions when there was a shortage of staff as a result of sickness but never where patient safety was compromised. As of June 2016, Surgery at NUH had sickness rates ranging from 0% to 7%. The following staff groups and specialties had the highest sickness rates: unqualified nursing/HCA in general surgery (7.0%); nursing & midwifery registered in general surgery (5.3%) and unqualified nursing/HCA in Theatres (4.3%).
- Actual staffing on East Ham ward on the day of our inspection was three registered nurses and two health care assistants (HCA) instead of the planned staffing which should have been four registered nurses and three HCAs. Staff told us they were busy, but good teamwork ensured that patients were being cared for to a good standard.
- Theatre nurses told us how the skill mix was well balanced. They rotated between the main site theatres and the orthopaedic centre known as The Gateway Centre, to ensure rounded skills in different surgical procedures. A nurse we spoke with told us this was good for patients as it meant there was a good standard of knowledge across the surgery team and it was also good for their personal development as it helped to develop their skills.
- We were told that when the paediatric list was running, each patient had 2:1 nursing, which we saw reflected on the rota.
- Ward managers told us internal bank nursing staff were used as a preference to cover shifts, but agency staff were employed when necessary.
- Theatres had one band 8 matron and three band 7 nurses. There was one band 6 nurse in each theatre and an additional one rotating on the floor, as well as an operating department practitioner. We were told that there was almost full establishment, with some staff waiting to start, subject to HR clearance.
- We looked at nurse staffing data between April and October 2016 which confirmed that vacancy rates were improving, for example from 31.7 in April to 23.5 in October. Bank staff were used where possible but agency staff were also used for maternity cover and long-term sickness.

Surgical staffing

- As of June 2016, Surgery at NUH had vacancy rates ranging from 0% to 20%. General Surgery and Orthopaedics had vacancy rates of 20%.
- Surgical treatment was consultant led. There was a stable cohort of consultant surgeons and anaesthetists working in the surgery service and many doctors we spoke with had worked at the trust for several years. There were seven surgery consultants two of whom were breast surgeons, one upper GI, three colorectal (one of whom treated cancer) and one general surgeon.
- Arrangements were in place to ensure adequate surgical out of hours and weekend cover. Consultant surgeons were on call 24 hours varying across seven days and were free of all routine work when on-call. They did a regular Saturday and Sunday ward round. Staff grades were on a 54 hour per week contract in anaesthetics.
- However, inadequate numbers of anaesthetic staff grade was identified as a high risk on the hospital wide risk register. The risk register noted that there was an inability to deal with multiple time and life critical situations, particularly out of hours.
- We spoke with the clinical lead for anaesthetics. They told us there were currently 11 consultants in post, with a further two posts already advertised. There were 9.6 whole time equivalent (WTE) middle grade doctors in post, with one vacancy. Newer staff assisted with surgery for three months before being assessed as competent to work more independently with someone.
- CT1 and CT2 doctors (doctors partaking in year 1 or 2 of core medical training) were not included on the on-call rota.

- Only known agency staff were used and all agency used joined the bank staff list. Authorisation from the medical director was required before employing agency staff.
- Sickness rates were low and ranged from 0% to 1.2%.

Major incident awareness and training

- The trust had a major incident plan which gave detailed guidance for the surgery service. This included theatres stopped for new cases with current cases completed and all available theatres prepared for surgery. It also listed the minimum staff requirement as three consultants, four registrars and two FY2.
- All staff did emergency planning training and submitted data showed that almost all surgery service staff were above the target compliance level of 90%.

Are surgery services effective?

Good

We rated effective as good because:

- There was a planned programme of local audits.
- Surgical pathways were delivered in line with referenced national clinical guidance.
- 99% of elderly patients were seen by an orthogeriatrician.
- There was effective pain management provision.
- Patients were regularly offered drinks and food was reported to be generally good.
- Medical staff appraisal rates were fully compliant.
- Staff reported a supportive learning environment on surgery wards.
- There were good continuing professional development opportunities for staff.
- All eligible nursing and medical staff had in-date revalidation at the time of our inspection.
- There was an effective multidisciplinary team working environment within surgery services.

However:

- Patient Reported Outcome Measures (PROMs) were worse than the England average for most measures.
- There was no current information available on appraisal rates for non-medical staff.
- The trust policy for consent to examination or treatment had not been audited within the past 12 months.

Evidence-based care and treatment

- Staff accessed policies and corporate information on the trust's intranet. There were trust wide protocols, policies and guidance for clinical and other patient interventions and care on the intranet.
- We reviewed a sample of trust policies for surgery and found appropriate reference to relevant National Institute for Health and Care Excellence (NICE) and Royal College guidelines.
- The trust's policy for recognition of and response to acute illness in adults in surgery services was provided in line with NICE CG50 guidance (Acutely ill adults in hospital: recognising and responding to deterioration)
- Surgical pathways were delivered in line with referenced national clinical guidance. Senior service leaders reviewed their service outcome data, such as Patient Reported Outcome Measures and National Joint Registry compliance.
- The previous CQC inspection in January 2015 found there was no consistent programme of delivery and learning from local audits. Data submitted for this inspection demonstrated that a local audit programme had been initiated and an action plan was introduced to address any areas of the audit which were below standard which was monitored at governance meetings.
- An audit of fluid management in general surgical patients was carried out to establish whether fluids were appropriately prescribed to allow for daily maintenance. Also, to establish if prescribed fluids matched the daily fluid and electrolyte requirement of the patients. The findings of this concluded there was below 85% compliance and 77% of patients did not receive adequate fluid replacement when compared to NICE guidelines on fluid management. 46% of patients did not receive adequate sodium replacement and 100% of patients did not receive adequate potassium. Recommended action was for the importance of fluids

and electrolytes to be highlighted, additional teaching on fluid balance to be put in place and the importance of fluid balance recording to be emphasised. This was deemed to be partially implemented at the time of our inspection.

- Another local audit related to emergency surgery risk stratification, the aim of which was to establish whether the surgical department was appropriately risk stratifying patients before emergency operations. The outcome of this audit indicated there was some evidence of compliance (below 85%), but significant service improvement was necessary. It was identified that the department was not good at formally stratifying risks preoperatively. The recommended action was to add a P-POSSUM score box on both the surgical clerking proforma and also on the operation booking sheet in theatres. P-POSSUM is a modification of the POSSUM (physiological and operative severity score for the enumeration of mortality and morbidity)
- The purpose of a P-POSSUM is to provide surgeons with the ability to calculate a P-POSSUM score for their general surgical patients online to enable them to provide further information on risk in terms of morbidity and mortality. This was fully implemented at the time of this inspection.
- A recent audit of major joint replacement pain management indicated a greater than 95% percentage of patients were satisfied with their pain management.

Pain relief

- There was a site based acute pain service which was available 24 hours a day, 7 days a week. There was specialist nursing cover Mon – Fri 8am - 4pm. Consultant sessions were held three times a week and there was an anaesthetist on call for theatres out of hours.
- There were effective processes in place to ensure patients' pain relief needs were met and pain was well managed in the surgery service. During the last CQC inspection we did not see an evidence-based pain tool in patient's records. This had been addressed and during this inspection we found good documentation of pain using evidence–based pain tool.
- Staff on wards did intentional rounding every two hours to ask patients about their comfort, including pain levels. We witnessed nursing staff regularly asking patients whether their pain was being effectively managed and if they were comfortable. Patients told us nurses were responsive to their pain relief needs. All of the patients we spoke with were aware they could use the call bell to request additional pain relief.
- Pain was assessed using a 10 point scale for measuring pain in adults. This included observing the patient and identifying any behaviour that indicated pain.
- There was an on-site acute pain service with three nurse specialists however, there was no chronic pain service at Newham. Staff we spoke with did not perceive this as a problem as they felt well supported by the pain service and knew how to access the trust chronic pain team as required.

Nutrition and hydration

- During the last CQC inspection in January 2015 we found there was no evidence of auditing nutrition and hydration. The trust used the Malnutrition Universal Screening Tool (MUST) to monitor patients who were at risk of malnutrition and provided us with a list of regular audits, amongst which was an audit of patient nutrition and hydration.
- Where patients were identified as at medium or high risk of malnutrition, food intake was to be recorded, and the patient was to be encouraged and given assistance with meals. Patients identified as at risk of dehydration also had fluid balance charts to monitor fluid intake and output. We saw most charts had been completed and added up correctly.
- There were regular protected meal times on surgical wards and we saw these were respected by staff and visitors. This meant all non-urgent activities on the ward would stop and patients would be positioned safely and comfortably for their meal and staff would assist patients with their meals as necessary.
- Patients told us nurses ensured they were kept well hydrated. Hot and cold drinks were provided throughout the day. Most said the food was of a good standard.
- Patients requiring dietetic services are referred from the ward and new referrals were seen within two working days. With more urgent referrals patients were usually seen within one working day from receipt of referral.

Surgery

Patient outcomes

- The trust contributed to relevant national patient outcome audits. Performance of the surgery service in these audits was included as an agenda item during the surgery service monthly meetings, the minutes of which were distributed to staff.
- At the time of our inspection, a recent audit of patient returns to theatre was undertaken and data was not available for inclusion in this report.
- The National Emergency Laparotomy Audit (NELA) has been collecting data on over 20000 patients annually since 2013. Data is fed back to hospitals in the form of annual reports, but also a real-time quality improvement dashboard that provide instant comparison of local vs national data. The trust performed poorly in the 2015 NELA audit. It achieved a green rating (greater than 70%) for no measures; an amber rating (50-69%) for two measures, and a red rating (lower than 49%) for eight measures.
- Between March 2015 and February 2016, patients at NUH had a similar to expected risk of readmission for both elective and non-elective procedures. The Trauma & Orthopaedics specialty had the largest relative risk of readmission for elective procedures. The Breast Surgery specialty had the largest relative risk of readmission for non-elective procedures, which was greater than twice that expected value.
- In the 2016 Hip Fracture Audit, the risk-adjusted 30-day mortality rate was 11.9%, which falls within expectations. NUH performed about the same as other trusts in the 2016 hip fracture audit. However, this performance was worse than it had been in the 2015 where it was 8.2%.
- There was a mixed set of results for the latest 2015 Bowel Cancer Audit though the trust showed an overall improvement compared with the 2014 audit.
- In the 2016 Oesophago-Gastric Cancer National Audit (OGCNCA), the age and sex adjusted proportion of patients diagnosed after an emergency admission was 25%. This placed the trust within the top quarter of all trusts for this measure. The 90-day post-operative mortality rate was 8.8% which was within the expected range and improved upon the 2015 rate of 9.4%.
- Patient Reported Outcome Measures (PROMs) measures health gain in patients undergoing hip replacement, knee replacement, varicose vein and groin hernia surgery in England, based on responses to questionnaires before and after surgery.
- The trust's PROMs performance in the period April 2015 to March 2016 was worse than or in line with the England average. For example, the percentage of patients for hip and knee replacement and groin hernia (EQ VAS) was in line with the England average. The trust performance was worse than the England average for almost all other results.

Competent staff

- Information provided by the trust for all surgery service lines showed 90% of surgery staff had received an annual appraisal up to November 2016 and all junior doctors on site were 100% compliant.
- Non-medical appraisals were showing as 57% complete up to March 2016. There was no current data available after this date; this was attributed to a changeover to a new leadership operating model in September 2015. All data was collated manually, pending the effective operation of an electronic recording system. The trust told us that not all appraisal data had been rigorously recorded.
- However, staff we spoke with told us they had an appraisal in the past 12 months and the discussion included their learning and development needs.
- All staff had a responsibility to identify their own learning and training requirements in order to carry out their role and duties effectively and ensure they are discussed and recorded as part of their annual appraisal. As part of this appraisal, all staff had their training and development needs identified and considered and formalised in a personal development plan.
- Newly qualified nursing staff reported a supportive learning environment on surgery wards. We saw the practice development nurse (PDN) signing off nurse medication competencies of a newly returned nurse and later saw them give feedback to the ward manager and nurse.
- We had a discussion with a PDN who told us they were responsible for staff development of new and existing

staff. They ran teaching sessions which included detection of the deteriorating patient and what to do in that circumstance. The PDN told us how they intended to include simulation training in the future around the deteriorating patient.

- We subsequently observed a training session run by the PDN for a number of newly qualified nurses. This was wide ranging and included how to record a patient's vital signs properly; Aseptic Non Touch Technique (ANTT), and good hand hygiene. The discussion also included female catheterisation, peak flow meter and blood glucose levels. Participation levels in this session were high.
- The trust had a robust corporate study leave and funding policy which made it clear to staff the trusts commitment to supporting them to develop and extend their role. It also highlighted the responsibility the member of staff had to their own development. We saw there was a wide range of external courses which medical and nursing staff attended between April and December 2016 as part of their continuing professional development.
- Human Factors training focuses on optimising human performance through better understanding the behaviour of individuals, their interactions with each other and with their environment. There was a request from ward nursing staff to formulate a training programme specific to resuscitation. Whilst all staff had completed immediate life support (ILS) as part of their mandatory training, they had little experience of actually delivering resuscitation and team work was something they expressed a desire to improve upon.
- In response to this request, the resuscitation team ran scenario based training with the hospital ward team, which looked at the ILS process, teamwork and individual roles within the team. There is a plan to roll this training out widely and introduce a regular programme of simulation training using mobile SIM equipment during 2017.
- Barts Health NHS Trust participated fully in the GMC revalidation initiative. The Medical Director for the Royal London Hospital is the responsible officer for the Trust. The Medical Director of Newham University Hospital is the deputy responsible officer for the Trust. There is a revalidation support team and an established process in place to review all supportive documentation for revalidation. The records of revalidation were held by the GMC and on individual consultant appraisal portfolios. We were told that the first cycle of revalidation has been completed and at the time of our inspection all eligible consultant surgeons and consultant anaesthetists had been revalidated.
- Nursing and Midwifery Council (NMC) revalidation is a positive affirmation of an individual's practise based on the new Code of Conduct (2015). Barts Health NHS Trust participated fully in the NMC revalidation process. Barts Health Revalidation policy for NMC registrants provided an outline of the support mechanisms available within the Trust and suggested a structured process to complete the process in a timely and robust manner. Data submitted to CQC confirmed that all eligible nursing staff had in date revalidation at the time of our inspection.

Multidisciplinary working

- There was an effective multidisciplinary team working environment within the surgery service at NUH. We found evidence of good multidisciplinary relationships supporting patients' health and wellbeing. We observed multidisciplinary input in caring for and interacting with patients on the wards.
- An orthogeriatrician attended a weekly board meeting to pick up on elderly patients who would benefit from their input. We saw minutes from an orthopaedic audit meeting held in October 2016 where it was reported that 99% of patients were seen by the orthogeriatrician. This specialist input enhanced patient experience and we were told speeded up their recovery.
- Patient records demonstrated input from allied health professional including physiotherapy, dieticians, occupational therapists, pharmacists as well as the nursing and medical teams. We also saw notes made by a dementia and delirium nurse.
- We observed a multi-disciplinary discharge planning meeting which included nurses, orthopaedic surgeon, community liaison nurse, district nurse, social worker and physiotherapist. There was a good discussion which included the views of the patient and their relative.
- Nurses reported good access to and effective support from physiotherapists, occupational therapists, the trust

pharmacy team and the palliative care team. Physiotherapists provided advice on exercises to improve mobility before and after surgery. Occupational therapists gave advice on aids and strategies to maximise independence and liaised with social services on behalf of patients and provided advice on any support patients may be entitled to.

Seven-day services

- The hospital delivered a full service over five days, with on call availability seven days per week. Operating theatres were used on Saturdays for elective and priority list patients dependent upon surgical cover and caseload. Consultants were on site on a Saturday and Sunday when on call, but not for elective work. There was a ward round on Saturdays and Sundays.
- There was a reserved emergency operating theatre, as recommended by the national confidential enquiry into patient outcome and death report (1990). This theatre (theatre 5) was available 24 hours per day seven days a week for emergency and trauma cases. It had a staff team of two trained theatre nurses and one support nurse, one operating department practitioner and one recovery nurse.
- Arrangements were in place to ensure adequate out of hours cover on surgical wards. Consultant surgeons were on call, rather than resident within the hospital. The weekend on-call included a daily consultant ward round for emergency admissions and inpatients with the consultant on site for between 4-6 hours, outside of which support was off site. There was an orthopaedic consultant on call 24 hours on a rolling rota. They were on site during working hours from 8am until 6pm, supported by a registrar on site until 8pm, then on call from home.
- The Gateway Centre was operational six days per week with some extra lists booked on a Saturday. There was out of hours cover provided by a resident medical officer (RMO), whose role it was to provide continuous care for orthopaedic in-patients. The RMO was required to be the first responder to crash calls and liaise with the Hospital crash team. ALS or equivalent is a mandatory requirement of the post holder.
- Haematology and Biochemistry provided a full laboratory service 7 days a week, 24 hours a day.
- There was a full microbiology laboratory service 24/7. Urgent samples only were processed between 8.00pm and 8.00am.
- Radiographers were available to provide emergency theatre cover 24/7.Out of hours images were reported by an on-site specialty radiology doctor and finalised by an off-site consultant radiologist.
- Physiotherapists and occupational therapists were available on site during weekdays and provided on call service to the surgery wards at the weekends.
- Pharmacy services provided on call service out of hours and at weekends. The pharmacy dispensary was open on both Saturday and Sunday from 10-2pm. High turnover wards were covered by a pharmacist on a Saturday who worked alongside nurses and discharge team, helping to resolve pharmaceutical issues and facilitating discharges. Other wards sent work down to pharmacy. A small pharmacy team operated on Sundays prioritising work sent down to the dispensary from wards, and visiting wards where necessary. After 2pm, there was an on-call pharmacist until 4pm after which the 24/7 service at the Royal London Hospital responded. Nursing staff told us there was good pharmacy support.

Access to information

- There were information posters on the walls by workstations on the wards and in the theatre for staff reference. These included outcomes of recent audits and copies of trust policies and procedures. The information board in theatre identified all staff on duty for the coming day whilst notice boards along the ward corridors contained information for patients and relatives, including visiting hours, protected meal times and senior nurse contact details.
- Computer stations with intranet and internet access were available for staff to use and access trust information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was a trust policy for consent to examination or treatment. However, there had not been an audit of compliance with the policy in the previous 12 months to ensure that when a patient has undertaken a procedure requiring written consent, the consent form was scribed

in accordance with national standards and the local policy. We were subsequently sent a quality improvement registration form which showed that this audit was planned to take place soon after this inspection.

- There was mandatory training for all staff in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), which was included in level 2 safeguarding adults training. Records showed 55% of staff on East Ham ward and 50% of theatre nursing staff was 50%.
- Staff had access to bilingual advocates, independent advocacy and other patient support services that might be required during the consent process, such as interpreters or signers. This included an out of hours advocacy and interpreter service.
- Patients told us staff explained treatment and care and sought consent before proceeding. All patients we spoke with said they had been given information about the benefits and risks of their surgery before they signed the consent form.
- Staff told us they knew who to contact for advice in cases where a patient may require safeguarding support. They were aware of the requirements of their responsibilities as set out in the MCA and DoLS, and told us they would refer patients to the trust safeguarding team if patients required a MCA referral. DoLS applications were also dealt with by the safeguarding team.
- Staff we spoke with demonstrated a good understanding of capacity and told us it was always considered when supporting a patient. We saw consent was clearly documented on all records we looked at.
- There were 13 DoLS applications made by surgery services in the past 12 months.
- A nurse could describe to us in detail a recent DoLS application where a decision was made in the patient's best interest to have enhanced care on a one-to-one basis.
- There was a delirium and dementia team of two registered nurses who were based on the Newham site and available by bleep during normal working hours; this team were available to support use of the Forget-Me-Not scheme, aimed at improving care for people with dementia.
- There was an off-site learning disability nurse specialist who is available by telephone to give advice or visit clinical areas as requested. There was also a community based learning disability nurse specialist based in the community who provided a resource box to each ward area. This box included ways in which to offer relevant support and care to people with a learning disability. The nurse specialist also supported staff in the effective use of the patient's hospital passport.

Are surgery services caring?

Good

We rated caring as good because;

- The majority of patients we spoke with were happy with the care and treatment they received.
- We observed kind and compassionate care given to patients.
- Patients' dignity and privacy was respected.
- Patients found their pre-operative assessment with surgeons to be informative.
- Senior nurses received training in how to communicate difficult messages in a sensitive way.

However,

- There was a poor response rate to the Friends and Family Test.

Compassionate care

- Between September 2015 and August 2016 the Friends and Family Test response rate for Surgery at NUH was 15%, which was worse than the England average of 29%.
- The trust did not gather additional local patient survey data.
- The majority of patients we spoke with were happy with the care and treatment they had received while in hospital. Direct comments from patients, which were representative of this feedback included: "staff are very

caring, they always seem concerned about me," "staff are friendly and smiley and take the time to chat with us," "staff keep me informed of what is going on and I feel involved" and "staff are very kind and give you their full attention."

- We observed how a health care assistant spent much time making an elderly patient comfortable and offering them reassurance.
- Patients told us staff respected their privacy and dignity. One told us how staff ensured they were properly covered up when being moved around the ward.
- We saw evidence of thank you cards from patients displayed around the nurses' stations on wards.
- We noted that patients were referred to by their initials during board rounds and the ward board had a roller blind to cover up patient details when not in use.

Understanding and involvement of patients and those close to them

- Patients on surgery wards and those whom we spoke with in theatre told us their pre-assessment by consultant surgeons fully explained the risks and benefits of the procedure and provided information about after care and home support.
- Theatre and recovery nurses told us how relatives and carers of children, and patients with learning difficulties or specific needs were allowed into the recovery areas to help them feel more secure.

Emotional support

- There was a new post for a specialist nurse to support patients with stomas, which was planned to commence in January 2017. They provided emotional and practical support to help them prepare to go home after discharge.
- There were also colorectal cancer support nurses and urology oncology support nurses, as well as a pain management team and tissue viability nurse.
- Ward staff attended weekly multidisciplinary team (MDT) meetings, which were used to identify patients' support needs, including emotional support. Senior nurses received training in communicating difficult messages in a sensitive way, as well as training in conflict resolution.

Are surgery services responsive?

Good

We rated responsive as good because:

- Flow within the surgery system was well managed and theatre utilisation was up to 84%.
- The average length of stay for elective and non-elective surgical patients was better than the England average.
- There was a substantial decrease in the percentage of patients not treated within 28 days.
- There was an enhanced recovery programme and joint school for patients booked to have a hip or knee replacement.
- Wards used an enhanced care bundle to identify patients who required additional support.

However,

- The trust suspended reporting on all 18-week referral to treatment target waits from September 2014.
- There was variation within surgical specialisms about length of time taken to respond to complaints.

Service planning and delivery to meet the needs of local people

- There had been some work around the colorectal pathway with local commissioners and providers from the local CCG, from within the hospital and from elsewhere within the trust. In addition to this, representatives from public health, local CCG, managers, nurses, gastroenterologists and surgeons had externally facilitated meetings to further develop the pathway.
- General surgery had recent network meetings with local commissioners to determine the structure and provision of surgical hubs.

Access and flow

- We were told how the theatre improvement programme in 2016/17 was focused upon the scheduling processes specifically within the Gateway Centre in order to

optimise the productivity and efficiency of theatre provision. The flow within the surgery system was well managed and we found effective patient pathways from admission, through theatres and on to the wards.

- Between April 2015 and March 2016 the average length of stay for elective surgical patients was 2.7 days, compared to 3.3 days for the England average. For non-elective surgical patients, the average length of stay was 3.5 days, compared to the England average of 5.1.
- Surgical services recently introduced a theatre utilisation tool which was used to initiate discussions between teams around how to continue to improve efficiencies.
- There was improvement in theatre utilisation since the last CQC inspection in January 2015. Overall theatre utilisation across all surgical specialties was at 96% for the period August – October 2016.There was a throughput of 723 elective day cases and 104 elective inpatients in general surgery between July and October 2016. Throughput for The Gateway Centre over the same period was 479 elective day cases and 288 elective inpatients.
- Elective patients did not go to theatre for surgery until a ward bed was allocated.Emergency patients would already be in a ward bed before going to theatre. No surgical patients were nursed overnight in recovery in the last 12 months and there were no mixed sex breaches in the last 12 months.
- Theatre staff prioritised different patient groups in operating lists, with priority given to elderly patients, children and young people, and patients with learning disabilities. Staff told us these patients were placed first on the list. In addition, paediatric surgery was performed only on dedicated days.
- We found theatres were based by procedure type, for example, general surgery and orthopaedic procedures were not included in the same session list. This minimised potential risks for cross-contamination and infection prevention and control.
- There was no separate space for children to recover however; additional recovery nurses were rostered on duty to provide one to one support until they were returned to a paediatric ward. We were told paediatric patients were transferred to the paediatric ward once they were extubated and had a safe airway.
- We saw data which confirmed that all nurses in theatre and recovery had in-date intermediate paediatric life support training.
- We were told that paediatric patients (up to 18 years) in The Gateway Centre were given a two bed bay to themselves as a safeguarding measure.
- The trust suspended reporting on all 18-week referral to treatment target (RTT) waits from September 2014 and had not resumed reporting at the time of this inspection.
- Surgical services were unable to supply CQC with any information about how they monitored their RTT waits and there was no data available on this at the time of our inspection.
- Between November 2015 and October 2016 there were four delayed transfer of care in surgical patients. One patient was awaiting neurorehabilitation, two required rehousing and one was awaiting placement in a nursing home.
- A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.
- There was a substantial decrease in the percentage of patients not treated within 28 days following a short notice cancellation although it remained slightly higher than the national average.
- Between February and November 2016 there were 63 on the day cancellation of operations in main theatres. 36 of these were attributed to running out of time. 10 cancellations were due to lack of surgeon/anaesthetist/ theatre staff and 10 due to lack of kit or equipment.

- There were 62 on the day cancellation of operations in The Gateway Centre for the same period, 32 of which were attributed to running out of time, 14 to lack of ward bed and 7 due to lack of surgeon/anaesthetist/ theatre staff.
- Bed management meetings were held three times per day attended by nurses and managers. However, we were told that lack of beds on the wards meant that patients were occasionally held in the recovery ward for long periods of time, when they would normally spend just 30 minutes in recovery. This in turn impacted on other patients whose procedures had to be delayed, if beds in the recovery ward were blocked with patients waiting to go to the wards.
- The most recent data from 2015 gathered by the national hip fracture database showed that 72.9% of patients had hip surgery on the day of or day after admission which was just above the national average of 75%; and 95.3% of hip patients were seen by a consultant physician within 72 hours, which was substantially above the national average of 87.5%.
- Outliers are patients who were under the care of a surgery service consultant but looked after on a different ward. Data submitted to us showed that there was a total of 50 surgery service outliers on medical wards between July and September 2016. These patients were seen daily by the surgical teams looking after them. There were 16 medical outliers on surgical wards for the same period.

Meeting people's individual needs

- Wards used an enhanced care bundle to identify patients who required additional support when on the ward. This support was provided by a permanent member of staff who wore a special tag to indicate that they were providing extra care to the patient and therefore could not attend to other patients.
- We saw a sample booklet designed for patients during their stay in hospital following their orthopaedic surgery. This included every aspect of their care, as well as all interventions by nursing and medical staff. It also included a planned after care and discharge plan.
- The Gateway Centre provided an enhanced recovery programme and joint school for patients booked to have a hip or knee replacement. The purpose of this was to ensure patients were fully prepared for their surgery and returned home as quickly as possible with the best possible outcomes.
- A nurse ran a joint school on two afternoons per week for these patients where they received detailed information about what the procedure involved, potential complications and post-operative care, including pain management. Where the patient required an interpreter or had a special need, we were told that a one-to-one session would be held for them in order to ensure they fully understood the whole process. There were 364 attendances at the joint school between April and November 2016.
- The Gateway Centre was a designated orthopaediatric centre. A small proportion of gynaecological procedures were carried out there. However, we were told that following their operation, they were then always transferred to the main hospital for recovery. We were told that this was in the patient's best interest in the event of any complications arising since Gateway was not an emergency response unit. Staff told us that all those patients who would be transferred post operatively were informed in advance of their operation that this would be the case. We were told that no day surgery patients were nursed overnight in day surgery in the last 12 months.
- We were told that the psychiatric team and medical teams would advise and facilitate appropriate management of patient's drug and alcohol dependency within the surgical ward areas as and when required. There was also an alcohol and drug liaison nurse from the community team who attended the hospital twice a week and reviewed adult inpatient in all ward areas. However, staff told us they felt that they did not have the relevant knowledge to best support those patients in challenging situations, apart from attending to their medical needs.
- Interpreting and advocacy services were available for clinical decision making and there was access to a interpreting service, bilingual advocates, independent advocacy and other patient support services such as interpreters or signers. This included an out of hours

advocacy and interpreter service. Most staff were familiar with the process for booking an interpreter. They told us there were no difficulties in accessing this support.

- Equality and diversity awareness was part of mandatory training for all staff. This was provided as a booklet and staff were required to confirm they had read it.
- A chaplaincy service was available 24 hours a day seven days a week and available to patients and relatives as required, including facilitating access to other religious faiths.

Learning from complaints and concerns

- There was a weekly complaints and serious incidents (SI) meeting chaired by the medical director or director of nursing where complaints were discussed for all directorates and was attended by the clinical director or assistant director of nursing. All complaints and SIs relating to the surgical directorate were reviewed and signed off by the medical director or director of nursing.
- Data from May-September 2016 showed that general surgery received a total of 8 complaints, urology 5 and orthopaedics 16, with the main themes around communication and surgical/invasive procedures.
- We noted there was variation within these surgical specialisms about length of time taken to respond to complaints. For example, general surgery had a 100% response rate within the accepted response time of 25 working days. However, whilst orthopaedics response was 100% for May and June, it fell to 80% in July, 66% in August and 50% in September.
- We saw that all theatre service staff had received training in complaints and conflict resolution.
- Service leaders told us where possible, staff endeavoured to deal directly with complaints as they arose in order to resolve matters as quickly as possible.

Are surgery services well-led?

Good

We rated well-led as good because:

- Newham University Hospital introduced a new and effective leadership structure in September 2015.
- Clear and effective clinical governance structures were in place across the surgery service lines.
- Staff we spoke with understood their role and function within the hospital.
- Many staff reported the site specific management as a positive change.
- Staff across all service lines told us the senior leadership were visible.
- Staff told us that culture and morale was much improved since the time of the last CQC inspection in January 2015.

Leadership and culture within the service

- Following the last CQC inspection in January 2015 when we rated well-led as inadequate, the trust adapted a new operating model which focuses the accountability for delivery of services and financial control through site clinical leadership and management teams at each of the main hospital sites.
- Newham University Hospital introduced a new leadership structure in September 2015 which was made up of four directorates, one of which was the directorate of surgery, led by a triumvirate of clinical director, general manager and associate director of nursing. They reported into the Newham site executive team of medical director, director of operations and director of nursing.
- This model followed the clinical academic group (CAG) structure, the principal purpose of which is to concentrate on the strategy, clinical transformation, definition, improvement and assurance of clinical standards and development of services and the clinical workforce. The main delivery mechanism for these activities is through a collection of multidisciplinary clinical networks which are directly responsible to the CAG boards. The surgery service CAG included cancer.
- The surgery service divisional structure included a clinical director, general manager, associate director of nursing theatre and ITU and associate director of

nursing surgery. Each specialism including general surgery, urology, trauma and orthopaedics, anaesthetics and ITU has a clinical lead, service manager and senior nurse.

- Many staff reported the site specific management as a positive change which helped to develop a strong identity for the hospital.
- We observed the surgical staff to be a small cohesive group of people who demonstrated a strong commitment to NUH and who expressed the determination to continue to develop the service.
- Staff across all service lines told us the senior leadership were visible and they felt confident to address matters directly with them if necessary.
- Senior nurse managers had recently initiated a change to the role of the ward manager. They worked clinically up to three days per week, rather than in their previous fulltime supernumerary or supervisory role. This ensured their expert knowledge and support was more available on the wards. Nursing staff told that this was a positive change and the additional support of ward managers was beneficial.
- There was a recently established ward manager's forum meeting and we saw samples of meeting minutes. The recent change to the role of ward manager was discussed and it was noted that there needed to be clarification with regards to what their clinical role entailed.
- We found, for the most part, an inclusive and constructive working culture within the surgery service. Staff we spoke with felt that Newham University Hospital was a good place to work. Nurses and doctors reported approachable and supportive colleagues and described the working environment as made up of a happy staff group with supportive managers.
- Many described the culture and morale as hugely different since the time of the last CQC inspection in January 2015.
- Senior staff were demonstrably proud of their teams and the support staff provided to each other across wards and theatres.
- Consultant doctors across specialties told us the consultant body was a cohesive group.
- Locum doctors told us they enjoyed working at the hospital and made a conscious choice to do so. They reported supportive consultants and colleagues and good dissemination of information.

Vision and strategy for this service

- Leaders of individual surgery service lines were clear on the direction for their service and were able to articulate a long term vision for developing their services. We were told that the strategic aspirations for surgical services for the next one to two years were at various stages of development.
- These included the development of core emergency surgical provision. The plan was to develop a surgical assessment unit with the inclusion of ambulatory pathways for selected surgical conditions.
- The general manager told us that key to the delivery of the above strategies was the continued increase in theatre utilisation.

Governance, risk management and quality measurement

- There was a monthly hospital site risk assurance meeting which included representatives from emergency care and medicine, women's and children, trauma and orthopaedics, and general surgery. High risks, rated 12 or above out of 20, were always discussed and risks rated moderate to low were discussed on a quarterly basis. This meeting comprised of the director of operations, head of governance, risk owner, general manager for the area and the director or deputy of nursing. We looked at minutes from six previous meetings and saw there was a good attendance rate.
- Clinical governance structures were in place across the surgery service lines and staff felt they were effective. A monthly multidisciplinary quality and safety committee (Q and SC) chaired by the medical director was held with representation from each directorate. The entire site dashboard on complaints, incidents, SIs and never events pertaining to all directorates was discussed.
- There were monthly governance meetings within the surgical directorate. One manager told us it was a challenge to encourage a wider range of staff to attend and also to disseminate information from governance meetings to all staff.

Surgery

- At the time of our inspection there were eight approved risks on the hospital wide risk register which related to the surgery service. Of these, four related to medical devices three to staff and one to access to treatment and capacity.
- The highest rated risks were for staff and medical devices with two for each rated as 16 where the highest rating is 20. For example, with regards to staff, emergency care of critically ill children was on the risk register because of the recognition that exposure to critically ill children at NUH was limited. It was noted that there had to be robust classroom training such as APLS for all doctors including anaesthetists in order to maintain their skill level. The other highly rated staff risk was listed as inadequate numbers of anaesthetic staff grade rota to handle multiple time and life critical situations, particularly out of hours.
- The two medical device risks rated at 16 included deteriorating power tools for trauma surgery where their functionality was noted to be unreliable and which could result in the cancellation of surgery. The other high risk related to monitors in recovery which could not monitor ETCO2 levels as recommended by Association of Anaesthetists of Great Britain and Ireland guidelines for all anaesthetised or intubated patients regardless of their location in healthcare premises and the type of airway device used.
- Staff we spoke with understood their role and functions within the hospital and demonstrated a strong identity with their place of employment. They told us they were committed to a shared responsibility to develop the good reputation of Newham University Hospital.

Public engagement

- Whole trust results of the most recent NHS staff survey from 2015 showed that whilst staff engagement was lower than the national average (3.78%), it increased from 3.62% to 3.68% from the previous 2014 staff survey. Percentage of staff feeling pressure in the last 3 months to attend work when feeling unwell was 55% as compared with 58% for other acute and combined trusts. 3.11% of staff reported good quality of appraisals compared with 3.03% for other acute and combined trusts. Staff views on the quality of non-mandatory training, learning or development equalled that of other trusts.
- However, the trust scored 37% for the percentage of staff who experienced harassment, bullying or abuse from staff in last 12 months as compared with the national average of 24%. Other areas in which the trust scored worse included 70% of staff believed that the organisation provided equal opportunities for career progression or promotion where the national average was 87% and 21% of staff experienced discrimination at work in the last 12 months where the national average was 10%.
- 2016 patient-led assessments of the care environment (PLACE) were only available as a whole site survey. Newham performed better than the national average for cleanliness, food and general appearance. However, scores were significantly lower than the national average for privacy and dignity 74% where the national average was 84%; dementia 56% where the national average was 75% and disability 66% where the national average was 79%.
- We looked at data submitted by the patient liaison service (PALS) to the quality and safety meeting and saw that orthopaedics was amongst the top three specialisms of concern for both July and September, comprising of 33% and 36% of concerns raised by patients. The main themes of these were related to length of wait on the telephone, delay in appointments being sent and delays in appointments due to referrals being mislaid.
- We saw publicity designed to encourage patients to choose to have their orthopaedic surgery at Barts Health Orthopaedic Centre (The Gateway Centre) rather than other parts of the trust.

Innovation, improvement and sustainability

- Throughput in The Gateway Centre had increased by 25% over the previous nine months, with theatre utilisation regularly above 85%. The centre supported new pathways of care and achieved amongst the shortest length of stay in the country. The average length of stay for hip and knee replacements is between two and three days.
- The surgical service plans to reinstate elective paediatric surgery at Newham for children over three years of age in March 2017. CQC is unclear about the sustainability of this in the light of inadequate numbers of anaesthetic staff grade identified as a high risk on the risk register.

Maternity and gynaecology

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

Information about the service

Newham University Hospital (NUH) provides maternity services to women in the London Boroughs of Newham and Barking and Dagenham. There were 6026 births between March 2015 and April 2016.

Maternity services are located together into one purpose built section of the hospital where ante-natal, intrapartum and postnatal care is provided. The hospital has a range of ante-natal and postnatal services, including early pregnancy diagnostics, inpatient and outpatient ante-natal screening and assessment.

The maternity unit has two delivery areas. The central delivery unit is a shared consultant and midwifery led unit and has 15 delivery rooms. There is a co-located birth centre with 9 birthing rooms. There is one obstetric theatre. The inpatient ward (Larch Ward) has 41 beds for ante-natal and postnatal care, and induction of labour. Six of these are fee paying amenity rooms where a partner can stay overnight. The day assessment unit is attended by women over 20 weeks pregnant who have complications of pregnancy.

In the midwifery led birth unit there are approximately 120 babies delivered a month. Birth centres are suitable for women who have a normal low-risk pregnancy, go into labour between 37 - 42 weeks and are expected to have an uncomplicated birth. All nine rooms at Newham birth centre have birth pools.

The obstetric unit is the recommended place of birth for women with complicated pregnancies or those who go into labour before 37 weeks. They are also available for women who would like a natural birth experience with medical expertise close by. A high dependency unit for mothers who develop complications around the time of birth and require close monitoring. A level 3 neonatal unit is on site for babies born prematurely or needing additional support after birth.

Community midwifery services deliver ante-natal and postnatal care for low risk women in the catchment area. Specialist ante-natal clinics are run for women with additional conditions such as diabetes, or mental health, heart, kidney or neurological problems.

We carried out an unannounced focused inspection of the service in November 2016. During our inspection, we visited the labour ward, Larch ward, the ante-natal clinics, the early pregnancy assessment unit, operating theatres and the surgical assessment unit. We spoke with six patients and 26 members of staff within the service including consultant obstetricians and anaesthetists and anaesthetic team, consultant neonatologists, midwives, midwifery assistants, operating department practitioners and theatre nurses, admin clerks and housekeepers.

We observed care and treatment and reviewed 10 care and medical records. We received comments from people who told us about their experiences and we reviewed performance information about the trust's maternity service. We visited all areas of the maternity unit and spoke with midwives, support workers, obstetricians, senior managers, women attending the antenatal clinic and women who had recently given birth.

Maternity and gynaecology

Summary of findings

Overall, we rated this service requires improvement because:

- There was insufficient consultant cover resulting in less than 50% of women in labour with a consultant present on the labour ward. Staff told us this meant women were waiting longer for pain relief and treatment.
- Out of hours medical cover at all levels was overstretched, leading to delays in care. The trust had not approved the proposal to fund additional consultant posts at the time of our inspection.
- Although there had been some staff recruitment there were shortages of midwifery staff at the time of our inspection. Many midwives were inexperienced and midwives were overstretched. The trust had recruited additional nursing staff from overseas that were expected to be in post by the end of October 2016. Seventeen newly qualified band 5 nurses had been recruited but that still left 14 whole time equivalent (WTE) vacancies across midwifery services. The service had submitted a paper to the trust board outlining the case for further recruitment. Several staff told us that the lack of appropriately skilled midwives meant they were often spread thinly and this could impact on women's care.
- There were concerns about the management of incidents and serious incidents. There was a backlog of more than 150 incidents waiting to be reviewed, which had led to a delay in learning. However, the trust were working with commissioners to review overdue serious incidents and incidents, with a plan for completion by December 2016.
- Trust guidelines for the reporting of serious incidents and root cause analyses were being followed. However, not all incidents were correctly identified as a serious incident. We saw examples where similar outcomes had been categorised differently and the reason given by the trust did not follow their own policy.
- There was only one staffed obstetric theatre. Many staff commented on the difficulties this caused for women such as having to wait longer for a caesarean. This was raised as a concern at the last inspection. In response a bid had been put forward for funding for staffing a second theatre however this had not progressed. Staff were dependent on operating time being available and nursing and medical staff being available to use the second theatre.
- At the last inspection staff told us they felt like the poor relation to one of the trust's other acute hospitals even though Newham University Hospital had the larger maternity unit. They perceived the senior leadership as remote and that leaders imposed decisions rather than listening to the concerns and ideas for improvement. At this inspection we found staff repeating the same concerns. Several staff commented that middle managers as well as senior managers were not listening to them.
- Mortality and morbidity meetings were held regularly and doctors gave presentations on specific cases. It was not clear how learning was drawn from this or how it influenced future practice because no minutes or actions were recorded.
- Some staffing issues impacted on women receiving timely pain relief. Some women had to wait longer than 45 minutes when an epidural anaesthetic was called for, exceeding national guidance. Midwives had to regularly call on operating department practitioners (ODPs) from the main theatres for epidurals, which also delayed pain relief for some women.
- At the previous inspection in May 2015, the security of babies in maternity services had been identified as a risk because of insufficient staff to monitor access to the unit. Although approval had been given, security measures had not been implemented.
- Midwifery, nursing and medical staff were not up to date with safeguarding adults and safeguarding children's training. The trust had not met its targets for medicines management and equality and diversity training in midwifery services.

Maternity and gynaecology

- Most staff we spoke with were not clear about their roles and responsibilities under legislation around capacity and deprivation of liberty. Staff responses were variable and several staff thought it was about health and safety issues.
- There was an effective training programme for midwifery staff, although some midwives felt they did not have time to develop their skills outside the framework of mandatory training because they were so busy. Trainee doctors were well supported and had opportunities to put their learning into practice

However:

- Staff did their best to ensure they provided the best care they could. A clinical educator had been employed to support all preceptor midwives to the hospital. The practice development midwife had recently been supported with administrative support to help with maintaining an accurate database of staff training.
- The education team had a rolling system for looking at skills gaps and putting in place development opportunities for midwifery staff. There were 12 supervisors of midwives and a preceptorship programme for band 5 and 6 midwives. Supervisors of midwives helped to develop all midwives' skills and expertise. Several staff commented on the benefit in having a named member of staff to refer to if they had any concerns or queries.
- Some women we spoke with were happy with the care they had received. They were treated with dignity and their privacy was respected. Women were informed and involved in their care and treatment.
- There was a clear care pathway in the maternity unit, according to women's clinical needs. Women felt that the level of communication from midwives and doctors was good. They felt listened to and well supported.
- The inpatient environment was spacious and clean. Women were involved in choices about their care; there were initiatives to encourage natural birth.

- Processes were in place to assess and manage risk. These included the use of team briefings and the World Health Organisation (WHO) surgical safety checklist in obstetric theatre

Maternity and gynaecology

Are maternity and gynaecology services safe?

Inadequate

We rated safe as inadequate because:

- There was insufficient consultant cover resulting in less than 50% of women in labour with a consultant present on the labour ward. Staff told us this meant women were waiting longer for pain relief and treatment.
- The unit had a high proportion of complex cases and we observed midwives to be overstretched. Several newly qualified nurses commented they felt out of their depth at times, although senior staff were supportive. Several staff told us that the lack of appropriately skilled midwives meant they were often spread thinly. A trust review had identified that more midwives were needed. A proposal had been submitted to the trust board outlining the case for more.
- The trust had been working to recruit more staff and had increased its staffing levels, recruiting more newly qualified nurses and nurses from overseas. However lack of staffing was still an issue. Staff told us the labour ward was often short of staff and mothers in labour did not always get one to one care in early labour. Therefore mothers may not have received the screening and/or monitoring when they needed it. Although the hospital had met its target to ensure 100% of women received one to one midwife care in established labour, it had meant that midwives were spread thinly elsewhere. Midwifery and consultant obstetric staff were often under pressure because of the number of births in relation to the number of staff.
- Not all incidents had been correctly identified as a serious incident. We saw examples where similar outcomes had been categorised differently. Staff were not always given feedback on incidents that they were not directly involved in. There was a backlog of more than 150 incidents waiting to be reviewed, which had led to a delay in learning. However, the trust were working with commissioners to review overdue incidents and SI's with a plan for completion by December 2016.
- Mortality and morbidity meetings were held regularly and doctors gave presentations on specific cases. It was not clear how learning was drawn from these meetings to influence future practice, because no minutes or actions were recorded.
- Five out of six nursing records we reviewed were incomplete, with loose notes, no documented management plan, antenatal risk assessment not flagged on two records and some signatures not legible. This was not in accordance with trust policy.
- At the previous inspection in May 2015, the security of babies in maternity services had been identified as a risk because of insufficient staff to monitor access to the unit. Although approval had been given, security measures had not been implemented and this remained a concern.
- Overall, the trust were not meeting its target to ensure all midwifery, nursing, obstetrics and gynaecological staff had the required training in safeguarding.
- There were gaps in the number of staff that had completed their statutory and mandatory training and levels were below the trust's target of 90% in medicine management, resuscitation, basic life support and equality and diversity.
- There was not a full second obstetric theatre team. The hospital's emergency theatre team was relied upon to provide this. Midwives were concerned by the lack of a dedicated second theatre and getting theatre staff was dependent on the theatre and theatre staff not being needed for operations in other departments which meant mothers had to wait longer for operations.

However:

- Staff did their best to ensure they provided the best care. Seventeen newly qualified nurses had recently been recruited. A specialist cardiotocography (CTG) midwife had been appointed to assist with CTG training. Several staff commented on the benefit in having a named member of staff to refer to if they had any concerns or queries.
- Processes were in place to assess and manage risk, including systematic antenatal assessments of women at risk, the use of team briefings and surgical safety checklists in obstetric theatres.
- We saw systems to identify women with complex social needs including liaison with adult social services to address the needs of women with learning disabilities. All midwives were involved in the triage process. At the

ante-natal booking appointment, women had a full assessment of physical, social and mental health needs completed and were allocated either a consultant or midwife lead, depending on their needs.
- Midwifery staff completed observations on patients and babies and recorded these on neonatal early warning score (NEWS) charts. A baseline
- There were improvements in the number of patients with management plans in their notes (90% on larch ward compared with 59% previously). 97% of women had a modified early obstetric warning score (MEOWS) chart in their notes compared to 68% previously.
- The hospital and community midwifery team worked proactively to support women to breastfeed and provided continuing support to women at home. The percentage of women breastfeeding remained high. Between April and September 2016 an average of 90% of women were breast-feeding.

Incidents

- In accordance with the Serious Incident Framework 2015, maternity services reported 17 serious incidents (SIs) as meeting the reporting criteria set by NHS England between October 2015 and September 2016. However, not all incidents had been correctly identified as a SI. We saw examples where similar outcomes had been categorised differently and the reason given by the trust did not follow their own guidance on categorisation as it was stated in the trust's adverse incident policy. In another incident we saw it met the trust criteria for a SI however it had not been recorded as such.
- The total number of other incidents for the year was not available**.** There were 134 incidents raised in July 2016. There was a backlog of more than 150 incidents waiting to be reviewed, which had led to a delay in learning. The trust were working with commissioners to review overdue incidents and SI's with a plan for completion by December 2016.
- There had been no never events reported by the service in the past year. A never event is described as a wholly preventable incident, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- Incidents in maternity services were reviewed at a weekly multidisciplinary risk forum which identified potentially serious incidents or other incidents requiring the involvement of a consultant. A supervisor of midwives attended the maternity meeting and took part in the investigation of complaints and incidents when appropriate.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence where these were shared with the relevant managers. Staff understood how to raise concerns and record safety incidents including concerns and near misses. Staff were provided with information about incidents through newsletters and memos from the governance team. However, some staff said they did not always get to hear the outcome of incidents they had been directly involved in and feedback on others was variable. Systems for ensuring feedback was shared, was very much dependent on the individual manager's processes for feeding back.
- Daily huddles shared risk information verbally; however, not all staff came on shift at the same time. Some staff and bank or agency staff started later. This meant they would not know what had been shared unless told in addition to this, the responsibility of which was with the midwife in charge
- Mortality and morbidity meetings were held regularly and doctors gave presentations on specific cases. It was not clear how learning was drawn from these meetings to influence future practice, because no minutes or actions were recorded. The trust told us they regularly circulated a "risk management newsletter". However there was a lack of clarity as to how learning was followed up to ensure staff followed the recommendations.
- Staff were aware of actions they should take when a 'reportable patient safety incident' occurred and assured us they were open and transparent. They were aware of the Duty of Candour (DoC). The 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. Managers accurately explained what responsibilities they had under DoC.

Safety thermometer

- The maternity department had systems in place for recording and monitoring performance. A dashboard

was used to rate performance against key indicators. Performance was colour coded as 'red, amber or green' to enable management to see at a glance which areas required improvement.

- A range of safety and performance information was monitored by the service. This included the number of hospital acquired infections, the number of medication administration errors, friends and family test response rates, maternity documentation standards and maternity staffing levels.
- Maternity information collected included, the percentage of inductions of labour, number of caesarean section deliveries, complications of labour and delivery, number of stillbirths and breech births.
- From April to September 2016 there had been 107 unexpected admissions to the neonatal unit and 310 transitional care admissions. During the same period, 19% of women had an emergency caesarean. This was higher than the England average of 15%. 24% of women had their labour induced which was better than the England average of 27%. 5.7% of women were smoking in pregnancy compared to the London average of 6.3%.
- Although the hospital had met its target to ensure 100% of women received one to one midwife care in established labour, it had not met its target to ensure that 98% of women had a consultant present on the labour ward, which averaged 47.5% between April and September 2016. Staff shortages increased the risks for mothers and their babies.
- The hospital and community midwifery team worked proactively to support women to breastfeed and provided continuing support to women at home .The percentage of women breastfeeding remained high. Between April and September 2016 an average of 90% of women were breast-feeding.
- The number of women assessed by midwives and obstetricians for risk of venous thromboembolism (VTE) was 98.7%, the service had reminders in safety updates for staff to assess all women for VTE risk, which was being audited internally. Senior managers were monitoring audit outcomes to improve compliance and achieve a 100% compliance rate.
- There was a process in place for reviewing all deaths including stillbirths through the mortality and morbidity processes. Between April and September 2016, there had been one neonatal death and 15 ante-partum stillbirth, which averaged 4.52 per 1000 births. This was within the target of less than 5 per 1000 births. However, information provided only covered a six month period which was not a true reflection for the full year.

Cleanliness, infection control and hygiene

- The trust had policies for screening and treatment of C. difficile and MRSA infections. From March 2016 to May 2016 there were no reported infections of either MRSA or C. difficile within the service.
- Medical and nursing staff had access to training in sepsis management, infection control and prescribing antibiotics during their induction**.**
- The service had an annual infection prevention and control team programme of work for 2016/17. This showed the service had a plan for continuous improvement in the management of infection prevention and control. It highlighted the importance of accountable leadership, multi-agency working and the use of monitoring systems.
- Hand sanitising gel was available within the clinical areas, and we saw reminders prominently positioned to remind staff and visitors to use it.
- While ward staff followed hospital policy and 'bare below the elbows' guidance, we observed one clinician who did not and was not challenged by staff on the ward.
- Personal protective equipment, such as gloves and hand-washing facilities were available. We observed two staff using personal protective equipment appropriately, which was in line with national guidance.
- The areas we visited were clean and tidy. We saw evidence that cleaning staff adhered to standards, practices and the required frequency of cleaning. The intrapartum areas were appropriately designated a high risk area and audited weekly. Other wards were designated as high risk areas and were audited monthly. We saw good results from infection control audits. Women told us they were satisfied with the standard of cleanliness. We saw 'I am clean' stickers in all the areas we visited, with the day's date to indicate a clinical item was ready to be used again.
- All staff were required to complete infection control level one and two mandatory training. The majority of staff were recorded as completing this training. Level three infection control was mandatory for midwifery and nursing staff. The trust completion target of 90% was not

being met. Records showed completion rates of 63% for the ante-natal unit, 67% in the neonatal unit, 71 % in midwifery and 81% in medical obstetrics and gynaecology.

- There were systems in place for the segregation and correct disposal of waste materials such as sharp items. Sharps containers for the safe disposal of used needles were available in each consulting room. These were dated and were not overfilled.

Environment and equipment

- At the previous inspection, security had been identified as a risk because of insufficient staff to monitor access out of the unit. Visitors were admitted without checking their names or who they were visiting, which was a potential risk to women and babies. On the labour ward, a visitor log was kept by the person at the reception desk. The only mitigation was continuous recorded CCTV in the main reception, observable by security staff. However, there were only two site security staff. At this inspection we found a similar situation. We observed members of the public being let into wards without any checks about who they were**.**
- Entrances in all the areas where babies were cared for were secure, with locked doors and intercom communication. The doors could only be opened by internal mechanism or by a swipe card system on the outside. However doors could be opened on the inside by anyone wanting to leave the area and the area was not always monitored. The trust told us additional bank receptionist cover had been provided to mitigate this; however we were able to exit wards without being challenged or observed. This meant there was a possibility that staff, patients and visitors could leave the ward with a baby without anyone being alerted to this. Staff had raised this as a concern and the hospital were in the process of implementing recommendations to have a tag system in place for babies, but this was not yet in place and remained a concern. We were informed by the trust this would be in place by January 2017.
- Resuscitation equipment was available for use in an emergency. Staff were allocated to check resuscitation equipment and we saw that checks were recorded. The trolley drawers were not tagged, so were accessible to unauthorised persons. We were told it was not the hospital policy to tag resuscitation trolleys, which could be a risk in an area where small children could tamper with equipment. We also saw saline bags left on a trolley in a corridor that were easily accessible to children or anyone else in the corridor. Staff said they felt that although they knew it was a risk they would rather trolleys and equipment was easily accessible.
- Cardiotocography (CTG) equipment was available and equipment had been safety tested. CTG is a test usually done in the third trimester of pregnancy. It is done to see if baby's heart beats at a normal rate during contractions.
- Foetal blood analyser and foetal heart rate monitoring equipment for high risk pregnancy monitoring was available and safety checked. Laboratory facilities and blood products were available if required.
- An electrical maintenance team were responsible for annual safety testing. The equipment we looked at all had an up to date safety test and appeared in good condition.
- Waste management was compliant with national guidance.

Medicines

- A named pharmacist visited the maternity unit daily. Stock arrived weekly and was topped up by a pharmacy technician when required.
- Medicines were safely managed, accurately recorded, in-date and securely stored in locked rooms or locked fridges. Fridge temperatures were monitored daily. We checked the controlled drugs register and saw that daily stock checks were recorded, stock levels were correct.
- Arrangements were in place for safe disposal of waste and clinical specimens.

Records

- Women kept their own pregnancy related care notes in handheld records (the green notes), taking them with them when they attended the maternity unit and for examinations with their community midwives.
- Local audits had identified record keeping for women during labour and birth as a concern. The 2015/2016 maternity record keeping audit (February 2016) sampled 0.5% of maternity service records. Recommendations included: improve documentation on the place of birth, the documentation of VTE antenatal, intrapartum and postnatal in the hard copy of notes. It had also been highlighted on several serious incident reviews that records were incomplete. Individual care records we saw were often incomplete. For example, we reviewed six nursing records and four medical records. Five out of

six nursing records were incomplete with loose notes, no documented management plan, antenatal risk assessment not flagged on two records and some signatures not legible. This was not in accordance with trust policy.
- The audit recommended that record keeping audits to be embedded in the trust programme for 2016-2017 financial year. We asked the trust for information on audits completed since February 2016 but this was not provided.
- Electronic records were available only to authorised people. Computers and computer systems used by hospital staff were password protected.
- Pre-operative checklists were competed accurately and signed and dated in accordance with trust policy.

Safeguarding

- All permanent staff providing direct care to pregnant women had access to safeguarding children training**.** Staff with no direct contact with women and babies completed level 2 training online. There was training for first-year trainee doctors on perinatal mental health and safeguarding.
- There was a specialist midwife and a named midwife for safeguarding. Relevant staff had attended safeguarding supervision based on the Signs of Safety model and there was a process for monitoring completion.
- There was a well-established midwifery team, Acorn, for supporting mothers at risk.
- Staff understood their responsibilities and were aware of safeguarding policies and procedures. However, safeguarding adults training was below the trust target of 90% in every department. In the ante natal unit, 25% of nurses had completed, 73% in the labour ward, 83% on larch ward, and 50% of medical staff. For safeguarding children level 2 training there was a compliance rate of 67% in ante-natal, 75% for community midwives and labour ward, 63% for paediatrics and 100% for the midwifery led unit. For level 3 safeguarding children was 75% on the antenatal and labour ward and 77% of staff on Larch ward.
- It is the duty of healthcare organisations to ensure that all health staff have access to appropriate safeguarding training. The Safeguarding children and young people: roles and competences for health care staff intercollegiate document 2014, sets out the requirements related to roles and competencies of staff for safeguarding vulnerable children and young people. Level two training is required for all non-clinical and clinical staff that have any contact with children, young people and/or parents/carers. Level three training is required where clinical staff work with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns.
- Policies contained information about child sexual exploitation and female genital mutilation. We saw that the maternity and gynaecology guidelines about female genital mutilation were in place and some staff told us they had attended training. We saw evidence that cases of female genital mutilation (FGM) had been reported correctly following the FGM guidelines.
- The chief nurse of the trust had overall responsibility for safeguarding adults and children. There was a named safeguarding nurse who supported staff in the service whenever required. All staff we spoke to knew how to raise safeguarding concerns appropriately.

Mandatory training

- There was mandatory multi-professional team training for CTG assessment, and 'skills and drills' to rehearse obstetric emergencies. Every member of staff was given a copy of the Practical Obstetric Multi-Professional Training (PROMPT) manual.
- Staff were required to attend mandatory training in obstetric emergencies; Practice Obstetric Multi Professional Training (PROMPT). Training was provided for multidisciplinary groups that included consultants, staff grade doctors (such as registrars and senior house officers) junior doctors and all grades of midwives. The training included classroom sessions and simulations of events.
- Training was updated in four mandatory study days each year. Line managers monitored completion of training, which now included customer care. Most staff had completed their statutory and mandatory training, although completion was below the trust's target of 90% in medicines management, resuscitation, basic life support and equality and diversity.
- Attendance at mandatory training for medicines management was 63% for the ante-natal unit, 94% for labour ward, 84% for the midwifery led unit and 86% for Larch ward. The trust target of 90% had been met for the majority of staff in moving and handling patients. The

majority of staff had completed basic resuscitation with ante natal at 88% and the community midwifery unit at 82%. The labour ward and larch ward were above the 90% threshold for staff completing basic resuscitation training.

- New staff attended a mandatory induction week that covered the mandatory training programme including basic life support, information governance, infection control, health and safety, fire safety, safeguarding children and adults, equality and diversity and manual handling. All staff undertook a mandatory induction week to the trust.
- Staff received training in pre-eclampsia, sepsis, maternal collapse and haemorrhage, breech presentation and shoulder dystocia. Staff all said that the training was very relevant and useful.
- There were several mandatory training programmes in place to address learning points that had arisen from serious incidents. Including a cardiotocography training course that had been put in place in response to the outcome of several serious incident reviews.

Assessing and responding to patient risk

- Early booking improved the chances of women receiving appropriate care. The proportion of women booked before 12 weeks had fluctuated over the previous six months and averaged 75.5% which was well below the target of 90%. In that last quarter the trust had met its target to ensure an average of 50% of women were booked by 10 weeks.
- We saw systems to identify women with complex social needs including liaison with adult social services to address the needs of women with learning disabilities.
- At the ante-natal booking appointment, women had a full assessment of physical, social and mental health needs completed and were allocated either a consultant or midwife lead, depending on their needs. This ensured women with risk factors were seen by appropriately trained professionals.
- All midwives were involved in the triage process. A woman could telephone or arrive on the ante-natal assessment unit or labour ward, and be assessed and triaged by any of the midwives on duty. The trust policy about maternity triage had clear guidelines on the criteria of admission and treatment of women to the maternity unit. The policy was evidence based and referred to Royal College of Obstetricians and Gynaecologists guidelines regarding preterm premature rupture of membranes (PPROM), foetal movement guidelines and foetal monitoring guidelines.
- Staff told us that if they were unsure of their assessment, they felt confident in seeking advice from more senior colleagues. The risk of delayed recognition of pathological cardiotocography (monitoring the foetal heart) had been reduced through annual multidisciplinary training.
- Risks for women undergoing obstetric or gynaecological surgery were reduced as staff following the five steps of the World Health Organisation (WHO) surgical safety checklist. Checks were recorded on the patient electronic patient record. We saw an audit and reviewed records for women who had a caesarean section, which showed that checks were completed appropriately.
- Women, who had had caesarean sections were prepared for surgery, consented and had the risks of surgery explained to them. Pre-operative checklists were fully completed. This was in accordance with the World Health Organisation surgical checklist: Five Steps to Safer Surgery. We asked several patients about their experiences and they told us that they felt that they had fully understood the process, had all their questions answered and felt that they and their partners were fully involved.
- Patients were monitored using the modified early obstetric warning score (MEOWS) to assess their health and wellbeing and detect signs of deterioration. This allowed staff to recognise the deteriorating patient and escalate any concerns to senior staff. Staff were trained during induction on the use of the early warning score
- Midwifery staff completed observations on patients and babies and recorded these on neonatal early warning score (NEWS) charts. A baseline audit completed in February 2016 showed that 68% of women had a modified early obstetric warning score (MEOWS) chart in their notes. A re-audit in September 2016 showed that of a sample of 60 case notes from the pre and post-natal and CDS departments, 97% of notes had a MEOWS chart present.
- There was an improvement in the number of patients with management plans in their notes (90% on larch ward compared with 59% previously). The hospital recommended they continued to audit records with an

aim to achieve 100% compliance. We reviewed some of these charts and found them appropriately completed, enabling mothers or babies to receive additional medical support if required.

- Staff had access to emergency trolleys in the event of an obstetric emergency. These were easily accessible in corridors.
- A risk to patient safety had been reported on at the quality improvement board, regarding the use of cardiotocography (CTG). This is a way of monitoring a babies' heart activity in the womb. In response, a training schedule had been implemented and ongoing training took place with all staff, with the aim of decreasing the number of incidents that may have arisen due to poor interpretation of CTG monitoring. A specialist CTG midwife had been appointed to assist with CTG training. Several staff commented on the benefit in having a named member of staff to refer to if they had any concerns or queries.

Midwifery staffing

- Trust information stated the midwife to birth ratio was 1:30 against the nationally recommended 1:28 (Minimum Standards for the Organisation and Delivery of Care in Labour (Royal College of Obstetricians and Gynaecologist 2007). At the last inspection there were concerns about the mother to midwife ratio and the number of vacancies. Some staff had been recruited to fill these vacancies.
- Over 50% of patients were in the higher risk group because of pre-existing health issues, risk of premature or still birth, and postpartum complications. Birth-rate Plus (a framework for maternity workforce planning) showed that a ratio of 1:26 was appropriate for the assessed levels of acuity.
- The service had reviewed this staffing ratio and it had been agreed by relevant commissioners there was a need to increase staffing. A business case had been made to improve the mother-to-midwife ratio. It had been estimated that 35 additional midwives would be needed. However, the staffing budget had not been increased to enable this to happen. The trust were aware there were anomalies in their data and were proactively looking at how they could improve staffing ratios.
- At the last inspection we identified that lack of staffing placed patients at risk as not every woman had been able to have one-to-one care in labour. Since then the trust had been working to recruit more staff and had increased its staffing levels, recruiting more newly qualified nurses and nurses from overseas. However lack of staffing was still an issue.
- Managers were able to use bank staff to cover shifts. Staffing rotas showed bank staff were used for over 40% of days in the central delivery suite (CDS). If the lead midwife identified a risk, the trust escalation policy required them to contact the on-call manager. However, we heard from staff and saw on incident reports that managers were sometimes unavailable to respond to this identified risk.
- Midwives said they did not always take breaks and often worked beyond the end of their shift. Staff told us that due to staff shortage not all mothers received one-to-one care while in the first stages of labour. They told us it was one nurse to two mothers and sometimes more. Staff did their best to ensure they provided the best care, however several staff told us that the lack of appropriately skilled midwives meant they were often spread thinly. For instance, prioritising one-to-one care of women in labour meant there was a risk that other women did not receive appropriate care. We saw an example of an incident where deterioration in the mother and baby's condition that had not been identified as quickly as it could have been.
- The September 2016 staff meeting minutes stated there were 'currently 19 band 5 nurses, many from recruitment overseas, waiting to start and 35 vacancies across maternity, mostly on Larch ward and community midwifery'. The service were using bank and agency staff to cover vacancies.
- Staff told us agency staff received an induction and this was confirmed by one nurse we spoke with.
- Between November 2015 and October 2016 the midwifery led unit had used agency staff on average for around 13.5% of the time. Managers and staff said they were short of qualified midwives. The trust was recruiting qualified nurses and supporting them to undertake midwifery training. Midwife supervisors were proactively supporting all staff with additional training if required.
- The trust were below their planned staff whole time equivalent (WTE) for band 7 nursing and midwifery staff. There was a shortfall of just over 87 hours for October 2016. Staff told us they were short of experienced nurses and this impacted on the amount of supervision they were able to give to less experienced staff.

Maternity and gynaecology

Medical staffing

- During the last inspection in January 2015 we highlighted that some recommendations of The Safer Childbirth London Safety Standards and the Royal College of Obstetricians and Gynaecologists were not being met. Significantly, we identified there were risks associated with being unable to meet the recommended hours of consultant presence on the labour ward.
- There was insufficient consultant cover which was less than the previously recommended number of hours for an obstetric unit of this size. This had been raised at the last inspection. Latest guidance from the RCOG states, "All units need to ensure a locally agreed, safe and sustainable solution to address workforce issues to manage care in both obstetrics and gynaecology". The present consultant cover had been increased to 98 hours; however less than 50% of women in labour had a consultant present in the labour ward. Staff told us this meant patients were waiting longer for pain relief and treatment. The trust had not approved the proposal to fund additional consultant posts at the time of our inspection.
- A system was in place for providing locum doctors with an appropriate induction.
- Out-of-hours medical cover at all levels was overstretched, leading to delays in care. The medical rotas and cover for the labour and gynaecology wards showed that emergency and on-call cover was provided by different grades of doctor.
- Obstetric anaesthetic cover consisted of 2 anaesthetists between the hours of 08:00 and 20:00 Monday to Friday; one anaesthetist covered the night and weekends, supported by a second anaesthetist who covered surgical emergencies. In addition, a third anaesthetist on-call consultant was available. However, staff told us that an anaesthetist was not always available to promptly respond to a woman in labour due to other demands, especially overnight. This meant that some women had to wait longer than 45 minutes for an epidural anaesthetic when in labour. Safer childbirth recommendations from the Royal College of Obstetricians and Gynaecologists (RCOG) 2007 states, "When women choose epidural analgesia for pain relief in labour they should be able to receive it within a reasonable time ... the response time should not normally exceed 30 minutes and must be within one hour, except in exceptional circumstances".

Theatre staffing

- There was a dedicated theatre team for one of the obstetric theatres. This included a consultant anaesthetist from 8am to 7pm on weekdays and for six hours on Saturdays and Sundays, as well as 24-hour staff-grade cover.
- There was not a full second theatre team even though the second theatre (theatre 7) was often in use. When a second theatre was needed, staff called on the hospital's emergency theatre team. Midwives we spoke with were concerned by the lack of a dedicated second theatre. They said getting theatre staff could be a problem and was dependent on the theatre and theatre staff not being needed for operations in other departments. This meant mothers had to wait longer for operations if one theatre was already in use.
- A business case had been prepared for more theatre staff and a dedicated second theatre. There was only one operating department practitioner (ODP) for the delivery suite, so midwives had to call on ODPs from the main theatres for epidurals. This delayed pain relief for some women.

Major incident awareness and training

- The trust had an incident response plan. This was a trust wide document and whilst it had no reference to maternity services, there was a 'Maternity Escalation, Unit Closure and Business Continuity Plan'. This was a clear plan to manage high levels of patient activity and times when the maternity unit was full to capacity. Roles and responsibilities were clearly defined and processes for decision-making identified.
- The hospital had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff and business continuity plans ensured the delivery of the service was maintained.
- All staff had access to annual fire training and nursing staff explained the evacuation procedure for maternity wards. Managers assured us all maternity staff were up

to date with annual fire training and training data we saw confirmed this. Safety checks on fire extinguishers and emergency lighting had taken place at regular intervals.

Are maternity and gynaecology services effective?

Good

We rated effective as good because:

- There was a systematic programme to review and update guidelines in line with recommended standards. Staff knew how to access professional guidance. Midwives were supported to maintain their competencies and consultant midwives supervised staff professional development.
- The maternity services collected maternity data to provide information on how it performed against national indicators. It produced a monthly dashboard so managers knew how the unit was performing against service targets although this was not shared with staff.
- The maternity service was working towards level 3 of the UNICEF UK Baby Friendly Initiative to promote good care for newborn babies and had appointed an infant feeding coordinator. Between April and September 2016, 90% of women were partially breastfeeding when they left the hospital.
- There were regular local audits to assess and evaluate the effectiveness of care; the results of these were presented to staff, with action points identified and proposals for follow-up audits as appropriate.
- Outcomes for women and their babies in maternity services were within national guidelines. Women could choose where to receive antenatal and postnatal care, either in the community or antenatal appointments at the hospital when appropriate.
- There were 12 supervisors of midwives who helped develop all midwives' skills and expertise. A midwifery education team worked across the trust's sites and a practice development midwife had recently been supported with administrative support to help with maintaining an accurate database of staff training and a clinical educator had been employed to support recently recruited midwives from overseas.
- There was an effective multidisciplinary team working environment within the maternity service and good multidisciplinary relationships supporting patients' health and wellbeing.

However:

- Some staffing issues impacted on women receiving timely pain relief. Some women had to wait longer than 45 minutes when an epidural anaesthetic was called for, exceeding national guidance. Midwives had to regularly call on operating department practitioners (ODPs) from the main theatres for epidurals, which delayed pain relief for some women.
- Over the twelve month period April 2015 to March 2016 there had been 31 stillbirths. In the six months from April to October 2016 the stillbirth rate had almost doubled to 24 stillbirths. We did not see any meeting discussions or action plan that acknowledged the trust were aware of, and were looking at, the reasons for the increase in stillbirths.
- As of June 2016 the nurses and midwives appraisal rate was 63%, below the trust target of 90% and some staff said it was difficult to fit in training beyond mandatory training. Staffing shortages led to midwives being taken off training as they were needed on the wards. Several staff said they had to cancel training because they were needed on the unit due to staff shortages. E-rostering meant staff could not easily fit in training unless booked well in advance.
- Most staff we spoke with were not clear about their roles and responsibilities under legislation around capacity and deprivation of liberty. Staff responses were variable and several staff thought it was about health and safety issues.

Evidence-based care and treatment

- There was a programme to review clinical guidelines with reference to the National Institute for Health and Care Excellence (NICE), the Royal College of Obstetricians and Gynaecologists (RCOG) and other relevant bodies.
- There were regular morbidity meetings in gynaecology and joint monthly perinatal morbidity and mortality meetings. Presentations were prepared for these meetings, but actions were not recorded in the minutes, so it was not clear how these had impacted on practice.

- Regular audits of procedures and practice took place. The findings of which were disseminated with actions identified. There were monthly audit meetings in maternity services. Information from audits was emailed to managers and medical staff. It was then the responsibility of managers to disseminate information to their teams.
- The trust contributed data to the National Neonatal Audit Programme (NNAP) and to the Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK). The trust employed a bereavement/ MBRRACE midwife.

Pain relief

- Care records we viewed contained information about pain relief. Women's options included epidural analgesia, opiates, nitrous oxide (gas and air), and paracetamol.
- Water birth facilities were available on the birth unit to help women relax**.**
- Some staffing issues potentially impacted on women receiving timely pain relief. Staff told us that an anaesthetist was not always available to promptly respond to a woman in labour due to other demands, especially overnight. Some women had to wait longer than 45 minutes when an epidural anaesthetic was called for. Safer childbirth recommendations from the Royal College of Obstetricians and Gynaecologists (RCOG) 2007 states that they should be able to receive it within a reasonable time, not normally exceeding 30 minutes and must be within one hour, except in exceptional circumstances.
- There was only one operating department practitioner (ODP) for the delivery suite, so midwives had to call on ODPs from the main theatres for epidurals, which delayed pain relief for some women.

Nutrition and hydration

- In the May 2016 patient led assessment care environment (PLACE) survey, 89% of women had said that food was adequate and snacks were available outside meal times. This was an increase of six points from the 2015 survey of 83%.
- The maternity service was working towards level 3 of the UNICEF UK Baby Friendly Initiative to promote good care for newborn babies. The trust had appointed an infant feeding coordinator to introduce sessions for new mothers and improve monitoring of breastfeeding. Between April and September 2016, 90% of women were partially breastfeeding when they left the hospital.

Patient outcomes

- The maternity dashboard collected key indicators of maternity and neonatal outcomes. Between April and September 2016 there had been 3319 births with 74% of deliveries in obstetric units.
- Between April and September 2016, there were 107 unplanned admissions to the neonatal unit and two unplanned admissions to the intensive care unit with no maternal deaths. The maternity unit had increasing numbers of women referring for ante natal care. In the six months between April and September 2016, 4125 women had registered for ante natal care.
- The total of emergency caesarean section was 19% which was higher than the national average of below 15%. The total percentage of patients that required a caesarean section was 26.8% which was higher than the national average of 25%. The hospital had a high percentage of women with complex needs and was aware it had a higher than average number of caesarean section, with an action plan in place to review its processes.
- The percentage of elective caesarean section rate was 8% which was lower than the national rate of 25%. Instrumental deliveries were 11.7% which was slightly above their target of 10%.
- The trust contributed data to the National Neonatal Audit Programme (NNAP) and to the Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK).
- Over the twelve month period April 2015 to March 2016 there had been 31 stillbirths. In the six months from April to October 2016 the stillbirth rate had almost doubled to 24 stillbirths. We did not see any meeting discussions or action plan that acknowledged the trust were aware of, and were looking at, the reasons for the increase in stillbirths.
- Safety thermometer information on post-partum haemorrhage rates was available for the six month period April to September 2016. This showed the overall percentage of post-partum haemorrhage was 2.6%. However it was unclear how many patients this referred

to as patient numbers were not included. Therefore we were unable to ascertain whether the information provided was an accurate reflection of the number of patients overall who had post-partum haemorrhage.

Competent staff

- As of November 2016, 84.78% of medical staff had an appraisal completed. This was just below the trust target of 85%.
- As of June 2016 the nurses and midwives appraisal rate was 63%, below the trust target of 90%.
- There were 12 supervisors of midwives and a preceptorship programme for band 5 and 6 midwives. Supervisors of midwives helped to develop all midwives' skills and expertise. Staff were responsible for their own training updates using a training passport where competencies were recorded.
- A midwifery education team worked across the trust's sites. The practice development midwife had recently been supported with administrative support to help with maintaining an accurate database of staff training. The education team had a rolling system for looking at skills gaps and putting in place development opportunities for midwifery staff.
- A clinical educator had been employed to support recently recruited midwives from overseas to the hospital.
- Some staff said it was difficult to fit in training beyond mandatory training, and that training was sometimes cancelled at short notice. Staffing shortages led to midwives being taken off training as they were needed on the wards. E-rostering meant staff could not easily fit in training unless booked well in advance and several staff said they had to cancel training because they were needed on the unit due to staff shortages.

Multidisciplinary working

- Staff reported good and improving multi professional working. They had good working relationships with medical staff. All staff said they worked closely with medical staff at all levels and had built good relationships with teams.
- There was an effective multidisciplinary team working environment within the maternity service. We found evidence of good multidisciplinary relationships supporting patients' health and wellbeing. We observed multidisciplinary input in caring for and interacting with patients on the wards.
- Nurses had access to support and advice from other services, for example dieticians.
- Patient records confirmed staff communicated with GP's and the community maternity team during ante-natal care and discharge.

Seven-day services

- Ante-natal and scanning clinics were offered from Monday to Friday, 9am to 5pm, with occasional additional clinics at weekends after bank holidays.
- The hospital had introduced a resident on-call consultant in September 2016 which had meant that in November 2016, there had been 98 hours of night on-call consultant presence. This meant there was 24 hour consultant on-call presence every Thursday and every fourth Monday. They were available from 1pm to 4pm and 9pm to 8am on a Monday and a Thursday.
- At the weekend a consultant was available from 8am to 4.30pm, covering obstetrics, gynaecology and wards. After this time there was on-call cover from 4-30pm to 8am; however the consultant may be on or off site, depending on clinical need. The reduced lower grade medical cover at nights and at the weekend was a potential risk to patients.
- There was a rota of 16 consultants participating in the on call rota. On weekday there is labour ward cover between 8am and 5pm on site. The night on-call consultant was available until 9pm. There is no dedicated labour ward consultant cover as the consultant covers gynaecology as well from 1pm onwards.
- The NUH pharmacy provided a dispensary, distribution and ward based service seven days of the week, with a reduced level of services at the weekends and in the evenings. Normal working hours were 9am to 5pm on weekdays. There was an on call pharmacist from 5pm to 8pm.
- At the weekends, the NUH pharmacy dispensary was open on Saturday and Sunday from 10am to 2pm. High turnover wards were covered by a pharmacist on a Saturday who would prioritise work along with the nurses and discharge team, helping to resolve pharmaceutical issues and facilitating discharges. Other wards will send any work down to pharmacy. A small team on Sunday's prioritised work sent down to the dispensary from wards and visited wards where necessary. After 2pm, there was an on-call pharmacist until 4pm.

- After 4pm, pharmacy cover was provided by one of the trust's nearby acute hospitals, as they remained open 24 hours a day, seven days a week and calls were directed through to them.

Access to information

- There were various information posters on the walls in the ante natal clinic and lots of leaflets on a range of subjects. For example, eating well in pregnancy and information and contact information for various agencies and support networks.
- Notice boards in ward corridors contained information for patients and relatives, including number of births, health and safety information, protected meal times and senior nurse contact details.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The department liaised with local adult social care services when assessing the needs of women with learning disabilities. This included discussion on patient choices and patients capacity to consent. Mental Capacity Act and deprivation of liberty safeguards training was not part of the on-going mandatory training.
- Most staff we spoke with were not clear about their roles and responsibilities under legislation around capacity and deprivation of liberty. Staff responses were variable and several staff thought it was about health and safety issues.

Are maternity and gynaecology services caring?

Requires improvement 

We rated caring as requiring improvement because:

- We had a mixed response from women about the care and treatment they received. Some were positive and others said staff caring for them did not always work well together. Communication with staff was variable, for example being told one thing by one nurse and then something different by another.
- Women commented that at times there was a lack of respect, care and compassion and that midwives were often abrupt. Women said that midwives seemed overworked and understaffed and were very busy.
- Bart's health NHS trust was below expected on 74% of the questions asked about labour and birth in the national maternity survey.

However:

- Patients were positive about the care they received at antenatal appointments and said doctors and midwives answered any questions they had.
- Women told us their privacy was respected on the pre and post natal ward. We observed most patients had the curtains pulled round their beds. Staff told us it was the women's choice to pull curtains round for privacy if they wanted.
- Women described good support around the choice of place of birth, including home birth and partners were welcome to stay.

Compassionate care

- Women commented that at times there was a lack of respect, care and compassion and that midwives were often abrupt. Women said that midwives seemed overworked and understaffed and were very busy.
- Patients told us staff caring for them did not always work well together. Communication with staff was variable, for example being told one thing by one nurse and then something different by another.
- Women told us their privacy was respected on the pre and post natal ward. We observed most patients had the curtains pulled round their beds on the ward. Staff told us it was the women's choice to pull curtains round for privacy if they wanted.
- The trust performed worse than other trusts for 12 out of 16 questions in the CQC Maternity survey 2015 and below expected on 74% of the questions asked about labour and birth in this survey. The trust scored worse than expected for respect and dignity during labour and birth and worse than expected for kindness and understanding in the hospital after the birth of your baby.
- Between September 2015 and August 2016 the trust's maternity friends and family test, antenatal

performance was generally worse than the England average. In August 2016, the most recent record, the trust's performance was 78.6% compared to a national average of 95.2%.
- Between September 2015 and August 2016 the trust's maternity friends and family test performance for 'birth' was 95.5% which was similar to the England average of 96%. The trust's postnatal ward performance was 86.2% which was worse than the national average of 93.3%.
- Patients told us that staff caring for them did not always work well together because of communication with staff was variable, for example being told one thing by one nurse and then something different by another.
- The layout of the department meant that women and their new-born babies could be cared for in an environment that promoted their privacy during their stay.
- Specialist midwives were available for women in vulnerable circumstances and for women with HIV and other infectious diseases. A helpline was available that offered help, reassurance and advice for women and we were given examples of the service being able to reassure women and signpost them to other services.

Understanding and involvement of patients and those close to them

- The trust were encouraging women to be booked in by 10 weeks and aimed to provide women with a named midwife by 16 weeks. Staff in the ante-natal clinic explained they were endeavouring to ensure women were looked after by a team of three midwives, in order to provide continuity of care. The community midwifery team were meeting this target in 90% of cases.
- Patients were positive about the care they received at antenatal appointments and said doctors and midwives answered any questions they had.
- We saw that where there had been a miscarriage, stillbirth or termination because of foetal anomaly, women were given a full explanation about the choices available to them: doing nothing, surgical management or evacuation under anaesthetic. Where possible, mothers were also given choices about the management of ectopic pregnancy.
- Parents were also asked how they would like to manage the disposal of the baby or the foetal remains. A specialist bereavement nurse was available to support mothers and their families if needed.

Emotional support

- Women described good support around the choice of place of birth, including home birth and partners were welcome to stay. Partners staying on maternity wards overnight, were requested to sign in to the ward so that a record could be kept. However, minutes recorded that not all partners were signing in. Staff had been requested to be more vigilant and ensure records were up to date.
- After birth, partners and the patient's own children were welcome to between 8am and 8pm. Other guests wishing to visit were asked to come between 2.30pm and 8pm to enable families to rest and have some private time with their newborn. This also allowed for midwifery care and assessments during the morning.
- Counselling was offered to women whose screening results meant they needed to make a further decision about diagnostic testing. The hospital had an effective system for checking that all relevant women had been offered, and had accepted or declined, screening.
- A multi-faith chaplaincy offered a bereavement service and emotional support to families that needed it.
- Women who had suffered foetal loss or stillbirth were offered debriefing and counselling. The service was culturally sensitive to the needs of different women and their families. In the event of a baby's death, the family was given a named link with the hospital, who was either the bereavement midwife or a supervisor of midwives.

Are maternity and gynaecology services responsive?

Requires improvement

We rated responsive as requires improvement because:

- Women who came for induction of labour were sometimes asked to return home or had to wait until a bed was available on the ante-natal ward. elective caesarean sections were frequently delayed because there were no beds available or the theatre was being used for an emergency.
- Staff reported regular difficulties meeting demand in the maternity unit. This caused delays, including in planned induction of labour and in elective caesarean sections.

However:

- The team worked together to provide a responsive and effective service and offer women a clinically appropriate choice of care.
- Services were generally planned to meet people's individual needs.
- The Early Pregnancy Unit/Emergency Gynaecology Unit offered a one-stop service with a full range of medical and surgical treatment options to manage miscarriage and ectopic pregnancy.
- Managers regularly reviewed complaints to identify themes and identify actions and these were then shared with staff.

Service planning and delivery to meet the needs of local people

- The Early Pregnancy Unit/Emergency Gynaecology Unit offered a one-stop service with a full range of medical and surgical treatment options to manage miscarriage and ectopic pregnancy. The team of nurse specialists, consultants and sonographers worked effectively together to provide a responsive and effective service and offer women a clinically appropriate choice of care.
- The maternity unit was colour coded to help women find their way around. This was to assist, in particular, women whose first language was not English to find their way around.
- Women were asked about their preferred place and type of birth when booking. This was reviewed with the consultant or midwife throughout the pregnancy.
- Weekly hospital tours were available for women to view the facilities on offer in the birthing unit and to ask any questions.
- A helpline was available that offered easy access to advice for women that were pregnant. We were given examples of the service being able to reassure women or signpost them to other services so that they did not come to hospital unnecessarily. When staff judged that a woman needed to come to the hospital, midwives on the helpline liaised with the maternity assessment unit to try to prevent delays in treatment.
- Women were advised to come to the maternity assessment unit with problems rather than calling their community midwife first. This was to ensure that they met the needs of many in the local population who did not speak English, as the assessment unit had easy access to interpreters in an office just down the corridor from the unit.
- Specialist midwives were available for women in vulnerable circumstances and for women with HIV and other infectious diseases.
- Counselling was offered to women whose initial screening results meant they needed to make a further decision about diagnostic testing. For example, when screening indicated that the baby may have Down's syndrome. The hospital had an effective system for checking that all relevant women had been offered and either accepted or declined.
- Parents were able to stay in the maternity unit, in an area with an adjoining room where they could view their baby, which was away from the main ward. Bereaved families could stay there, and there was a shower (not en suite) and a room where they could view their baby. A memory box was available if the parents wanted one.
- Services for termination of pregnancy were available at the hospital and in the community. All women were offered counselling and referred to community gynaecology services for contraception.

Access and flow

- Women referred themselves by telephone or online, or could be referred by their GP. Women referred from outside the area were seen at the antenatal clinics in the maternity unit.
- Women living within the hospital's catchment area and deemed to be at low risk were seen by a community midwife for their first booking at the hospital and then allocated to a named midwife in the community midwifery team at a GP's surgery or children's centre near their home.
- There were dedicated consultant lists for elective caesareans, with five lists a week, giving a capacity for 15 cases per week. There was week day ward round cover for antenatal, postnatal, gynaecological wards and CEPOD theatre from 9am to 1pm. Staff consistently told us that elective caesarean sections were routinely delayed and patients were sent home.
- Staff reported regular difficulties meeting demand in the maternity unit. This caused delays, including in planned induction of labour and in elective caesarean sections.

- Doctors sometimes delayed category 3 caesarean sections (women needing earlier-than-planned delivery, usually done within 24 hours) because of concern about keeping one theatre free for an emergency.
- The maternity assessment unit (MAU) was open from 8am to 8pm on weekdays for assessing women referred by GPs and triaged for monitoring. Women who came for induction of labour were sometimes asked to return home or had to wait until a bed was available on the antenatal ward. We were told that elective caesarean sections were frequently delayed because there were no beds available or the theatre was being used for an emergency.

Meeting people's individual needs

- Women were given an information pack when they were booked for maternity services. They were also given a comprehensive discharge pack, which included advice on breastfeeding and how to identify a sick baby.
- The hospital did not produce leaflets in languages other than English, because of the high number of languages spoken in Newham. However, the back of the leaflets gave a number to contact the Barts Bilingual Health Advocacy and Interpreting Service for help in interpreting the leaflets in other languages.
- Interpreters from the interpreter advocacy service were on site or could be accessed via the 'language line' telephone service.
- Women were given a questionnaire at 22 weeks to help staff check they had understood information they had been given at 16 weeks.
- Clear information was on display in waiting areas, including information on breastfeeding, induction of labour, vitamin K, perineal tears, jaundice and antenatal classes.

Learning from complaints and concerns

- There was a weekly complaints and serious incidents meeting chaired by the medical director or director of nursing. Complaints for all directorates were discussed and complaints relating to the maternity services were reviewed and signed off by the medical director or director of nursing.
- Patients and their families were encouraged to provide feedback on their experiences. Complaints and concerns were addressed, whenever possible, at the time they were raised. Managers told us they tried to sort out complaints locally and as quickly as possible.
- Between January and December 2016 there were 57 complaints about maternity services. The main themes related to staff attitude, communication and delays in care.
- Complaints were generally dealt with within 25 days. Complex complaints were managed by arranging meetings with staff and patients. When complaints were linked to a serious incident investigation in maternity services, women or their partners were given a named contact and there was a process to make sure the family was kept fully informed of the results of the investigation.
- Managers regularly reviewed complaints to identify themes and identify actions and these were then shared with staff. This was confirmed by staff we spoke with.

Are maternity and gynaecology services well-led?

Requires improvement

We rated well-led as requiring improvement because:

- The risk register did not reflect all the current risks. For example, it did not include the low levels of consultant cover in maternity services or the possible risks to patients.
- Data figures in the maternity dashboard were inconsistent. Target criteria was missing on some KPI's and the red/amber/green (RAG) rating was inconsistent with performance for those we looked at.
- There were concerns about the categorising and length of time the trust took to complete incident reports and serious case reviews. Targets were not being met and there were concerns about the processes for managing incidents. There was a lack of evident assurance that learning was properly followed up and embedded.

However:

- There was a clearer governance structure and clearer lines of management accountability.

- The quality improvement board helped to drive improvements throughout the maternity service. There were goals, action plans and regular reviews of the service improvement plans.
- Although some difficulties remained in gaining the support of midwifery staff affected by changes the trust had imposed, morale among many midwives had improved since the last inspection.
- The medical and midwifery staff at the hospital were committed to providing a safe and effective service for women. Staff felt managers were aware of the staffing difficulties but not aware of the challenges and impact on the care they were able to give to women because of staff shortages and lack of experienced staff.

Leadership and culture within the service

- The trust had implemented a new leadership operating model (LOM) in September 2015. Overall leadership in maternity and gynaecology services was provided by the women's and children's clinical academic group (CAG).
- The hospital's directorate of women's and children's health was led by the clinical director, general manager, head of midwifery and senior nurse for paediatrics and neonatology. They reported to the hospital's site executive team, which was made up of the medical director, director of operations and director of nursing.
- Lead midwives had access to a leadership training programme that encouraged them to adopt a more active management role. Lead midwives told us this had increased their confidence in leadership. The midwives held a weekly meeting to discuss concerns and ways of managing demand which had increased their confidence and understanding of leadership roles and responsibilities.
- We observed visible leadership with good working relationships between consultants and midwives. Consultants were proactive in supporting the midwives with a clear and visible leadership presence within the maternity unit and were always prepared to assist colleagues. However, this was not so visible among the midwives at other levels and staff commented on the difficulties they had in getting other parts of the service to support them when stretched and understaffed.
- At the last inspection we found that the trust's decision to reduce the banding level of some nurses and midwives had resulted in disharmony. The reduction in the number of midwifery managers had increased managers' workloads and had ultimately proved unsustainable. At this inspection we saw a new management structure was in place with clearly defined roles.
- Staff told us that generally the maternity unit was a welcoming and friendly place to work, however not all staff agreed. Several staff felt they could not complain about workloads and skill mix of staff and if they did they would get into trouble. One member of staff gave us an example where they had raised a concern about what they considered to be an unsafe skill mix which had been ignored. Other staff said not all managers were proactive in supporting them when they were short staffed. However the overall perspective was that changes were being made and staff could see improvements.

Vision and strategy for this service

- The trust's maternity review had proposed plans to transform maternity and newborn care services for women. This included ensuring women had 'continuity of care, with a named midwife and developing a culture that empowers midwives'.
- Plans included widening choice across clinical commissioning group (CCG) boundaries and working with other providers to offer maternity services across combined localities, thus offering women more choice of providers to meet their needs and preferences and enabling women to make decisions and choices.

Governance, risk management and quality measurement

- The quality improvement board met every two months and had participation from relevant stakeholders and commissioners. We saw plans in place that were being monitored to drive improvements throughout the maternity service. There were goals, action plans and regular reviews of the service improvement plans. An example of practice being reviewed in this forum related to the use of cardiotocography (CTG). In response, a training schedule had been implemented and ongoing training took place with all staff, with the aim of decreasing the number of incidents that may have arisen due to poor interpretation of CTG monitoring.
- The trust had introduced the leadership operating model at the NUH site and responsibility for risk registers had been devolved to local management. Over the last twelve months the trust had realigned the risk

registers as although some risks had applied to all sites, some were site specific but combined for a trust wide view with cross site owners. The service was aware they had gaps on the risk register and were reviewing high risk on an ongoing basis and as part of business planning.

- Monthly local governance meetings were held within the maternity and gynaecology service, where risks were discussed and ratings agreed. This was then approved by the hospital's site executive team, which was made up of the medical director, director of operations and director of nursing at hospital wide governance meetings.
- The trust did not have effective systems in place to monitor outcomes of audits and incident reports. Serious incident reviews and incident reports had highlighted incomplete patient records as an ongoing problem. A patient record audit was completed in February 2016 and assessed antenatal, intrapartum and postnatal case note documentation. The audit identified incomplete documentation as a theme. However, it was unclear what measures had been put in place to monitor or improve the quality of documentation.
- There were concerns about the categorising and length of time the trust took to complete incident reports and serious case reviews. For example, we reviewed 10 serious incident reports dating from five months ago that had not yet been reported on. The trust's adverse incident policy followed NHS England guidance in stating there was a maximum 60 working day deadline for reporting on and submitting to commissioners. They were not meeting this target and there were concerns about the processes for managing incidents and the lack of evident assurance that learning was properly followed up and embedded.
- Staff raised concerns about obsolete scan machines that affected accurate maternal screening and foetal anomaly. Staff felt women were at risk of harm because they did not always pick up deteriorating situations when women were in labour. This was on the risk register. However, it was recorded that there was no 'credible plan' to deal with the issue and no evidence of any measures in place to minimise the risks it posed to women and their unborn babies.
- The maternity dashboard provided an overall description of a number of key indicators in relation to maternity services, including activity, clinical outcomes and key performance indicators. The aim of the dashboard was to enable quality and safety assurance monitoring. However, we found data figures varied. Target criteria was missing on some KPI's and the RAG rating was inconsistent with performance for those we looked at. This had been noted in governance meeting minutes.
- Weekly emergency caesarean section audits reviewed the outcome of every caesarean section at the hospital. The trust told us they had identified learning points and shared them with staff. However, sharing or learning of themes or issues could not be identified.
- There was inconsistency in documents presented at meetings relating to monitoring the quality of the service which meant we could not be assured that performance information collected was accurate or up to date. Birth to midwife ratios were not consistent in all documents we viewed. The clinical quality review meeting (CQRM) stated that maternity services were not meeting the 1:28 ratio and suggested they were performing at 1:30 and in one case 1:33.
- The local commissioning group provided funding for the hospital's maternity liaison services committee (MSLC), which met quarterly. We saw evidence of the MSLC's contribution to the service, such as providing feedback from women, with actions identified by the maternity service.

Public and Staff engagement

- During the previous inspection we saw that mechanisms for communicating with maternity staff were top down rather than two way. During this inspection we found similar themes with staff feeling under pressure due to the volume of work and communication, still feeling it was top down although several staff felt there had been some improvement.
- The maternity unit produced a monthly newsletter. Receiving regular feedback from women and their partners about maternity services was part of the 'Great Expectations' programme. We saw a copy of feedback from women that was fed back to the maternity quality assurance and safety committee (MQASC) however there was no discussion recorded in those minutes or the following meeting minutes about the negative patient feedback or concerns raised about their experience.

Maternity and gynaecology

- Trust wide we saw there was an action plan in place to respond to negative feedback and to monitor progress in improving the patient experience.

Services for children and young people

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

Information about the service

Rainbow Ward, the hospital's general paediatric ward, has been moved into the hospital's West Ham Ward which is an adult clinical area. West Ham Ward is temporarily being used as a children's ward, whilst a new children's unit, the Rainbow Unit, is under construction. All building work on the new children's unit is scheduled to be completed and handed over to the hospital on 19 December 2016. CYP will be admitted to the new children's Rainbow Unit commencing in February 2017.

Newham University Hospital (NUH) had 2,776 spells, these are periods of admission, between April 2015 and March 2016. Emergency spells accounted for 2,179 (78%); day case spells accounted for 459 (17%); and the remaining 138 (5%) were elective.

The children and young people's (CYP) service have invested in a new Rainbow Unit building project. This will provide modern inpatient and outpatient facilities for children and young people. The new unit is due to open in February 2017.

CYP services at Newham Hospital are consultant led. CYP are admitted for a range of medical and surgical conditions, including oncology, general surgery, plastic surgery, ear, nose and throat (ENT), and orthopaedics.

Rainbow Ward accommodation, on the West Ham Ward, consists of four bays of five beds and four cubicles, two of which are en suite. Rainbow Ward also has an 'ambulatory care' outpatients area. This provides observation, investigations and treatment for children who do not require inpatient admission.

The Neonatal Unit (NNU) is designated as a Level 2 NNU within the North Central and East London Neonatal Network. The NNU had three levels of care that a baby may require: Intensive care for critically ill babies; high dependency care for babies who require continuous observation and support; and special care for babies requiring some support and observation or help with feeding. The level of care provided within this unit allows for all categories of neonatal admissions, with the exception of babies who require complex or long term intensive care.

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an unannounced visit on 1 November 2016. We also carried out an unannounced visit on the 11 November 2016.

During the visit we spoke with over 20 staff on the wards including consultants, doctors, nursing staff and support staff.

We also talked with three CYP who use services and six visiting parents. We observed how CYP were being cared for and talked with carers and/or family members. We met with CYP who use services and their carers, who shared their views and experiences of their care and treatment. We reviewed 10 care or treatment records.

Services for children and young people

Summary of findings

Overall we rated the service requires improvement because:

- The service had systems in place to ensure that incidents were reported. However, incidents were not always investigated in a timely way and in accordance with published guidance.
- Infection prevention and control on Rainbow Ward did not always comply with the trust's policies for infection prevention and control.
- Expressed breast milk was stored in the same fridge as other products on Rainbow Ward, this was not in accordance with the trust's policy on breast milk storage.
- Maintenance issues were not always addressed in a timely way. There were leaks in the ceilings of Rainbow Ward and the Neonatal Unit (NNU) which had not received thorough investigation and repairs.
- Some senior staff on the NNU we spoke with were unaware of UNICEF Baby Friendly accreditation, this is a global accreditation programme to support breast feeding.
- Rainbow Ward was unable to deliver adequate pain management for patient-controlled analgesia (PCA), nurse controlled analgesia (NCA).
- 65% of babies received retinophathy of prematurity (ROP) screening, this tests diseases of the eye in premature babies. However, this was below the trust target of 100%.
- Parents did not receive food on the ward, unless they were diabetic or breast feeding. There were limited facilities for parents to prepare or purchase food.
- There was a limited amount of printed information leaflets for children and their parents or carers on Rainbow Ward.
- Rainbow Ward was temporarily accommodated on West Ham Ward during the construction of a new paediatric department, the Rainbow Unit. Rainbow Ward was not a purpose built paediatric ward, conditions for staff in the ward were cramped. There were a number of comments from staff and patient and relative surveys in 2016, that were negative about the environment on Rainbow Ward.
- The décor of Rainbow Ward did not cater for children and young people and was not child friendly. Bay 1 was of particular concern due to its multi-purpose usage and lack of natural light.
- The recovery facilities in theatre were not child friendly due to an absence of a child friendly recovery bay with appropriate décor.
- Emergency readmissions for non-elective patients under the age of one year and children between the age of one and 17 years, were worse than the England average.
- There was a trustwide strategy for children and young people's services at Newham Hospital, but this was not embedded. There was no long term local strategy for children and young people's services.
- There were new governance arrangements for children's services, but these were not fully embedded. The agendas for governance meetings did not always reflect the governance meeting terms of reference (TOR).
- Identified risks were not always included on the trust's risk register in a timely way. Actions the service had taken to mitigate risks were not always recorded on the risk register.

However we also found:

- The Rainbow Unit rebuilding project would provide modern inpatient and outpatient facilities for children and young people, the new department was due to open in February 2017.
- The hospital reported data on patient harm each month to the NHS Health and Social Care Information Centre (HSCIC) Safety Thermometer. From August 2015 to August 2016, Rainbow Ward and neonatal unit (NNU) had reported 100% harm-free care during this period.

Services for children and young people

- Staffing levels and skill mix were planned, implemented and reviewed to keep children and young people safe. Any staff shortages were responded to quickly and adequately.
- Risks to children and young people were assessed, monitored and managed on a day-to-day basis; and risk assessments were child-centred, proportionate and reviewed regularly.
- Risks to safety from anticipated changes in demand and disruption were assessed, planned for and managed effectively. Plans were in place to respond to emergencies and major situations.
- Staff we spoke with understood their safeguarding responsibilities and knew what to do if they had concerns.
- There were sufficient numbers of nursing staff to ensure that shifts were filled. However, this was sometimes based on the use of bank staff.
- Procedures and policies were up to date and reflected recent evidence for best practice and NICE guidelines.
- The children's service had a practice development nurse who monitored staff training and competence.
- There was evidence of multidisciplinary team (MDT) working in all children's and young people's departments. Information sharing between wards and departments, and medical and nursing staff was effective.
- Parents were involved in giving consent to examinations, as were children when they were at an age to have a sufficient level of understanding.
- Children and young people and their primary carer were supported, treated with dignity and respect, and were involved as partners in their care. Feedback from children, young people and parents was positive about the way staff treated patients.
- Admission pathway protocols were in place.
- There had been no formal closures to admissions to Rainbow Ward in the previous 12 months.

- Complaints were managed in accordance with the trust's policy and lessons were learnt. Staff and managers told us that they preferred to resolve concerns "on the spot."
- Staff were aware of the trust's vision and values.
- Department level leadership was effective. Consultants' roles and responsibilities were defined by the trust's job planning process.
- Staff supported each other well. Staff told us the culture of the service was very focused on meeting the needs of children and young people who used the service.
- Staff were provided with information on developments at the trust such as the new children and young people's Rainbow Unit.

Services for children and young people

Are services for children and young people safe?

Requires improvement

We rated the service require improvement for safe because:

- Infection prevention and control on Rainbow Ward did not always comply with the trust's policies for infection prevention and control.
- Maintenance issues were not always addressed in a timely way. There were leaks in the ceilings of Rainbow Ward and the Neonatal Unit (NNU) which had not received thorough investigation and repairs.
- The service had systems in place to ensure that incidents were reported. However, incidents were not always investigated in a timely way and in accordance with published guidance.

However, we also found:

- All building work on the new children's Rainbow Unit was scheduled to be completed and handed over to the CYP service on 19 December 2016. CYP will be admitted to the new children's Rainbow Unit commencing in February 2017.
- The hospital reported data on patient harm each month to the NHS Health and Social Care Information Centre (HSCIC) Safety Thermometer. From August 2015 to August 2016, Rainbow Ward and the NNU had reported 100% harm-free during this period.
- Staffing levels and skill mix were planned, implemented and reviewed to keep children and young people safe. Any staff shortages were responded to quickly and adequately.
- Risks to children and young people were assessed, monitored and managed on a day-to-day basis; and risk assessments were child-centred, proportionate and reviewed regularly.
- Risks to safety from anticipated changes in demand and disruption were assessed, planned for and managed effectively. Plans were in place to respond to emergencies and major situations. Senior staff were aware of the plans and were able to explain their roles in the event of an interruption to normal service.
- Staff we spoke with understood their safeguarding responsibilities and knew what to do if they had concerns.
- There were sufficient numbers of nursing staff to ensure that shifts were filled. However, this was sometimes based on the use of bank staff.

Incidents

- The service had systems in place to ensure that incidents were reported. There had been 215 incidents recorded on the trust's electronic incident reporting system electronically between December 2016 and October 2016. However, incidents were not always investigated in a timely way and some incidents were held in a 'holding area' awaiting review. For example, staff on Rainbow Ward had reported an incident on the 8 May 2016 where the temperature on the ward was over 30 degrees. A student nurse was reported to have become faint. The incident was reviewed, but due to the time between the incident being reviewed and the incident occurring, no actions were taken and the incident was closed. A further incident took place on 23 August 2016 where staff reported that the NNU felt hot and this had adversely affected staff. There was no record of actions the service had taken in response to the incident. The incident was recorded on a spreadsheet dated 31 October 2016 as 'in the holding area'.
- Staff and managers told us there had been improvements in staff reporting incidents and they were satisfied there was a culture of reporting incidents promptly within children's and young people's services. Staff told us they understood their responsibilities to report incidents using the electronic reporting system, and knew how to raise concerns
- Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. Between October 2015 and September 2016 Newham University Hospital reported no incidents which were classified as Never Events for children's services.
- The NHS Serious Incident Framework outlines the process and procedures to ensure that serious incidents

are identified correctly, investigated thoroughly and, most importantly, learned from to prevent the likelihood of similar incidents happening again. The CYP service were not investigating incidents in accordance with the Serious Incident Framework (SIF) 2015. Newham University Hospital reported no Serious Incidents (SI) in children's services which met the reporting criteria set by NHS England between October 2015 and September 2016. However, there had been an incident in July 2016 where a young person had absconded from Rainbow Ward, via a rear exit on Bay 1. The service informed us this was not investigated as an SI as actions had been taken to report the incident to the local authority safeguarding team and the missing person's unit. The incident had also been reviewed in partnership with the local authority. The service informed us that they had also stopped placing young people in Bay 1 on Rainbow Ward, and had moved the door release higher up the wall. However, when we pressed the door release we gained access to a corridor that was not equipped with CCTV. The bay was also accessible from Rainbow Ward, and a young person could gain access to the corridor via Bay 1. This meant the risk had not been fully addressed at the time of the incident or during the review. The SIF 2015 identifies a "security breach/ concern" as meeting the criteria for a serious incident. Staff also told us they had reported the risk to the estates department, but the estates department had not taken timely action to address it. However, during our follow-up unannounced visit on the 11 November 2016 we saw the estates department fitting a new swipe card door release on the Bay 1 rear exit.

- Incidents were standard agenda items at monthly governance meetings. The meetings were attended by medical and nursing staff. However, from meeting minutes it was unclear if reported incidents had been fully investigated and whether steps had been taken to ensure lessons were learnt. Staff told us learning from incidents was cascaded to ward staff at team meetings, as well as handovers.
- Ward managers received safety alerts and were responsible for taking action to respond to relevant alerts. This included discussion of alerts at the CYP clinical governance meeting. Staff told us completed actions would be reported to the Department of Health's (DOH) central alerting system, (CAS).
- There was a contractual duty imposed on all NHS providers of services to 'provide to the service user and any other relevant person all necessary support and all relevant information' in the event that a 'reportable patient safety incident' occurred. Staff and managers we spoke with were aware of and able to explain the 'duty of candour'. Staff told us the 'duty of candour' (DoC) was included in the trust's safeguarding training, and said the DoC had a high profile at the trust. For example, the trust's electronic incident reporting system prompted staff when entering information to consider DoC requirements. This meant staff were encouraged to consider the DoC in the event of incidents involving CYP.
- Children's services medical staff held monthly morbidity and mortality meetings to review any patient deaths and identify areas for improvement. The trust minuted the meetings to track actions more easily.

Safety Thermometer

- As required, the hospital reported data on patient harm each month to the NHS Health and Social Care Information Centre (HSCIC). This was nationally collected data providing a snapshot of patient harms on one specific day each month. This included data from the paediatric ward as well as the NNU.
- The safety thermometer covered hospital-acquired (new) pressure ulcers, including the two more serious categories of grade three and four; patient falls with harm; urinary tract infections; and venous thromboembolisms (deep-vein thrombosis). From August 2015 to August 2016, Rainbow Ward and the NNU had reported 100% harm-free care during this period.

Cleanliness, infection control and hygiene

- We viewed the results of the Rainbow Ward hand hygiene audits from October 2016. Overall, the service achieved 97% compliance for staff hand hygiene. We observed most clinical staff complying with the trust's policies for infection prevention and control. This included wearing the correct PPE, such as gloves and aprons. Staff washed their hands between each patient, and we noted good use of the hand sanitising gel. However, we observed a porter delivering boxes of equipment to Bay 1 on Rainbow Ward and not observing hand hygiene practices or using personal protective equipment (PPE) before entering the bay. The bay was used as an isolation bay for children with

bronchiolitis. This meant all the Rainbow Ward areas did not always provide a safe environment for children and families where infection prevention and control procedures were adhered to at all times.

- On our first visit on the 1 November 2016, Rainbow Ward Bay 1 had isolation room posters attached to the door with blu-tack. When we returned on the 11 November 2016 the posters were not visible. We drew this to the attention of staff and the posters were replaced. We asked staff if Bay 1 was an isolation bay. Staff told us it was used for isolation, but only for children with bronchiolitis. Staff told us it would not be used for children with infectious diseases or children with vomiting and diarrhoea to ensure other children on the bay were not exposed to these risks.
- Staff were using Bay 1 overspill area to hang their coats on both of our visits. We spoke with senior managers about this during our unannounced visit. The managers showed us a decommissioned toilet and told us there were plans to convert the toilet into a locker room for staff on the bay.
- In the milk preparation room on Rainbow Ward the fridge was clearly labelled for use as storage for 'expressed breast milk only'. Expressed breast milk should not be stored in the same fridge as any other products. However, we found two expressed breast milks in the fridge being stored together with a carton of soya milk. The lead nurse checked the soya milk to try and determine who the milk belonged to, but it was not labelled. The lead nurse said, "I have told them continually about the storage of breast milk."
- We found breast milk storage on the NNU was appropriate on the 1 November 2016. However, when we returned to the NNU on 11 November 2016. We found the alarm on the breast milk fridge sounding and the temperature above the recommended level due to the fridge not having been closed and the fridge door being left ajar. We also found the freezer in the NNU was in need of defrosting.
- We saw housekeeping staff cleaning on the wards and in the departments throughout our visit.
- Clean equipment had an 'I am clean' sticker applied when it was cleaned. Staff told us they only used equipment from the storage area that had an'I am clean' sticker applied.
- We saw the receptionist on the NNU stopping visitors visiting the unit until they had washed their hands, and asking them to remove clothing so they would comply with hygiene standards.
- The ward areas had a supply of appropriate toys that could be cleaned safely. Play specialist staff told us the toys in the children's ward were cleaned by them as part of their role. Play specialists told us toys were cleaned prior to being taken to children in isolation and cleaned again when they came out of the child's isolation room.
- An established audit programme was in place for reviewing infection control and cleanliness in clinical areas. In the previous 12 months children and young people's services were fully compliant with National Institute for Health and Care Excellence (NICE) standards for infection control, achieving the trust's minimum target. We reviewed the Rainbow Ward quarterly infection prevention and control audit dated 21 July 2016, and found most NICE standards were met. Standards that had not been met had been acted upon and rectified, with the exception of boxes being stored on the floor in the Bay 1 overspill area. However, staff removed these during our inspection and senior managers told us during our follow up visit that further storage would be available in the orthopaedic administration department pod next door to the bay.
- We reviewed Rainbow Wards patient led assessments of the care environment (PLACE) audits. These were audits undertaken by patients on 31 May 2016. The ward received a 100% rating for ward cleanliness, condition and appearance from the PLACE assessors.
- Staff were following the trust's policies on the removal and disposal of clinical waste. We spoke with a member of the housekeeping staff who explained the procedures for handling and disposal of clinical waste.
- There were no reported cases of meticillin-resistant staphylococcus aureus (MRSA) in CYP services in the previous 12 months. Babies on the NNU were screened on admission and re-screened on a weekly basis.

Environment and equipment

- An assessment of ligature risks on Rainbow Ward had been completed by the service in 2016. The risk was also identified on the trustwide risk register on 6 January 2016. The risk register recorded that risks from cords on

cublicle blinds was minimal as long as staff followed the correct procedures. The Rainbow Ward manager told us, "We are very aware of ligature risks due to an increase in young people with mental health needs."

- The milk preparation room, ward office, and staff room had limited storage and were cluttered.
- The hospital had an effective system of alerting the NNU and Rainbow Ward when equipment required servicing. Staff were aware of where the asset register for Rainbow Ward and the NNUs equipment was held.
- Staff on the NNU told us access to equipment could be, 'frustrating'. Nursing staff on Rainbow Ward told us there had been a shortage of blood pressure monitors in 2015, but this had been addressed by the hospital, and there was an excess of blood pressure monitors on the ward. A staff member said, "We are now overflowing with blood pressure monitors." Rainbow Ward Bay 3 and Bay 4 had a monitor each and these had been checked daily. We also found five monitors in a cupboard in Bay 1 which had not been checked daily. Staff told us these would be checked prior to use and would be checked daily when in use.
- Security doors on the NNU and Rainbow Ward main entrances were used appropriately. Main entrances to all children's ward areas were secure. On Rainbow Ward and the NNU access was granted by a ward clerk at reception during the day and by ward staff at night. CCTV was used to monitor main entrances at all children's wards. However, we did not see any tailgating notices on Rainbow Ward to alert visitors not to allow people they didn't know onto the wards.
- In the CQC Children and Young People Survey 2014, the trust was found to be about the same as other trusts in question 25: "does the ward where your child stayed have appropriate adaptations or equipment." However, the survey results were compiled prior to Rainbow Ward relocating to West Ham Ward.
- During our follow up visit we spoke to the hospital's fire officer about the fire risk assessment for Bay 1. They told us Bay 1 risks had been assessed as, "Low." Risk assessments we viewed confirmed that Rainbow Ward had been risk assessed in November 2016. We asked about the cardboard and paper being stored in the overspill area on the bay. The fire officer told us this had been assessed and there was no ignition risk. Staff assured us the cardboard, equipment and paper would be moved into the pod next door to the bay, "In the next few days," once the pod had undergone a deep clean, which was scheduled for 11 November 2016.
- Bay 1 also had a recurrent leak in the overspill area on the bay, the overspill area was used for storage. This had led to a corner of the ceiling collapsing onto cupboards where equipment was being stored. Staff told us the estates department had put a tarpaulin above the suspended ceiling to stop water from entering the overspill area until a permanent repair could be completed. Staff said that due to the age and structure of the building permanently repairing the leak was difficult while the ward was in use. The estates department were checking the tarpaulin regularly to ensure water could not enter the overspill area where equipment and records were being stored.
- During our unannounced follow up visit on 11 November 2016, we found work in progress on making improvements to Bay 1. However, we also saw a nurse catch her foot on a wooden plinth in the bay's overspill area and trip, due to the plinth overlapping the entrance to the area, which did not have a door.
- Bay 1 had limited natural light. There was one child in the bay during our scheduled visit. The bay had one window which was screened and the light in the ward was limited. Staff told us the window had been screened at a parent's request to enable their child to sleep.
- The lighting at the nurses station was quite subdued. We addressed this with staff during our initial visit on 1 November 2016. During our unannounced visit on the 11 November 2016, we saw the service had installed strip lighting above the nursing station to improve the amount of light in the area.
- Staff across the service told us the estates department could be unresponsive to requests for maintenance. For example, from our review of the NNU electronic incident report log we saw staff reported an incident of a leaking roof in the NNU roof top milk expressing room on the 23 June 2016. The estates department had not taken any action, and said the leak was due to the volume of rain. However, the likelihood was that the NNU leak could happen again if it rained heavily.

- The service's risk register identified a risk from Rainbow Ward not being fully supplied with piped medical gases. To mitigate the risk the ward were using portable oxygen and suction.
- Age-appropriate resuscitation and emergency equipment was available for staff across CYP services. We saw that resuscitation trollies were checked daily and records were up to date.
- In the CQC children's survey 2014 the trust scored 9.6 for the question 'Did you feel safe on the hospital ward?' This was about the same as other trusts. The trust scored 9.3 for the question 'Did you feel that your child was safe on the hospital ward?' This was about the same as other trusts. The trust scored 8.7 for the question 'Did the ward where your child stayed have appropriate equipment or adaptions for your child?' This was about the same as other trusts. However, the survey was undertaken prior to Rainbow Ward being relocated to West Ham Ward and did not reflect parents views and opinions of CYP services on West Ham Ward.

Medicines

- The trust had a divisional pharmacist for CYP services who staff could liaise with and ask for advice. The pharmacist worked across all the ward and department areas; and attended Rainbow Ward and NNU daily, reviewing prescriptions and making recommendations.
- We viewed the mandatory training spreadsheet dated October 2016 and found 100% of staff on Rainbow Ward had completed training in medicines management. However, the figure on the NNU was 70%, this did not meet the trust's target of 90%.
- We checked seven prescription charts on Rainbow Ward and found children's weight was clearly documented. We also viewed five children's medicine administration records (MAR) and found children and young people's allergies were clearly recorded in their medical records and there were no missed doses.
- Medicines on the NNU and Rainbow Ward were stored safely, and treatment room temperatures had been checked and recorded regularly. Records confirmed medicines were being stored at the required temperatures. The service had installed a portable air conditioning unit in the treatment room on Rainbow Ward to regulate the temperature and ensure temperatures were in the required range for the safe storage of medicines. Controlled drugs were stored according to legal requirements.
- Overall we found medicines were in date across both Rainbow Ward and the NNU. However, we found one oral medicine stored on the NNU that was two days out of date. We drew this to a staff members attention and they removed the medicine.
- Prescriptions were prescribed daily by the registrar and checked by the consultant.
- Emergency medicines were checked, age appropriate, in-date, tamperproof and available for immediate use.
- Medicines reconciliation rounds occurred on CYP wards. Medicines were restocked through a 'top up' system, ensuring a continued supply. Out of hours, the hospital had an on-call pharmacist.
- CYP medicines were audited at regular three monthly intervals by the trust's pharmacy. We saw the pharmacy audit dated 8 October 2016. Staff told us they were required to report any actions they had taken in response to audits to the pharmacist.
- Staff had access to all policies relating to medicines management including the paediatric formulary via the trust intranet. Nursing staff were aware of policies on the administration of controlled drugs and the Nursing and Midwifery Council's Standards for Medicine Management.
- Staff were open and reported medicines incidents. Where the incident was a prescribing error, senior medical staff were informed and the error was followed up with the doctor concerned.

Records

- We looked at 10 sets of notes on Rainbow Ward and the NNU; we found them to be accurate and legible. Patient Information was easy to find. However, staff highlighted that there was no universal children's paperwork in other departments. This meant staff in other departments might not be familiar with CYP services documentation.
- Records were kept confidential on Rainbow Ward in lockable trolleys in the reception area. However, we also found filing cabinets that were unlocked and contained

eight patient paper based records in the Bay 1 overspill area. Staff said Bay 1 always had a member of staff on duty who monitored the overspill area. However, if staff were busy or distracted it was possible that someone could gain access to the area. This meant the personal information in these records was not stored in accordance with the Data Protection Act 1998. During our unannounced visit, 11 November 2016, staff said the filing cabinets were being moved into the pod as part of the ward improvements, and personal information would be secured and protected in the pod.

- Senior ward staff audited patient paediatric early warning score (PEWS) charts by monthly random sampling of a selection of records. We viewed a PEWS audit dated 10 October 2016. The audit recorded that 10 CYP PEWS records had been audited and discrepancies had been identified. The service told us learning from the audits was fed back to staff at handovers.
- Information governance was part of the trust's mandatory training. The staff training spreadsheet recorded that 100% of staff mandatory training in information governance was up to date.
- We did not see leaflets explaining patients' rights to access their medical records available on Rainbow Ward. However, the trust's website carried information on people's rights under the Freedom of Information Act 2000.
- The service was using electronic patient records system. However, a new electronic patient record system was being rolled out across the trust. Staff told us the new system would be rolled out to CYP services once they had moved to the new Rainbow Unit.

Safeguarding

- The hospital had a safeguarding team made up of a named nurse and specialist nurse, named midwife and named doctor. Staff could name the members of this team and could give examples of when they contacted them, including for advice and to escalate concerns.
- The Chief Operating Officer was the executive lead for safeguarding children. The children and young people's safeguarding named nurses managed complex safeguarding cases and worked collaboratively with other health and social care organisations. The safeguarding named nurse also worked with wards and departments, raising awareness and offering advice and support where necessary. Safeguarding advice was available 24 hours a day by an on-call rota of safeguarding nurses across the trust. Staff we spoke with told us they would liaise with the safeguarding named nurse if they had concerns.
- Staff on Rainbow Ward and the NNU had access to the contact details of the local authority safeguarding team for out of hours safeguarding advice or to report concerns. The trust had information sharing protocols in place with the local authority.
- A system was in place for referring children and adolescents to the local Child and Adolescent Mental Health Services (CAMHS). We spoke with staff who could name the person they would speak with at CAMHS.
- We viewed the CYP services mandatory training spreadsheet for October 2016 and this recorded 70% of qualified nursing staff had completed level three enhanced safeguarding training, this did not meet the trust target of 90%. The compliance figures for level 3 safeguarding training for the NNU in October 2016 was 83% this was lower than the trust target of 90%.
- Safeguarding policies and procedures were in place. This included referral pathways for children's safeguarding.
- The trust had comprehensive guidelines for staff in regards to female genital mutilation (FGM). Staff told us FGM was covered as an aspect of level 3 safeguarding training and was an area staff were particularly aware of.
- The CYP service returned figures for the percentage of staff that had received safeguarding supervision. These were: 79% in the emergency department (ED); 85% in the NNU; and 67% Rainbow Ward. The service told us the non-compliance figures were largely due to new staff having joined the service. An action plan was in place to address the shortfall, this included the safeguarding team offering extra supervision sessions.
- The trust was found about the same as other trusts in question 7, "do you feel that your child was safe on the hospital ward," and question 8, "did you feel safe on the ward," of the CQC Children and Young People's Survey 2014. However, the responses were compiled prior to the Rainbow Ward moving onto West Ham Ward.

Services for children and young people

Mandatory training

- Staff we spoke with confirmed that they were up to date with training, or had dates to attend scheduled training. Staff had access to a comprehensive programme of training, including medicines training and training in the use of specialist equipment.
- Mandatory training included 'the 4 harms'. These were: catheter acquired infections; pressure ulcers; slips, trips and falls; and VTEs. The mandatory training figure for staff completion of 'the 4 harms' training in October 2016 was 78%. Mandatory training also included: fire safety (86%), resuscitation and basic life support (81%), conflict resolution (86%), and health and safety (85%). This was not compliant with the trust target of 90%.
- Mandatory training records dated October 2016 indicated 78% of qualified nursing and additional clinical staff had completed training in the use of paediatrice early warning scores (PEWS), with 74% of NNU qualified nursing staff having completed training in the use of the neonatal early warning score (NEWS), compared to a trust target of 90%.
- Mandatory training records provided evidence that 81% of CYP service staff had completed the emergency planning training, this was training in the event of a major incident or emergency, against a trust target of 90%.

Assessing and responding to patient risk

- The CYP service used a PEWS system on the children's wards for monitoring the condition of children and young people. This was based on the NHS institute for innovation and improvement PEWS system. We spoke with staff, who were aware of the appropriate action to be taken if patients assessment scores were higher than expected. Patient deterioration would be identified and managed using the service's management of the acutely ill patient pathway consisting of PEWS and support from the Paediatric Acute Care Team (PACT). Staff could also contact the critical care team at Royal London Hospital (RLH) for advice in the event of a patient's deterioration.
- We reviewed 10 children and young people's PEWS notes and saw that where higher scores had been recorded, action had been taken to escalate concerns, or the rationale for not escalating had been documented.
- 82% of qualified in speciality nursing staff on the NNU had up to date neonatal immediate life support training, and 81% of qualified nursing staff on Rainbow Ward had up to date paediatric immediate life support (PILS) training, compared to a trust target of 90%.
- In case of an emergency within the CYP inpatient area, the paediatric resuscitation team would attend. Staff told us staff paediatric life support skills were considered when organising the staffing roster, to ensure there were appropriately trained staff on every shift.
- Staff said they were increasingly receiving referrals for young people with mental health needs. CYP awaiting an appropriate mental health bed were cared for on Rainbow Ward. CYP with mental health needs would usually receive a child and adolescent mental health services (CAMHS) assessment in the emergency department (ED). In the interim families or carers were invited to stay with their child on the ED where appropriate. Staff told us an agency registered mental health nurse (RMN) would be employed to provide, "one to one," care for children or young people with mental health needs who were admitted to Rainbow Ward. We viewed a flowchart which provided staff with guidance on actions to take dependent upon the symptoms and behaviour of a young person experiencing mental distress or disturbance.
- Staff told us they had not completed any training on sepsis, blood poisoning. However, they added CYP services were scheduled to be supplied with a sepsis trolley in the new Rainbow Unit, and staff would receive training in recognising and treating sepsis once the service moved into its new premises.
- CYP services had processes in place to manage the safe transfer of patients to the appropriate intensive care units (ICU) when required. The service used a children's acute transfer service (CATS) to transfer patients to other hospitals ICU. Paediatric critical care staff were available to provide support to colleagues on Rainbow Ward, and could respond to requests from the CYP service.

- There was an up to date child abduction policy dated 7 November 2016, this identified actions staff should take in the event of a child being abducted from the hospital.

Nursing staffing

- We viewed the children's health nursing 'establishment vs actual' spreadsheet dated from November 2015 to October 2015. For example, in October 2016 the nursing establishment was 79 whole time equivalent (WTE), these were the planned qualified nurses working hours for the month. The actual WTE number of qualified nurses available in October 2016 was 62. This meant the CYP service would need to use either bank or agency staff, to ensure there were enough nurses on duty to provide CYP with safe care.
- CYP services did not have a formal acuity tool for measuring the number of staff needed on shift. The service informed us that an acuity tool was being developed in consultation with staff, but that acuity was currently monitored through handovers, ward rounds and safety huddles.
- During our inspection staff were very visible, particularly on the NNU. Staff and managers told us they met surges in activity by using bank staff who were familiar with the ward areas. Staff told us agency staff would only be used as a last resort. Procedures were in place to request agency staff. However, staff told us the use of agency staff was infrequent.
- The safe staffing dashboard was displayed in the NNU and children's wards. This showed details of the required levels of staffing, and actual levels present on each shift. Staffing levels were adequate, as was the required skill mix at the time of our visit.
- Staffing levels conformed to the Royal College of Nursing (RCN) guidance 'defining staffing levels for children and young people's services' 2013. There was a minimum of six registered children's nurses at all times in all children and young people's inpatient and day care areas during the day and five registered nurses at night.
- The NNU nursing establishment figure was 57. However, at the time of our visit staff told us the actual number of whole time equivalent (WTE) registered nurses was 44; the NNU had a shortage of 13 WTE registered nurses. Staff told us the service had taken steps to mitigate risk. This included the use of bank and agency staff and on call cover, as well as advertising vacancies.
- Between April 2015 and March 2016 CYP services had nursing bank and agency staff rates ranging from 0% to 44%. Paediatrics including urgent and emergency care had the highest use of bank and agency staff.
- Staff rosters we viewed confirmed staff had access to a band 7 nurse at all times in any 24 hour period. Staff had access to a lead nurse or ward matron for 24 hours a day, seven days a week.
- In the 12 months leading up to June 2016, CYP services had vacancy rates ranging from 0% to 28%. Paediatrics including urgent and emergency care had the highest vacancy rates.
- Senior CYP staff had flown to the Phillippines in 2016 to interview and recruit new NNU nursing staff. As a result eight NNU nurses had been recruited and were undergoing pre-employment checks.
- As of June 2016, CYP services had turnover rates ranging from 0% to 32%. Paediatrics including urgent and emergency care had the highest turnover rate.
- As of June 2016, CYP services had sickness rates ranging from 5% to 6%.
- Nursing staff on Rainbow Ward told us they had a twice daily handover; staff were not to be disturbed during handovers as this was classed as protected time. Nursing handovers occurred at each change of shift using a situation background assessment recommendation (SBAR) tool to highlight safety concerns on the wards. The ward manager had the overall co-ordinating role and received a detailed handover from their counterpart. We viewed a Rainbow Ward handover sheet and saw that staffing for the shift was discussed, as well as any high risk patients or potential issues.

Medical staffing

- The CYP service operated a consultant of the week model. Consultants were on site at the hospital until 7.00pm during the week and for five hours a day at the weekends. At other times they were available on call

and would visit the hospital as necessary. Two to three registrars were available for acute and elective care during the day until 5.00pm. Out of hours one registrar was resident at the hospital.

- From Monday to Friday the paediatrics medical team consisted of: a hot week intake consultant from 8.30am to 5.00pm; a registrar from 8.30am to 9.00pm; a junior doctor on the ward from 8.30am to 9.00pm; a junior doctor at the paediatric emergency department (ED) from 8.30 to 9.00pm; a resident on-call consultant from 5.00pm to 7.00pm; and a non-resident on-call consultant from 5.00pm to 8.30am. As part of the winter pressures management there was an extra ad hoc paediatric registrar in the paediatric ED from midday to midnight.
- At weekends a resident consultant was on site for five hours on Saturday and Sunday, including ward rounds. The medical team at weekends consisted of a registrar and a junior doctor from 8.30am to 9.00pm. A consultant was on call from 8.30am on Saturday to 8.30am on Monday.
- Monday to Sunday nights: The medical team consisted of: a registrar and junior doctor from 8.30pm to 9.00am; and an on call consultant from 5.00pm to 8.30am: Monday to Friday, there was a resident consultant from 5.00pm to 7.00pm; there was a non-resident consultant from 7.00pm to 9.00am, and a non-resident consultant from 8.30am on Saturday to 8.30am on Monday. This meant CYP had access to specialist medical cover throughout the week.
- The Rainbow Ward had 24 hour cover by specialist trainees, who were responsible for providing the first port of call for all non-emergency clinical enquiries.
- The trust were meeting British Association of Perinatal Medicine(BAPM) 2014 guidelines for medical staffing on the NNU. A neonatal consultant was on-call at all times; none of the staff reported any difficulties or delays in receiving attention from a consultant. Nurses told us when they were concerned about a patient, they were encouraged to call the consultant.
- There were two handover sessions per day for the medical teams. A consultant was present at all handovers.
- In the 12 months leading up to June 2016: CYP services had a medical vacancy rate of 19%, a turnover rate of 24% and sickness rates of 0%.
- Between April 2015 and March 2016 CYP services had medical bank and locum staff rates ranging from 0% in May 2015, to 13% in August 2015.
- Between June 2015 and June 2016, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was lower than the England average.

Major incident awareness and training

- The trust had a major incident plan which was available on the intranet. Senior staff were aware of the plan and were able to explain their roles.
- There was a plan for cross site working during the winter months, whereby the trust's other acute hospitals would provide extra CYP beds during the winter months when services were under most pressure. The plan was designed to cover the period until building works on the new Rainbow Unit were completed. However, staff told us they had not had to utilise the extra beds as there had been no increased demand on the service.
- Staff told us that emergency planning training was part of the mandatory training programme, but were not aware of any recent training exercises to test the service readiness.
- We viewed the business continuity policy in the statement of purpose (SOP) for West Ham Ward and found this to be up to date.

Are services for children and young people effective?

Requires improvement

We rated this service requires improvement for effective because:

- Some senior staff we spoke with on the neonatal unit (NNU), were unaware of UNICEF Baby Friendly accreditation, a global accreditation programme to support breast feeding.

- Rainbow Ward was unable to deliver adequate pain management for patient controlled analgesia (PCA) and nurse controlled analgesia (NCA).
- The trust took part in the national neonatal audit programme (NNAP) in 2015, published in 2016. The trust did not achieve the standard that all (88%) of babies of less than 28 weeks gestation had their temperature taken within one hour of delivery.
- 65% of babies received retinophathy of prematurity (ROP) screening, this tests diseases of the eye in premature babies. However, this was below the trust target of 100%.
- The 2014/15 national diabetes audit indicated there was a higher risk of complications in CYP services than the average in England.

However, we also found:

- Procedures and policies were up to date and reflected recent evidence for best practice and NICE guidelines.
- There was evidence of multi-disciplinary team working in all children's and young people's departments.
- Information sharing between wards and departments, and medical and nursing staff was effective.

Evidence-based care and treatment

- CYP services had a system of clinical audit in place to monitor adherence to evidence based practice. The service took part in national clinical audits that they where eligible for. Audit proposals were discussed at paediatric governance meetings. For example, we saw audits were planned to assess the need for a jaundice clinic, and an audit was planned to assess the services practice against the guidelines for childhood obesity assessments.
- Some senior staff on the NNU we spoke with were unaware of UNICEF Baby Friendly accreditation. The Baby Friendly Initiative is based on a global accreditation programme from UNICEF and the World Health Organization. It is designed to support breastfeeding and parent infant relationships by working with public services to improve standards of care.
- Procedures and policies in place across the hospital's CYP and NNU service were up to date and reflected recent evidence for best practice and NICE guidelines. Policies we viewed were up to date and regularly reviewed. There were clinical guidelines for both neonatal and paediatric care available on the trust's intranet. The trust also had a range of clinical guidelines and pathways that were shared with the services clinical networks, including the London Cancer Network.
- Policies, procedures and guidelines were available to all staff, including temporary staff, via the trust intranet. Staff we spoke with knew how to access them when necessary. A band 6 nurse demonstrated how staff could access policies and procedures on the trust's intranet.
- A paediatric oncology shared care unit (POSCU) nurse told us children and young people's services followed the clinical guidelines for haematology and oncology, from a specialist children's hospital.
- Trust staff we spoke with stated that the availability of reliable information to the Clinical Academic Groups (CAGs) remained a problem for CYP services. Senior staff stated they were developing systems to provide better information to support services, and the new governance structure had improved the availability of information. However it would take time to embed the structures into practice.

Pain relief

- The trust was found about the same as other trusts in question 11 of the CQC Children and Young People survey 2014, "do you think the hospital staff did everything they could to help your pain." However, these results related to Rainbow Ward prior to the relocation to West Ham Ward.
- The trustwide risk register reported that Rainbow Ward was unable to deliver adequate pain management for patient controlled analgesia (PCA), nurse controlled analgesia (NCA). This was included on the trust's risk register on the 4 March 2014 and was due for review on the 23 November 2016.
- The play specialist team were available in each ward and department, and provided distraction technique therapy for children undergoing a variety of procedures. Play specialists described to us numerous distraction therapies and techniques they used to help reduce children and young people's pain and distract them from painful procedures.

- Parents we asked confirmed that staff ensured their children were not in pain.

Nutrition and hydration

- The trust was found about the same as other trusts in questions 24 of the Children and Young People Survey 2014, 'did your child like the hospital food'. However, the results related to Rainbow Ward prior to the ward being relocated to West Ham Ward.
- The CYP ward areas had a protected mealtimes policy, which ensured that children and young people could eat without being disturbed, with the exception of their parents and siblings. The policy was observed and implemented by staff on the ward.
- Children's likes and dislikes regarding food were identified and recorded as part of their nursing assessment on admission. CYP wards used a nationally recognised screening tool for the assessment of malnutrition in CYP to determine if they were at risk. Support was available from dietitians for specialist dietary advice and support. Staff were also aware of how to order specialist menu choices, such as halal food or gluten-free meals.
- Children and babies were frequently weighed. Records we viewed demonstrated that CYP fluid and dietary intake was monitored and recorded.
- There were adequate facilities for the management of bottle-feeding.
- The NNU had a breast pump room with dedicated breast feeding chairs available as well as a coffee room and full kitchen facilities. Breast milk fridges were available in each nursery where mothers' could label and store their milk. Donor breast milk was available as required.

Patient outcomes

- The trust took part in the national neonatal audit programme (NNAP) in 2015, published in 2016. The report showed that the trust was worse than the England average in the NNAP audit. For example, the trust did not achieve the standard that all (88%) babies of less than 28 weeks gestation had their temperature taken within one hour of delivery, the trust achieved 53%.
- The 2014/15 diabetes audit indicated there was a higher risk of complications at the service than the average in England. The NICE Quality Standard QS6 stated, 'people with diabetes agree with their healthcare professional a documented personalised HbA1c target, usually between 48 mmol/mol and 58 mmol/mol (6.5 and 7.5)'. (HbA1c levels are an indicator of how well an individual's blood glucose levels are controlled over time.) The 2014/15 diabetes audit showed that the trust's performance, 11.1, was worse than the England average of 22.1. The service also had fewer CYP with a HbA1c value of less than 58 mmol/mol at 74.1, compared to the England average of 70.5.
- The hospital had processes in place to undertake mortality and morbidity case reviews should this be required as part of the children and young people's services governance arrangements. Staff told us the service had very few child deaths.
- The NNU had a performance dashboard to monitor patient outcomes. The dashboard was red, amber, green (RAG) rated. We noted from the dashboard that 65% of babies received retinophathy of prematurity (ROP) screening, this tests diseases of the eye in premature babies. However, this was below the trust target of 100%.

Competent staff

- All new staff received a two week nursing orientation linked to the RCN competencies. This included the corporate induction, mandatory training, and training on the trust's IT systems.
- Staff completed a booklet, 'clinical and statutory responsibility', as part of their continuous professional development (CPD). A band 7 nurse on the NNU demonstrated how the booklet worked by ensuring staff were up to date with the responsibilities for their role.
- We viewed the children and young people's services annual appraisal record for April 2016. Overall, we found 80% of staff in all staff groups had received an annual appraisal in the previous 12 months in CYP services.
- Staff we spoke with during the inspection confirmed they had received an annual appraisal. All of the nursing staff we spoke to told us they felt well supported by their ward teams and the senior nursing and managerial staff.

- All band 6 nursing staff had attended or had dates to attend advanced paediatric life support (APLS) training. This would ensure there was an APLS accredited nurse on duty during every shift.
- There were staff with up to date continuous positive airway pressure (CPAP) competencies on every rota, this is a positive airway pressure ventilator which applies mild air pressure on a continuous basis to keep the airways continuously open in CYP who are able to breathe spontaneously on their own.
- The CYP service had clinical nurse specialists (CNS), these were nurses who had completed extra training to provide advice for oncology and diabetes. This ensured children and young people had access to specialist nursing staff with specialist skills.
- The CYP service had a practice development nurse who monitored staff training and competence. Nursing staff had annual study days covering clinical scenarios and update sessions. Nursing staff told us Rainbow Ward's band 7 nursing staff or the practice development nurse regularly assessed their competence in medicines management and drug insertion.
- 62% of NNU staff were qualified in neonatal speciality. We requested but did not receive the figures for the number of paediatric nurses that were qualified in speciality for Rainbow Ward.
- Staff told us the hospital would fund courses in excess of their mandatory training, a band 7 NNU nurse told us, "They will fund extra courses if it's relevant to our role."
- We observed a handover on Rainbow Ward where three consultants were present. The handover conformed to most of the requirements as set out in the Royal College of Paediatrics and Child Health (RCPCH) 'Facing the Future: Standards for Paediatric Services'. However, we did not see any evidence of teaching or learning for staff during the handover.
- The medical staff we spoke with all confirmed they had received an appropriate induction when they started work and had an appraisal to identify training needs. Staff said they received access to clinical supervision and training opportunities. Junior doctors had a teaching programme that was mapped to the RCPCH curriculum. The junior doctors we spoke with said the consultant staff took an active interest in their teaching. 100% of consultants had a job planning review in 2016.
- Theatre staff told us they did not have any registered paediatric nurses employed in the department. However, 16 staff were trained in paediatric immediate life support (PILS). All band 6 nurses in recovery had received specific training for paediatric cases and one of these nurses was always on duty when a paediatric list took place.

Multidisciplinary working

- In the CQC Children's Survey 2014, the trust scored 8.3 for the question, 'did the members of staff caring for your child work well together?' This was about the same as other trusts.
- There was evidence of multidisciplinary team (MDT) working in all departments. There were regular weekly MDT meetings. We also saw evidence of engagement with external agencies and networking with other CYP services to share specialist expertise. There were weekly psychosocial meetings on both the Newham University Hospital (NUH) and the Royal London Hospital (RLH) sites, which were multi-agency as well as multidisciplinary. We saw evidence that minutes were taken of these meetings.
- Staff told us one of the main challenges with MDT working was providing services for young people with mental health needs. CYP services had access to a psychiatric liaison service seven days a week. The CAMHS liaison service was comprised of one part time children's registered mental health nurse (RMN). The RMN visited Rainbow Ward from Monday to Friday to get an update on any specific issues and see children or young people on the ward. Children admitted following self harm would be seen in the ED or on the ward by a mental health professional from the CAMHS rota. There was a designated child psychiatrist with an interest in liaison psychiatry who would see children on the ward if needed, and could give staff advice on managing young people with complex needs. The psychiatrist would conduct joint consultations with paediatric consultants for CYP where a CYP presented difficult or unexplained symptoms.

Services for children and young people

- CYP services were covered by the hospitals on-call service out of hours and at weekends. For example, weekend cover included diagnostics and imaging.
- Play specialists were an integral part of Rainbow Ward and CYP department teams. Play specialists worked with children to make the hospital environment welcoming and fun. They answered questions children may had about what would happen on the ward and reassured children prior to and post operatively. The play specialists were all NVQ 3 qualified in their specialism.
- The trust had clear pathways and protocols in place in regards to operating theatres; these were based upon the world health organisation (WHO) protocols. Almost all surgery at NUH was carried out as day case admissions. Children receiving surgery outside the dedicated paediatric lists were placed at the beginning of theatre lists.
- The service had a paediatric haematology oncology, (blood cancer), service. This was a level 1 paediatric oncology shared care service (POSCU) with the London cancer network.
- Staff worked closely with staff from the paediatric accident and emergency (ED) department and had shared guidelines. The emergency department (ED) had qualified paediatric nurses that attended to children or young people in the ED.
- Staff and parents had access to the paediatric diabetes team. Parents could contact diabetes nurses from 9.00am to 5.00pm. Out of hours service was provided by an on-call paediatric registrar who had access to a guideline for telephone queries. An informal arrangement also existed where a consultant with a special interest in diabetes could be consulted. During holidays, consultant cover was provided by the Royal London Hospital (RLH). However, staff told us work was in progress for an on call service to be provided by a joint group of doctors and specialist nurses.
- The service worked closely with the Children's Acute Transfer Service (CATS) and the Neonatal Transfer Service for London to ensure safe inter-hospital transfers of critically ill children and babies to specialist centres. The service had yearly training and simulation days with the retrieval service teams.

Seven-day services

- Rainbow Ward, ED, and the NNU operated a 24 hour service.
- A play team was able to provide qualified play specialists and play assistants to children's services seven days a week. The play specialist were informed of all planned admissions at handover, and were involved in multidisciplinary ward rounds, as necessary.
- The pharmacy department was open seven days a week. There were pharmacists on call out of hours. This ensured children and young people had timely access to medicines.
- Physiotherapy services were available seven days a week. Out of hours support was available through an on-call system.
- X-Rays and CT scans were available from the diagnostic and imaging departments 24 hours a day, seven days a week.

Access to information

- Senior managers were aware of the trust's Caldicott Guardian, this is an appointment whereby the holder has responsibility to ensure the protection of patient confidentiality.
- GPs were informed of CYP discharge on the day of discharge. Care summaries were sent to their GP on discharge to ensure continuity of care in the community. GPs could telephone consultants and registrars for advice following discharge.
- Staff across CYP services told us information sharing between wards and departments, and medical and nursing staff, was effective. Nursing staff told us medical staff were approachable.
- Staff on Rainbow Ward told us there was a shortage of computers on Rainbow Ward. There were two computers in Bay 1, two in the nursing station, and one in the ward manager's office. Staff said it could be difficult to get access to a computer.
- Staff had access to X-rays and other imaging results via an electronic patient data management system, CYP information could be accessed by medical and nursing staff via the electronic record.

Consent

Services for children and young people

- Parents were involved in giving consent to examinations, as were children when they were at an age to have a sufficient level of understanding. Staff we spoke with were aware of Gillick competence, this is a decision about whether a child aged 16 years or younger is able to consent to their own medical treatment, without the need for parental permission or knowledge.
- In the CQC Children's Survey 2014 the trust scored 8.4 for the question, 'did a member of staff agree a plan for your child's care with you?' This was about the same as other trusts.
- We saw staff talking and explaining procedures to children in a way they could understand.
- The trust had a consent to examination and treatment policy that was ratified in May 2016. The policy had flowcharts which provided clear guidance to staff on the trust's consent procedures, including: adults or children detained under the Mental Health Act; and Gillick competence.
- All the parents we spoke with told us they felt involved in their child's care and were supported throughout their time in hospital, whether as an inpatient or an outpatient.
- There was no programme of consent audits to ensure CYP services had mechanisms in place to ensure CYP and families were involved in consenting to their care and treatment.

Are services for children and young people caring?

Good

We rated this service as good for caring because:

- Children and young people (CYP) and their parent were supported, treated with dignity, respect and kindness, and were involved as partners in their care.
- Feedback from CYP and parents was positive about the way staff treated children and young people.
- CYP and families relationships with staff were positive.
- Staff helped CYP and those close to them to cope emotionally with their care and treatment.
- CYP and those close to them were informed of their care and treatment options, and involved in making decisions about their care and treatment.

Compassionate care

- The trust were rated as performing about the same as other trusts in the 14 questions relating to compassionate care within the CQC's Children's Survey 2014.
- We observed that children and young people's privacy and dignity was respected by staff, for example, drawing curtains when providing intimate care or treatment.
- Play specialists worked with nursing staff on Rainbow Ward to ensure that children and young people were not left unsupervised for prolonged periods when they didn't have a parent or carer visiting.
- Throughout our inspection, we observed positive interactions between staff, parents and children. We saw staff responding in a considerate manner with CYP and their families in all of the areas we visited.
- Parents we spoke to told us they had been treated with respect and compassion by the staff and praised staff for their attitude and approach. A parent told us, "The ward manager is lovely. She's got great people skills." A young person on Rainbow Ward told us, "They've been really nice." The young person's parent told us, "The staff have been kind."
- We viewed the results of the Friends and Family Test (FFT), this is a patient feedback test to help service providers understanding of patients experiences of services. The results of the children and adolescent services FFT on the NHS Choices website in January 2017 found: 83%, from a total of 70 responses, responded they would recommend CYP services at NUH.
- We also viewed a range of qualitative comments provided by the service dated from 9 October 2016 to 28 October 2016. We found these to be mostly positive. For example, a typical comment was, "The staff were very professional and friendly."

Understanding and involvement of patients and those close to them

- Staff encouraged parental involvement in ward rounds. Most CYP and parents we spoke with said they had been

involved in their care and in making decisions around their treatment. We observed staff communicating with CYP and parents to ensure they understood their care and treatment. Most of the CYP and parents we spoke with said that they had been involved in making decisions about their care and treatment. For example, a parent told us, "You can ask the ward manager anything."

- The trust was found about the same as other trusts in section C2 of the CQC's Children and Young People Survey 2014. Questions included, 'did the hospital tell you what was going to happen to your child while they were in hospital', and 'did members of staff treating your child give you information about their care and treatment in a way that you could understand'. The trust scored 9.2 out of 10, and performed better than other trusts, for the question, 'afterwards, did someone from the hospital explain to you how the operation or procedure had gone in a way you could understand.'
- Rainbow Ward had pull down portable beds for a parent to stay overnight on the ward next to their child. However, we spoke with a parent who told us they had spent the night sleeping in a chair and had not been informed by staff they could have a bed. Another parent told us they had been bringing in milk and nappies for their child. The parent told us staff had not informed them if any of these items would be provided by the hospital.
- Staff told us the hospital had access to interpreters and information in other languages for people whose first language was not English. We did not observe any interpreters being used during our inspection, and did not see any information on how to access interpreters on Rainbow Ward.

Emotional support

- It was evident from our discussions with staff that they were very aware of the need for emotional support to help CYP and families cope with their care and treatment. Parents and relatives we spoke with confirmed this during our discussions with them.
- The play specialist team worked alongside nursing and medical staff to provide support to CYP. Staff were aware of how anxiety could impact on the welfare of a child and made provision, where needed, to manage this. For example, play specialists offered support to children who were undergoing surgery to alleviate their anxiety.
- Parents we spoke with told us they felt confident in leaving the ward and leaving their children in the care of staff of the ward.
- Children and young people who were experiencing mental or emotional distress had access to CAMHS and a RMN. Staff could signpost CYP and their families to a counselling service if they were in need of counselling support.
- Nursing staff we asked told us they had received training in breaking bad news. Staff told us the hospital chaplaincy would offer support for parents, and others close to a child, who had received bad news.
- The trust performed about the same as other trusts for the three questions relating to emotional support in the CQC Children's Survey 2014.

Are services for children and young people responsive?

Requires improvement

We rated this service requires improvement for responsive because:

- Rainbow Ward was temporarily housed on West Ham Ward, which was not a purpose built paediatric ward and conditions for staff on the ward were cramped.
- There were a number of comments from staff and from patient and relative surveys that were negative about the environments on Rainbow Ward and the CYP outpatients department (OPD).
- The décor of Rainbow Ward was not considerate of CYP and was not child friendly. Bay 1 was of particular concern due to its multi-purpose usage and lack of natural light.
- The recovery facilities in theatre were not child friendly due to an absence of a recovery bay with appropriate child friendly décor.

- Emergency readmissions for non-elective patients under the age of one year and children between the age of one and 17 years were worse than the England average.

However, we also found:

- Admission pathway protocols were in place.
- There had been no formal closures to admissions to Rainbow Ward in the previous 12 months.
- The NNU had three rooms available for parents staying overnight. The rooms were homely and had en-suite toilet and shower facilities.
- Complaints were managed in accordance with trust policy and lessons were learnt. Staff and managers told us that they preferred to resolve concerns "on the spot."

Service planning and delivery to meet the needs of local people

- Newham University Hospital (NUH) had 2,776 inpatient spells between April 2015 and March 2016. Emergency spells accounted for 2,179 of these (78%). There were 459 (17%) day case spells and the remaining 138 (5%) were elective.
- Rainbow Ward had been moved into the West Ham Ward of the hospital due to hospital capacity pressures. The move was temporary as the hospital had built a new children and young people's department, the Rainbow Unit. All building work on the new Rainbow Unit was scheduled to be completed and handed over to the hospital on 19 December 2017. The hospital staff contacted the builders during our inspection and had the handover date confirmed.
- Staff told us Rainbow Ward, a paediatric ward, had initially moved to Jasmine Ward for one week, but the Jasmine Ward environment was not suitable for paediatrics. The decision was then taken to move paediatrics to the West Ham Ward in December 2015.
- West Ham Ward had a standard operating procedure (SOP) that had been drawn up to accommodate Rainbow Ward.
- Rainbow Ward accommodation consisted of four bays of five beds and four cubicles, two of which were en-suite. However, the new Rainbow Unit would provide two bays of six beds and seven en-suite cubicles, as well as 12 day care beds and two stabilisation beds. The new Rainbow Unit would also provide a parents room with kitchen facilities and accessible bathroom facilities.
- As West Ham Ward was not a purpose built paediatric ward, conditions for staff in the ward were cramped. We viewed the hospital CYP Benefits Register for September 2016. This was a document that reviewed the benefits of building a new CYP unit. The register recorded patient and relative comments from a patient and relative survey in February 2016. A comment from the register about the ward's reception area was, "No space, environment poor."
- Bay 4 on West Ham Ward was being used as a temporary outpatients department (OPD). The bay was also used for day surgery Mondays to Thursdays. The hospital CYP Benefits Register recorded comments from the staff survey as, "OPD area not fit for purpose." Comments from the patient and relative survey in February 2016 also recorded, "Poor environment."
- Rainbow Ward Bay 1 was being utilised for multiple purposes. For example, Bay 1 had an administrator who had a workspace on the ward. On the day of our inspection the parent of a child on Bay 1 told us junior doctors had a "Training session" in the bay. There were cots stored on the bay. Bay 1 also had an overspill area which was being used for the storage of equipment and records. These included filing cabinets, boxes and records trollies.
- The Rainbow Ward manager's office was small, staff told us they sometimes used the ward manager's office due to a shortage of computers on the ward. Staff told us they were taking turns in using the space, as the size of the room meant it could not accommodate more than two staff members at a time.
- Staff told us the clinical commissioning group (CCG) and senior managers had walked the West Ham Ward and had considered it suitable as a temporary paediatric ward. Most staff we spoke with on the ward said they considered it unsuitable. However, senior managers said the ward was a temporary ward and had received fire and risk assessments prior to CYP being moved onto the ward.
- Senior managers told us Rainbow Ward Bay 1 needed to remain open as it was the only part of the ward with

piped air that could be used for continuous positive airway pressure (CPAP). This is a treatment for obstructive sleep apnea, a sleeping disorder. CPAP includes the use of a machine that supplies a constant and steady air pressure.

- Bay 1 had an administrator working from a desk in the bay. We were told by staff that the administrator's phone rang, "Sometimes." There was risk that this could wake up CYP who were trying to sleep on the bay.
- The temperature of Rainbow Ward felt very warm. We spoke to staff who told us the ward was often, "Hot", with one member of staff saying, "It was unbearable during the summer." Ward temperatures were not recorded and there was no thermometer to record temperatures on the ward. We asked a senior manager about the temperature. They told us the ward thermometers had been stolen, and even when replaced by the ward, they had been stolen again. The hospital had purchased a portable air conditioning unit during the summer to regulate the temperature of the ward. However, due to a lack of temperature records and a thermometer on the ward, the service could not assess how much difference the air conditioning unit had made to the temperature on the ward.
- Porters were seen delivering boxes of equipment to the ward. We saw a porter pushing boxes on a trolley through Bay 1 from the Rainbow Ward corridor. We spoke with a senior manager about this, they told us they were immediately introducing a procedure where kit and equipment would not be delivered via the Bay 1 entrance. Equipment would be stored in a pod next door to Bay 1 and would be delivered via the exit door at the back of the bay, to minimise the inconvenience and disturbance this may cause CYP who were accommodated on the bay.
- Staff in surgery told us that, due to insufficient surgery lists, there was a plan to transfer paediatric surgery from one of the trust's other acute hospitals, to Newham University Hospital (NUH). However, this was work in progress and had not been finalised.
- The CYP service had plans in place to introduce an outpatients jaundice clinic commencing in May 2017.
- There was no transitional care unit for neonates. Staff told us the transitional care unit had closed approximately six months before our visit.
- We had an escorted tour of the new CYP unit to view the work in progress. The new Rainbow Unit had a teenagers room which was being furnished and decorated for adolescents. There was an outdoor play area for younger children that would be equipped with outdoor play equipment. The unit had a large play room for younger children. Staff told us a selection of toys was available for the new department and a selection of children's books and DVD's.

Access and flow

- There had been 4836 paediatric inpatient spells, admissions to hospital, between April 2015 and November 2016. Of these: 4018 had been general paediatric admissions; 488 had been for paediatric clinical haematology; 147 were for paediatric dentistry; 117 were for paediatric medical oncology; 61 were for paediatric diabetic medicine and five were for paediatric urology.
- Between April 2016 and October 2016 there had been 3832 births at the hospital. There had been 379 admissions to the NNU, with 308 of these babies born at the hospital, making the NNU admission rate in this period 8%. 56% of new parents were seen within 24 hours; and 97% of babies received a timely discharge from the NNU.
- The trust performed about the same as other trusts for three out of four questions relating to responsiveness in the CQC Children's Survey 2014. The trust scored 5.7 out of 10 for the question, 'did the hospital give you a choice of admission dates,' this was better than other trusts
- Admission pathway protocols were in place, these were either via the paediatric care decision unit (PCDU) or directly from the paediatric emergency department (ED). Elective or planned CYP admissions could be admitted from home via scheduled pathways or from the CYP OPD; CYP could also be transferred from one of the trust's other hospital sites for step down care or to support capacity issues at the other hospitals; CYP could also be admitted from primary oncology shared care units (POSCU).
- The service had introduced guidelines for staff at the hospital on choosing a place of admission and minimising admissions to the Rainbow Ward during the building of the new unit. The guidelines identified which children's conditions would be admitted to the Rainbow

Ward, and gave staff guidance on which conditions, for example conditions of a longer duration, they should consider sending to one of the trust's other hospital sites. Staff we spoke with were aware of the new guidelines and told us they would, where appropriate, arrange for CYP to be admitted to a different hospital, as close to their home as possible.

- The CYP ED was separate from the hospital's main ED. CYP were admitted via the ED for general surgical emergencies, the two most common being appendicitis requiring appendectomy and abscess requiring incision and drainage. Children under the age of five with emergency presentations were transferred to the Royal London Hospital (RLH) for surgery under the care of paediatric surgeons. Children presenting with ear, nose and throat (ENT) and ophthalmological surgical problems were transferred to Whipps Cross Hospital (WCH) for surgery.
- CYP were assessed by an anaesthetist and a surgeon, with paediatricians jointly managing their care. Orthopaedic non-elective procedures were transferred to RLH for primary surgical management. Post operatively children and young people were seen and reviewed daily both by surgeons and paediatricians.
- There had been no formal closures to Rainbow Ward admissions in the previous 12 months. The service informed us they worked with the emergency bed service (EBS) to support other hospitals, and received support from other hospitals for beds across the region. All children were seen by a consultant within 14 hours of admission to the ward.
- The NNU had been closed to admissions on two occasions in the previous 12 months. These were from 9 to 15 June 2016 and from 21 to 27 October 2016, due to capacity issues. Staff told us there were daily conference calls across the trust where capacity and acuity on all the trust's three acute hospital sites, RLH and WCH, were discussed and plans agreed.
- The NNU dashboard indicated that between April 2016 and October 2016 the average length of stay for babies and parents receiving transitional care was 16.8 days. The average bed occupancy rate during this period was 49%. There had been 51 transfers out of the unit to other units and 26 babies transferred in from other units in the same period.
- The multiple readmission rate within 12 months from April 2015 to March 2016 for children aged one to 17 years old was better than the England average for the following: asthma, (14.4% compared to the England average of 16.6%); epilepsy (28.6% compared to the England average 29.3%); and diabetes (10.5% compared to the England average of 13.1%).
- Emergency readmissions for elective CYP within two days of discharge following an emergency admission at 0.8% was better than the England average of 2.8%, in the age group one to 17 years. For the ED the rate was 1% compared to the England average of 2%. However, the rate was worse than the England average for paediatric plastic surgery, which was 2.3% compared to the England average of 1.3%.
- Emergency readmissions for non-elective children under the age of one year and CYP between the age of one and 17 years were worse than the England average.
- Between April 2015 and February 2016 there was a lower rate of emergency readmissions than the England average for the under one age group following emergency admission. The hospital had a rate of 0.8% compared to the England average of 3.4%.
- There had been one admission open to CAMHS in the previous 12 months. The young person had been admitted for several days, the service told us this was not due to a lack of CAMHS beds, but a disagreement between services about whether a CAMHS bed was the most suitable place for the young person.
- The CYP OPD ran a number of clinics including: a rapid access clinic for urgent referrals where CYP needed to be seen within 48 to 72 hours, but did not require urgent attention in the ED. With the exception of surgical or orthopaedic problems, referrals could be faxed directly to a clinic from the GP.
- Children's OPD had a number of specialist clinics, which were run in conjunction with tertiary, specialist, centres. These were not part of the trust's e-referral online booking system as consultants would triage referrals prior to booking appointments. Clinics included: paediatric diabetes, including an insulin pump service; paediatric haematology, and paediatric oncology.

- The service's to follow up ratio for outpatients was 1:1, which was in the top 20% nationally. This meant children and young people received timely follow up consultations.
- There was a paediatric phlebotomy service available for children aged from birth to seven years in the children's OPD via an appointment system.
- The NNU team discussed planned deliveries of babies with the anti-natal service and the delivery suite on a daily basis.
- We viewed the overall average occupancy level for NNU in the previous month. The optimum occupancy level was 70% according to British Association of Perinatal Medicine(BAPM) guidelines. We found the NNU was compliant with the BAPM toolkit for neonatal occupancy levels. This indicated that the unit was managing to maintain the availability of emergency cots and providing the optimum safe nursing levels.
- From April 2015 to March 2016 there had been: 318 level one intensive care days; 873 level two intensive care days; and 2912 level three special care days. The overall intensive care unit occupancy rate during the period was 49%, with intensive care cot occupancy for the period at 43% and a high dependency cot occupancy rate at 59%.

Meeting people's individual needs

- The décor of Rainbow Ward was not considerate of CYP and was not child friendly. Bay 1 was of particular concern due to its multi-purpose usage and lack of natural light. There were insufficient play areas on Rainbow Ward. Staff acknowledged that the ward did not offer children a play area, but highlighted this as a temporary measure while the new Rainbow Unit was completed.
- Rainbow Ward had a limited range of play equipment for all ages, which was kept to a good standard.
- The NNU had three rooms available for parents staying overnight. Two of the rooms were on the unit and one was in the main hospital corridor. The rooms were homely and offered parents en-suite toilet and shower facilities.
- The recovery facilities in theatre were not child friendly. This was due to an absence of a recovery bay with appropriate décor. Staff told us children would be reunited with their parents in a recovery bay as soon as they left theatre and would not be left alone in a recovery bay.
- The trust had a transitions policy in place for young people transitioning to adult services. However, due to the lay out of Rainbow Ward staff told us it was not always possible to offer adolescents a choice of single sex accommodation on admission. Staff said the new Rainbow Unit had specialist facilities for young people in transition to adult services and this would offer young people single sex accommodation. Staff added that young people aged between 16 and 18 years old would be offered a choice of either: accommodation on the children's ward, providing they did not display behaviour unsuitable for a children's ward environment; or a single sex adult ward. Staff said this would always be decided in consultation with the young person and their family.
- Staff told us support was available for children with learning disabilities or physical needs from the hospital's registered learning disability nurses as required. Staff we spoke with told us that the service could meet the needs of all children admitted to the wards, regardless of the complexity of their physical needs.
- Staff told us parents did not receive food on the ward, unless they were diabetic or breast feeding. Staff said parents could use the facilities in the staff room. However, parents would have to ask staff to warm food as they were not allowed in the staff room. Most parents told us staff would assist with food if asked. One parent told us their partner was bringing in flasks of hot water so that they could make hot drinks as they didn't, "Like to ask staff because they are so busy." There was a restaurant on site that was used by staff. A nurse on Rainbow Ward told us the ward had advised parents they could buy food from the on-site restaurant, but said there had been, "Some problems," with staff in the restaurant refusing to allow parents to purchase food in the staff restaurant.
- There was a limited amount of information leaflets available for children and their parents or carers on Rainbow Ward.

Learning from complaints and concerns

Services for children and young people

- Complaints were managed in accordance with the trust's complaints policy and lessons were learnt. Staff and managers told us that they preferred to resolve concerns "on the spot." Staff said these were not recorded, but if they could not deal with the concern immediately parents would be directed to make a formal complaint. All the parents we spoke with said they had not raised any complaints with the service, and they found staff approachable if they wished to raise issues.
- Information regarding complaints and concerns was on display in the parents' room on the NNU, on Rainbow Ward, and at the hospital's main reception. Leaflets detailing how to make a complaint were freely available across the hospital. Staff told us information on complaints in all languages could be requested on the same day from the hospitals accessible communications team.

Are services for children and young people well-led?

Requires improvement

We rated this service requires improvement for well led because:

- There was a trustwide strategy for children and young people's services at Newham University Hospital (NUH), but this was not embedded. There was no long term local stategy for CYP services. However, Rainbow Ward had a short-term strategy of moving into new premises.
- There were new governance arrangements for children's services, but these were not fully embedded.
- The agendas for governance meetings did not always reflect the governance meeting terms of reference (TOR).
- Identified risks were not always included on the trust's risk register in a timely way. Actions the service had taken to mitigate risks were not always recorded on the risk register.

However, we also found:

- Staff were aware of the trust's vision and values.
- There was a new governance framework in place and responsibilities were defined.
- Department level leadership was effective. Consultants' roles and responsibilities were defined by the trust's job planning process.
- Staff supported each other well. Staff told us the culture of the service was very focused on meeting the needs of CYP who used the service.
- Staff were provided with information on developments at the trust, such as the new children and young people's Rainbow Unit.
- The Rainbow Unit rebuilding project would provide modern inpatient and outpatient facilities for children and young people, the new department was due to open in February 2017.

Leadership and culture within the service

- Department level leadership was effective. Consultants' roles and responsibilities were defined by the trust's job planning process. Staff on wards were unanimous in telling us how the ward managers on both the NNU and Rainbow Ward provided effective ward level leadership.
- The nursing and medical management team were aware of how they fitted into the wider management model for the trust. For example, paediatric consultants had direct access to the clinical director, as did the matrons for CYP and NNU, and the CYP service manager. Nursing team leaders linked directly with the senior nurse and junior doctors linked directly with consultants.
- A few members of staff told us they had not always felt supported by all members of the senior management team, and said if they raised any concerns they felt they might not be listened to. A staff member told us, "They don't like you rocking the boat." Staff also said there had been an incident with a member of the ward staff and a senior manager. Staff told us they did not think the incident had been investigated robustly as staff were not informed of the outcome. However, staff said the senior manager had offered a verbal apology to the member of staff when they raised a complaint.
- We saw that local clinical leaders and managers encouraged co-operative, supportive relationships

among staff and teams, as well as compassion towards patients. Staff told us that local leaders were very visible and approachable. The ward manager on Rainbow Ward was supernumerary and was not allocated clinical work. We observed the ward managers and consultants advising staff on the wards on several occasions. The ward manager on Rainbow Ward told us they could contact the senior nurse and board lead for CYP, and would feel comfortable in discussing service issues with them.

- The service had introduced a RAG (red, amber, green) rated risk log. This was a register which identified risks to the new Rainbow Unit's planning. There was one red risk on the log, this related to delays in the new unit opening. The log recorded that works were on-track and handover from the building contractors was on schedule.
- Staff told us staff supported each other well. Staff said the culture of the service was very focused on meeting the needs of CYP.
- We found there was a difference of opinion between senior managers and staff on Rainbow Ward in regards to the safety of Bay 1. Ward staff told us they did not think the bay was appropriate for the provision of safe and effective care. All the senior managers we spoke with told us the bay had been risk assessed by the hospital's estates department and fire service and the identified risks were safely managed.
- Ward staff described an open culture on the NNU and Rainbow Ward, where they were encouraged to report incidents, concerns and complaints to their line manager. Staff we spoke with told us they felt able to raise any concerns with the senior nurse for paediatrics.
- Most staff we spoke with told us they were proud to work for the trust. We spoke with a student midwife who was on a work experience placement at the NNU they told us, "I didn't want to do my placement at Newham. I am now going to apply for a job here when I qualify. It feels like a family."

Vision and strategy for this service

- Staff told us the move to the new Rainbow Unit was the strategy for CYP services. Senior staff told us they would be producing a long-term strategy for CYP services. However, the vision and strategy was short-term at the time of our visit. The strategy was to move CYP services into the new Rainbow Unit. Senior staff told us the service had put a lot of thought and energy into the new CYP building project. A senior manager said, "We will get into the new build, and then look to see where we take services from there. It is difficult to have a longer-term vision when the move has taken up most of the focus."
- Most of the staff we spoke with understood the service's vision in regards to the new Rainbow Unit and said they felt they were kept informed about its progress. Staff were also aware of the trust's vision and values. Staff highlighted that the trust's vision and values were communicated on the trust's intranet and as footers on emails. Staff also told us their annual appraisals were aligned to the trust's values.
- The trust had recently implemented a CYP clinical strategy dated August 2016. The strategy outlined what the trust considered the strengths and weaknesses of CYP services across the trust. The strategy also outlined the trust's clinical priorities and key enablers to change across the trust. The trust had an outline process of how the strategy would be monitored and evaluated. However, the strategy was relatively new and not fully embedded.
- We viewed the CYP business plan for 2016 to 2017. This defined the vision as, 'the trust's vision is to change lives. Our ambition is for east London to have health services in which we can all take pride. These services will reach beyond our hospitals and provide care where it is needed most - at home, in our communities, or in specialist facilities across the boroughs'. The business plan was reviewed at monthly divisional performance meetings and a report was submitted from the meeting to the clinical director for women and children's health.

Governance, risk management and quality measurement

- There was a new governance framework in place and responsibilities were defined. We viewed an organisational flow chart; this gave staff guidance on the structure of the service's governance framework.
- The service had introduced a governance structure to monitor the building of the new Rainbow Unit. This included a project board that met monthly and reported

to the trust board via the clinical academic group (CAG) board. A project management group for the new Rainbow Unit also met weekly and reported to the project board.

- There were processes in place to ensure information from wards could be reported to the board. For example, CYP services team meetings fed into the wider divisional structure. The ED managers met weekly with the paediatric management teams. Ward managers attended governance meetings, these meetings were attended by the senior nurses for the NNU and paediatrics. The senior nurses attended clinical academic group (CAG) meetings, and CAG meetings fed into the board.
- The NNU used a quality dashboard to monitor the quality of services provided. This provided assurances by collecting information on the quality of care provision and patient outcomes. The dashboard was red, amber, green (RAG) rated to assist the children and young people's service to identify themes and trends. Staff told us the NNU dashboard was regularly reviewed at the NNU governance meetings. However, reviews of the dashboard were not always clearly documented in all the minutes we viewed.
- We viewed the terms of reference (TOR) for the paediatric and neonatology clinical governance programme for 2015/16. These meetings contained a number of standing agenda items including a review of incidents and SI's, new guidance, and regulatory compliance. The TOR stated that a standard agenda was in use for governance meetings. We reviewed three neonates governance meeting agendas and found these did not fully reflect the TOR for the group. For example, the neonates governance meeting agenda had seven agenda items in May 2016, eight items in June 2016, and nine items in July 2016. Complaints information was not a standard item on the agenda for any of the neonates meetings, even though complaints were listed as a standard agenda item in the governance meeting TOR. However, staff told us CYP services received very few complaints and would only discuss complaints at the meetings if there were current complaints.
- There were governance arrangements in place that monitored the outcome of audits, complaints, and incidents throughout the service. We looked at copies of governance meetings, risk registers, quality monitoring systems and incident reporting practices. These demonstrated that there were management systems in place but these were not robust. For example, a risk register was in place which identified the key concerns for CYP services. The risk register recorded, 'West Ham ward is an adult clinical area that is being used by paediatric inpatients while the total refurbishment of the paediatric ward is undertaken'. However, the identified risks on West Ham Ward were added to the risk register on 16 November 2016, which was almost a year after the move to the ward. There was no evidence that the risks had been identified previously on the risk register or plan of action recorded regarding actions the service was taking to mitigate the identified risks.
- There were no risks relating to the NNU on the register. Senior nursing staff we spoke with on the NNU were not aware of whether there were any NNU identified risks on the risk register.

Public and staff engagement

- The service had met with the trust's communications team in May 2015 to discuss methods of staff being updated on the progress of the new Rainbow Unit. Staff told us they had received email bulletins updating them on the progress of the project. Some staff had been invited to see work in progress on the project.
- Staff received a monthly newsletter via email. This provided staff with information on developments at the trust and carried information on projects the trust was focusing on.
- We asked for staff survey results for the CYP service. The service did not provide the results, but responded that there were no specific issues identified in the staff survey relating to CYP services.
- The trust had introduced a 'Listening into Action' (LiA)initiative to gauge staff feedback on the trust's services and performance. As part of LiA 'a staff pulse check survey' was undertaken in November 2015 and repeated in May 2016. The results related to all the hospital's staff and were not specific to CYP services. However, overall the LiA pulse check showed an improvement in staff satisfaction and engagement during the period.

Innovation, improvement and sustainability

Services for children and young people

- The Rainbow Ward rebuilding project would provide modern inpatient and outpatient facilities for CYP, the new unit was due to open in February 2017.
- The Newham Youth Diabetes Group was an initiative involving a number of local health and social care providers in the borough and the CCG. The project was based on a modern and sustainable approach to diabetes services for CYP and cross-organisational partnership working.

End of life care

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

Information about the service

End of life care was provided in most wards at Newham University Hospital (NUH), which is a 344 bed district general hospital. There were 278 deaths in the hospital between April and October 2016. The hospital's specialist palliative care (SPC) team received 223 referrals for the same period. 58% (130) of those referred had a diagnosis of cancer and 42% (93) of those referred had a non cancer diagnosis.

The SPC team provides specialist palliative care advice to colleagues, patients and their relatives. The role of the team includes assessment and care planning for patients with complex palliative care needs, information on disease process, treatment, medication, local and national services, advice on symptom control and psychological support for the patient and / or their carer.

The hospital had two multi faith rooms, a bereavement office, and a mortuary which was classified as a deceased holding unit.

We carried out an unannounced inspection on 1 November 2016 and returned again on 16 November 2016. We raised concerns with the hospital following our initial unannounced visit on the 1st November regarding the infection control of the mortuary area. The hospital responded by undertaking infection prevention and control review on 3rd November 2016. An action plan was put in place; this included a new cleaning schedule with weekly reviews for the following four weeks and monthly reviews thereafter and a deep clean of the environment and equipment. The trust reported that the site management team were assessing the risks and logistics associated with a specialist deep clean of the fridges. However, following a further unannounced visit on the 16th November we found that the initial issues raised were still outstanding.

On the 18 November 2016 the trust reported that the mortuary was closed on 17 November as a temporary measure for deep cleaning of the fridge to take place, which was scheduled for 23rd November. Contingency plans had been made for all deceased patients to be looked after by a local undertaker. The capital cost to replace the fridge from the current year's capital budget had been identified and the hospital's managing director reported that the estates team were sourcing a supplier and establishing the quickest route to replacement. The trust has since provided information regarding leadership and management of the mortuary, giving the hospital greater oversight and management.

During our inspection, we spoke with five patients and their relatives. We also spoke with over 19 members of staff, which included the consultant lead for palliative care, the SPC team, mortuary staff, chaplains, general nursing staff, medical staff, bereavement officer and porters.

We observed care and treatment within the wards, reviewed eight care records and 16 Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) forms. We observed the care of deceased patients within the mortuary. We reviewed the trust's performance data relating to end of life and palliative care.

End of life care

Summary of findings

We rated End of Life Care as requires improvement. This was because:

- The reporting process meant that the trust were unable to identify, review or learn from incidents or complaints that were related to end of life care. There were no risks identified on the risk register that related to end of life care. Minutes of one meeting stated that end of life care incidents were not easy to identify. The trust reported two incidents and zero complaints that related to palliative and end of life care between November 2015 and October 2016. This was raised as an issue at the last inspection.
- There were no specific care plans in place for patients receiving palliative and end of life care. The trust had developed a Compassionate Care Plan (CCP) to replace Liverpool Care Pathway (LCP). This was still not embedded across the hospital. This issue was raised as a concern at the last inspection and although progress has been made, further work is needed.
- The SPC team had 0.5 of a whole time equivalent (WTE) consultant in post. This did not meet the 'Commissioning Guidance for Specialist Palliative Care: Helping to deliver commissioning objectives' (Dec 2012.) which recommended a minimum requirement of 1 WTE consultant in palliative medicine per 250 hospital beds (NUH has 344 beds).
- There were poor standards of cleanliness, dignity and upkeep in the mortuary for which the hospital's senior management team knew little about and had poor oversight of. It was managed centrally from Royal London Hospital by the clinical support services, which operated trust wide.
- We found that the mortuary area was not clean. There were no daily cleaning check lists available for completion by staff. This meant the hospital had no assurance that areas were cleaned routinely and in a specific time scale.
- There was no policy or guidance in place for how the mortuary should be cleaned to ensure that health and safety requirements were met and that deceased patients were treated with dignity throughout cleaning processes.
- Within the mortuary we found that there was a hole in the wall exposing electrical cabling. Staff told us this had been reported in early October 2016. There was no signage on the fridges or in the mortuary to identify correct location of bodies to indicate how many days they had been stored in the fridges.
- We found that infection control procedures were not followed for safe storage of deceased patients. Fridge temperatures were not checked between 11th October and 1st November 2016 which meant the trust had no assurance that the body storage facility was at the correct temperature.
- There was no policy to determine correct transfer of deceased patients in the event of a fridge breakdown.
- Medical and nursing notes were not always easy to navigate, there were loose sheets and they were not in any order.
- Barts Health NHS Trust contributed to the National Care of the Dying Audit (NCDA) March 2016. The trust was below the England average on three out of the five clinical indicators and only achieved one out of the five organisational key performance indicators (KPI).
- An audit of the use of the CCP undertaken by the SPC team, showed that only 8 (28.6%) out of 28 sets of patient notes had a documented CCP in their notes.
- A hospital survey undertaken in July 2016 to identify awareness of patients approaching end of life was low amongst medical staff and clinical nurse specialists.
- The end of life CQUIN audit undertaken in August 2016 looked at 17 deceased patient notes. These showed that only 6 patients (35.3%) had their preferred place of death (PPD) documented and only one patient was transferred to their PPD.

End of life care

- Not all the patient records we reviewed had pain assessments on file, despite having diagnosed conditions which often cause pain and discomfort.
- T34 syringe pump training was not mandatory for all registered practitioners working on the wards.
- Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) audits for the period January 2016 to October 2016 showed that 66.6% (201) forms were completed incorrectly.
- Palliative care patients were not prioritised for side rooms. There was a lack of facilities for dying patients and their relatives; this meant that patients privacy and dignity was compromised.
- The results from the bereavement survey undertaken between January and September 2016 showed that only 23% (3) of the respondents rated their overall experience as excellent or good.
- The Fast Track process was not routinely audited; without this information, the hospital was unable to monitor their progress or improve.
- The trust was not routinely auditing patients' preferred place of care (PPOC). Without this information, they were unable to monitor their progress or improve.
- There were no designated facilities for relatives' or carers' overnight accommodation. Wards could provide chairs for relatives who wished to remain at their relatives' bedsides.
- The trust had an 'End of Life Care Strategy 2016 - 2019'. It had been ratified by the trust on the 19th October 2016. However, staff we spoke with were not aware that the strategy had been ratified by the trust and many nursing staff knew nothing about it.
- The trust had a draft business case to increased staffing to improve end of life care and specialist palliative care across the trust. However, this business case had not taken into consideration other services such chaplaincy and therapies and how they would link in to the overall vision of end of life care.
- There were no risks identified on the risk register that related to end of life care. However the 'end of life care key line of enquiry report' presented to the quality assurance committee meeting in September 2016 highlighted two risks. These related to the recruitment to of additional staff for end of life care.
- The trust carried out surveys for patient and staff satisfaction. However, these did not specifically identify end of life care results.

However

- There was guidance for prescribing palliative medication and guidance for use of anticipatory medication at end of life.
- The trust provided evidence of a maintenance schedule and asset list of syringe drivers including when they were purchased and last service date.
- We found that most patients under the care of the SPC team were prescribed anticipatory medication.
- We saw that the hospital had recently introduced 'End of Life Care Wednesdays'; a series of one hour interactive workshops led by the SPC team for all clinical staff.
- There was a weekly hospital palliative care multidisciplinary meeting. Medical staff, nurses, social services and the chaplaincy attended this meeting.
- The DNACPR forms were stored at the front of the patients' notes. They were easily identifiable and allowed easy access in an emergency.
- We saw that verbal consent to treatment was recorded in all the patient records we reviewed.
- Relatives we spoke with told us that the staff communicated with them and their relative in a way that helped them understand their care, treatment and condition. They told us discussions with staff had been handled very sensitively.
- We saw staff carrying out care with a kind, caring, compassionate attitude. Staff spoke to patients politely and respected their privacy and dignity, asking for consent to proceed with tasks.
- The chaplaincy service visited patients on a daily basis to provided support for patients and their relatives irrespective of their individual faith. They could be called upon 24 hour a day seven days a week.

End of life care

- Between April and October 2016 97% of the patients had been seen by the SPC team within 24 hours of referral.
- There were no visiting time restrictions for family and friends visiting a patient in the last days or hours of life. This allowed family and friends un-limited time with the patient.
- The trust had a defined management and governance structure for end of life care. The trust's Chief Medical Officer (CMO) and a Non-Executive Director had specific responsibility for end of life care on the trust board.
- The trust had an end of life strategy which identified priorities to improve care and treatment delivered at the last stages of life.
- The SPC team attended the trust wide palliative care team meetings which were held monthly.

Are end of life care services safe?

Requires improvement

We rated safe as requiring improvement because:

- There were two incidents reported which were related to palliative care between November 2015 and October 2016. We noted in the minutes of one meeting that end of life care incidents were not easy to identify. This meant that the trust were unable to identify and review incidents that may be related to end of life care. This was raised as a concern at the last inspection.
- The trust had developed a Compassionate Care Plan (CCP) to replace Liverpool Care Pathway (LCP). However, we did not see evidence that this document was embedded across the trust. There were no specific care plans in place for patients receiving palliative and end of life care. Medical and nursing notes were not always easy to navigate, there were loose sheets and they were not in any order.
- There was 0.5 of a whole time equivalent (WTE) consultant in post. This did not meet the 'Commissioning Guidance for Specialist Palliative Care: Helping to deliver commissioning objectives' (Dec 2012), which recommends a minimum requirement of 1 WTE consultant in palliative medicine per 250 hospital beds (NUH has 344 beds).
- We found that the mortuary area was dirty. There were no daily cleaning check lists available for completion by staff. This meant the hospital had no assurance that areas were cleaned routinely and in a specific time scale. There was no policy or guidance in place for how the mortuary should be cleaned, to ensure health and safety requirements were met, and deceased patients were treated with dignity throughout cleaning processes.
- Within the mortuary we found that there was a hole in the wall exposing electrical cabling. Staff told us this had been reported in early October 2016. We found that there was no signage on the fridges or in the mortuary to identify correct location of bodies to indicate how many days they had been stored in the fridges.
- We found that infection control procedures were not followed for safe storage of deceased patients. Fridge temperatures were not checked between 11 October

and 1 November 2016, which meant the trust had no assurance that the body storage facility was at the correct temperature and there was no policy to determine correct transfer of deceased patients in the event of a fridge breakdown.

However

- The trust provided evidence of a maintenance schedule and asset list of syringe drivers including when purchased and last service date.
- There was guidance for prescribing palliative medication and guidance for use of anticipatory medication at end of life.
- We found that most patients under the care of the SPC team were prescribed anticipatory medication.

Incidents

- There were no never events for the reporting period November 2015 to October 2016. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- There were two incidents reported that related to palliative care between November 2015 and October 2016; graded as low and the other as medium harm. One related to a medication error and the other related to a missing patient.
- A review of seven end of life steering group meeting minutes held monthly between January and October 2016 indicated that there was one reported incident about the end of life care. However we noted in the minutes of one meeting that end of life incidents were not easy to identify. This meant that the trust was unable to identify, review or learn from incidents that may be related to end of life care. This was raised as a concern at the last inspection.
- Incidents were reported through the trust's electronic reporting system. The SPC team we spoke with were familiar with the process for reporting incidents, near misses and accidents.
- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The legislation requires an organisation to disclose and investigate mistakes, and offer an apology if a mistake had resulted in a severe or moderate level of harm.
- Staff we spoke with in the SPC team, were aware of their responsibilities and principles with regard to duty of candour regulation.

Safety thermometer

- There were no dedicated wards for the provision of end-of-life care. The hospital used the NHS Safety Thermometer information, which was ward specific and did not directly relate to the end of life care. The SPC team did not have a measure of the safety and quality of their service in place.

Cleanliness, infection control and hygiene

- We found that the mortuary area was dirty. We observed various spillages of body fluid and dried body fluids on the floor. The fridges looked dirty mainly due to rust and staff told us that the trays in the fridges were only cleaned periodically. There were no daily cleaning check lists available for completion by staff which meant the hospital had no assurance that areas were cleaned routinely and within a specific time scale.
- We found that there was no policy or guidance in place for how the mortuary should be cleaned, to ensure health and safety requirements were met, and ensure deceased patients were treated with dignity throughout cleaning processes.
- Within the mortuary we found that there was a hole in the wall exposing electrical cabling. Staff told us this had been reported in early October 2016.
- We found that there was no signage on the fridges or in the mortuary to identify correct location of bodies to indicate how many days they had been stored in the fridges. We observed staff checking the identification label on a deceased patient before they were taken by the undertaker.
- We found that infection control procedures were not followed for safe storage of deceased patients.
- We found that fridge temperatures were not checked between 11th October and 1st November 2016 which meant the trust had no assurance that the body storage facility was at the correct temperature. Staff who were undertaking the fridge temperature checks were not aware of the temperature parameters that the deceased should be stored.

- The fridge was alarmed and alerts were sent directly to staff on call via the main reception should the temperature fall outside of the normal range. We saw that the hospital had a 'Fridge Temperature Alarm Escalation Standard Operating Procedure (SOP) for Out Of Hours (OOH)' dated 20.10 2016. This document stated that the 'site manager will arrange transfer of bodies to (appointed undertakers) and inform the Mortuary Service Manager via The Royal London Hospital if the fridges are not repaired within 2 hours of the alarm sounding. We saw that the last call out was on the 7th October 2016 and it took 2 hours for the fridge to be repaired. The mortuary had a service level agreement for repairs; the external contractor had a two hour time frame in which to respond when called. This meant that it could take up to four hours for the fridge to be fixed. We found that the 'Fridge Temperature Alarm Escalation SOP' had not been followed and there was no policy to determine correct transfer of bodies in the event of a fridge breakdown.
- In the mortuary there were no facilities for washing of the deceased. Staff told us that viewings were discouraged as porters are unable to wash the deceased.
- In the viewing area we found that soiled sheets and blankets had been left on a chair and not placed in a waste bag following a viewing that had occurred over night, and there was rubbish on the floor.
- We raised concerns with the trust leadership team immediately following our initial unannounced visit on the 1 November regarding the infection control of the mortuary area. The hospital responded to our concerns which have been reported in the overall summary of this report.
- The SPC team were aware of their roles and responsibilities with regard to infection control. We observed that SPC staff were bare below elbow and personal protection equipment (PPE) such as gloves and aprons as per trust protocol, were accessible on the wards we visited.
- Porters we spoke with said that they were aware of the PPE protocol for the mortuary and said they were able to access and dispose of the necessary equipment as required.
- Infection prevention and control level 1 and 2 training formed part of the mandatory training programme and was updated annually. The trusts target was 90% of staff having completed the training. Within palliative care medicine, 100% of nursing staff had completed infection prevention and control training. Compliance with infection prevention and control training was above the trusts target for nursing staff.

Environment and equipment

- In one of the multi-faith rooms cupboards that housed extractor fans for the ventilation of the outpatient departments and other clinical areas, were being used for storage of prayer mats, old boxes, chairs and light bulbs**.** This posed a health and safety risk.
- The mortuary was classified as a 'Deceased Holding Unit' and therefore was not subject to inspection by the Human Tissue Authority (HTA). The mortuary was equipped to store up to 12 deceased patients. There was no long term storage (freezer units), which were available at one of the trust's other acute hospital sites.
- Equipment was usually available to meet patient needs such as syringe drivers and pressure relieving equipment.
- Syringe driver equipment met the requirements of the Medicines and Healthcare Regulatory Agency (MHRA). The trust told us only one type of syringe pump was used at the hospital. This ensured continuity of care.
- The trust provided evidence of a maintenance schedule and asset list of syringe drivers including when purchased and last service date.
- Health and safety training formed part of the mandatory training programme. The trusts target was 90% of staff having completed the training. Within palliative care medicine 100% of nursing staff had completed the training. This was above the trusts target for nursing staff**.**

Medicines

- The specialist palliative care nurses worked closely with medical staff on the wards to support the prescription of anticipatory medicines. However, none of the specialist palliative care nurses were Nurse Prescribers. We were informed that one of the nurses was due to start a prescribing course.
- In patients records we saw that anticipatory medication had been prescribed and recorded in patient's drugs charts as per trust policy.
- There was guidance for prescribing palliative medication and guidance for use of anticipatory medication at end of life. The trust had a document for prescribing palliative medication and guidance for the

use of anticipatory medication at end of life. (Anticipatory medications refer to medication prescribed in anticipation of managing symptoms, such as pain and nausea, which are common near the end of a patient's life so that these medicines can be given if required without unnecessary delay.) It provided guidance on general principles for prescribing for the dying patient. It included use of continuous subcutaneous infusion (syringe driver medication) use of opioids for pain and dyspnoea, management of restlessness and agitation, management of pain using diamorphine, management of respiratory tract secretions and management of nausea and vomiting.

- There was one medication incident reported for end of life care between November 2015 and October 2016.
- Medicines management training formed part of the mandatory training programme. The trusts target was 90% of staff having completed the training. Within palliative care medicine 50% of nursing staff had completed the training. This was below the trusts target for nursing staff.

Records

- We reviewed the medical and nursing notes for eight patients who were receiving end of life care. The notes were not always easy to navigate. In three of the files there were loose sheets and they were not in any order which meant the notes would be difficult for staff to navigate.
- The Compassionate Care plan (CCP) was being rolled out across the trust. However, it was only in place in one of the records we reviewed. There were no specific care plans in place for patients receiving palliative and end of life care. We found some of the records did not document the patients' preferred place of care, some did not have pain assessments and in others mental capacity assessments had not been undertaken.
- In the patient notes there was detailed documentation of discussions with relatives. Where 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) forms were in place these indicated if there had been a discussion with the patient and or their relatives. All the forms had been signed by a consultant. We reviewed 16 DNACPR forms throughout the ward areas. All were kept at the front of a patient's notes, allowing easy access in an emergency.
- Information governance and clinical documentation training formed part of the mandatory training programme. The trusts target was 90% of staff having completed the training. Within palliative care medicine the 100% of nursing staff had completed the training. This was above the trusts target for nursing staff.

Safeguarding

- Staff had access to the trust's safeguarding policy via the trust intranet and knew how to access the safeguarding team for advice and guidance when required.
- Safeguarding adults and safeguarding children's level 1 and 2 training formed part of the mandatory training programme. The trusts target was 90% of staff having completed the training. Within palliative care medicine the 100% of nursing staff had completed the training. This was above the trusts target for nursing staff.

Mandatory training

- Staff were aware of the mandatory training they were required to undertake.
- The mandatory and statutory training programme included conflict resolution, equality and diversity, fire safety, health and safety, infection control levels one and two, information governance, moving and handling, resuscitation basic life support, safeguarding adults level 1 and 2, safeguarding children level 1 and 2.
- The trust's target for staff having completed their mandatory and statutory training was 90%. At the time of our inspection, compliance with mandatory training for nursing staff within palliative medicine was 94.6% and 100% for the chaplaincy team. This was above the trusts target for nursing and chaplaincy staff.
- Mortuary staff mandatory training was below the trust target of 90% for infection control levels one and two (50%) and information governance (50%).
- Portering staff mandatory training was above the trust target of 90%.

Assessing and responding to patient risk

- The results from the National Care of the Dying Audit 2016 were trust wide which meant an accurate understanding of NUH was not possible. However, it showed that the trust did better than the England average for patients recognised by the multi-disciplinary team as dying as 85%. The England average was 83%. 80% of patients across the trust were recognised as at end of life against a national average of 79%.
- The SPC team were rolling out a training programme for end of life care for all staff working on the wards. Staff

advised that sometimes wards had difficulty releasing staff for the training sessions and that on occasions no staff had attended. Staff we spoke with knew how to refer patients to the SPC team.

- There were daily morning handover meetings within the SPC team. Work was prioritised and patient visits were planned at these morning meetings.
- Advice and support from the SPC team concerning deteriorating patients was available on all wards. Staff on the wards informed us that the SPC team responded quickly to requests for advice and support.
- Although the hospital had withdrawn the Liverpool Care Pathway (LCP) from clinical practice in line with recommendations made in the publication: 'Independent Review of the Liverpool Care Pathway'. In its place the trust introduced the 'Compassionate Care Plan' (CCP) which reflected the '5 priorities of care for the dying person'. The CCP focused on encouraging staff, patients and families to continue with treatment in the hope of recovery, while talking openly about people's wishes and putting plans in place. The CCP was still not embedded within the hospital. Nursing staff informed us they had been trained to use the CCP but most staff we spoke with had not used the care plan. During the morning site safety brief, we heard staff make reference to the LCP.
- We saw that patients requiring end of life care were identified at the daily board round. This was a consultant led review meeting had replaced the traditional ward round due to confidentiality issues. Patients with DNACPR were also discussed.
- We reviewed the notes of eight patients. Risk assessments were in patient's notes. These related to moving and handling, risk of falls, and tissue viability. We saw that actions were documented to take place where risks were identified. For example; the risk of developing skin pressure damage was assessed using the Waterlow Score. Patients who were at risk of skin pressure damage were nursed on pressure relieving mattresses.
- We saw that the trust used the National Early Warning Score (NEWS) assessment tool for recording the observations of patients admitted to the hospital. This tool scored each aspect of patient's observations in order to prompt staff to follow clear procedures documented on the form. This meant that there was a system in place to monitor patient risk, including those patients receiving end of life care.
- DNACPR records had been signed and dated by appropriate senior medical staff and there was a clearly documented reason for the decision recorded on the form, with clinical information included. In the majority of cases, discussions with families were documented in the medical notes.

Nursing staffing

- The SPC team had one full time and one part time palliative care clinical nurse specialist (PCNS) in post that provided 1.6 whole time equivalent (WTE). There was also a vacancy for 0.4 PCNS. There was a 0.4 WTE PCNS team leader who worked across the trust, which encompassed four acute hospital sites. This met the 'Commissioning Guidance for Specialist Palliative Care: Helping to deliver commissioning objectives' (Dec 2012.) which recommends a minimum requirement of 1 WTE PCNS per 250 hospital beds.
- The SPC team were available Monday to Friday 9am until 5pm. The palliative care nurse specialists (PCNS) provided expert clinical advice and support for patients with complex palliative care needs and their families / carers. The PCNS role included assessment and care planning for patients with complex palliative care needs, information on disease process, treatment, medication, local and national services, advice on symptom control and psychological support for the patient and / or their carer.
- The SPC team informed us that end of life care link nurses were based on the wards. We saw that there was a training programme in place to help them identify patients who required end of life interventions. However some nursing staff we spoke with on the wards were not able to identify their link nurse.
- Nursing staff informed us they are able to access additional support and counselling from the nurse psychologist in the trust wide SPC team if they were distressed about losing a patient.

Medical staffing

- There were two part time palliative and end of life consultants that provided 0.5 WTE. Cover was provided four days per week. One consultant was based at the hospital and one was based at a local hospice. This did not meet the 'Commissioning Guidance for Specialist

End of life care

Palliative Care: Helping to deliver commissioning objectives' (Dec 2012.) which recommends a minimum requirement of 1 WTE consultant in palliative medicine per 250 hospital beds. NUH has 344 beds.

- The consultants took referrals from the SPC team based on the complexity of their needs and worked in an advisory capacity to consultants in other specialities.
- There was a 24 hour consultant telephone advice line for palliative care services which operated across trust sites, another NHS hospital and a local hospice.

Other staff

- The SPC team had designated administrative support, and a 0.6 WTE social worker (seconded). There was currently a WTE vacancy for an associate social worker.
- There was one full time mortuary attendant and general office co-ordinator for the mortuary service at NUH. The mortuary was managed by the clinical support services trust wide academic group that was over seen centrally. This meant that the NUH senior management had little oversight of the mortuary.
- Porters transported the deceased from the hospital wards to the mortuary and provided out of hours access.
- There was one full time bereavement officer who was available Monday to Friday 9am to 4pm.
- The bereavement officer and mortuary technician covered for each other when they were on leave. The mortuary technician would complete the death certificates and the bereavement officer would arrange viewings and release the deceased.
- The chaplaincy team comprised 0.8 WTE plus the lead chaplain who worked across the Barts NHS Trust sites. The Chaplains provided an on call service outside their working hours.

Major incident awareness and training

- There was a trust-wide major incident policy that was available to all staff via the hospital intranet.
- Mortuary staff told us that there were alarm systems in place to alert staff in the event of mechanical failure of the fridges. The fridge was alarmed with alerts going directly to staff on call via the main reception should the temperature fall outside of the normal range. On the occasion of an out of hour's fridge failure, the site manager would be contacted via the main reception to enable them to contact the on-call repair service.
- At NUH there were 12 spaces in the deceased holding unit.
- Emergency planning and fire safety formed part of the mandatory training programme. The trust's target was 90% of staff having completed the training. Within palliative medicine, 100% of nursing staff had completed the training. This was above the trusts target for nursing staff.

Are end of life care services effective?

Requires improvement

We rated effective as requires improvement because:

- Barts Health NHS Trust contributed to the National Care of the Dying Audit (NCDA). The trust was below the England average on three out of the five clinical indicators and only achieved one out of the five organisational key performance indicators (KPI).
- An audit of the use of the Compassionate Care Plan (CCP) undertaken by the specialist palliative care team showed that only 8 (28.6%) out of 28 sets of patient notes had a documented CCP in their notes.
- A hospital survey undertaken in July 2016 to identify awareness of patients approaching end of life was low amongst medical staff and clinical nurse specialists.
- The end of life CQUIN audit undertaken in August 2016 looked at 17 deceased patient notes. These showed that only 6 patients (35.3%) had their preferred place of care (PPOC) documented and only one patient was transferred to their PPOC.
- Not all the patient records we reviewed had pain assessments on file, despite having diagnosed conditions which often cause pain and discomfort.
- T34 syringe pump training was not mandatory for all registered practitioners working on the wards.

However

- Barts Health NHS Trust had an end of life care strategy plan 2016 - 2019. This had ratified by the trust in September 2016.
- We saw that the hospital had recently introduced 'End of Life Care' Wednesdays; a series of one hour interactive workshops led by the SPC team for all clinical staff.

End of life care

- There was a weekly hospital palliative care multidisciplinary meeting. Medical staff, nurses, social services and the chaplaincy attended this meeting.
- The DNACPR forms were stored at the front of the patients' notes. They were easily identifiable and allowed easy access in an emergency.
- We saw that verbal consent to treatment was recorded in all the patient records we reviewed.

Evidence-based care and treatment

- The specialist palliative care team told us that following the national withdrawal of the Liverpool Care Pathway in July 2014, the trust had produced the Compassionate Care Plan (CCP). This met the requirements for individualised care planning. The CCP guides delivery of the priorities of care for patients recognised to be in their last few days or hours of life, for whom no potential reversibility was possible or appropriate, and followed best practice.
- Barts Health NHS Trust had an end of life care strategy plan 2016 - 2019. This had been ratified by the trust in September 2016. The strategy reflected the National Institute for Health and Care Excellence (NICE) qualities standard 13 (NICE QS13), which defines clinical best practice in end of life care for adults, and the Department Health National End of life care strategy.
- Patient needs were assessed and care and treatment delivered in line with National Institute for Health and Care Excellence (NICE) quality standards. For example, clinical staff followed guidance relating to falls assessment and prevention, pressure ulcers, nutrition support and recognising and responding to acute illness.

Pain relief

- The trust had a guidance document for prescribing palliative medication and guidance for the use of anticipatory medication at end of life, which provided guidance for pain relief. (Anticipatory medications refer to medication prescribed in anticipation of managing symptoms, such as pain and nausea, which are common near the end of a patient's life so that these medicines can be given if required without unnecessary delay.) We saw evidence of appropriate prescribing, administration and documentation of medication.
- The hospital used syringe drivers for end of life patients who required a continuous infusion to control their pain. A syringe driver helps reduce symptoms by delivering a steady flow of injected medication continuously under the skin.
- Not all the patient records we reviewed had pain assessments recorded despite having diagnosed conditions which often cause pain and discomfort. In one record we saw that a relative had raised concerns about the pain the patient was in at night as they had to wait for analgesia. The patient's medication charts showed that the patient had been prescribed anticipatory medication for symptom control.

Nutrition and hydration

- Patients were assessed using the Malnutrition Universal Screening Tool (MUST) which identified nutritional risks. Nutrition and hydration risks were assessed and monitored on patients' records. Fluid balance and nutritional intake charts were held and completed at the patient's bedside.
- Nutrition and hydration was included in the CCP and in all end of life care provided.
- There was access to a specialist assessment from a speech and language therapist (for swallowing difficulties) and a dietitian.

Patient outcomes

- Barts Health NHS Trust contributed to the National Care of the Dying Audit (NCDA) March 2016. The trust was below the England average on three out of the five clinical indicators and only achieved one out of the five organisational key performance indicators (KPI).
- An audit of the use of the CCP undertaken by the SPC team showed that of the 28 case notes reviewed that: 25 (89%) of the notes reviewed were expected deaths; 26 (92%) of the notes had a DNACPR recorded; 8 (28.6%) of the notes had a documented CCP in their notes
- In July 2016 NUH undertook a survey which involved consultants, doctors and clinical nurse specialist to identify patients approaching end of life who were inpatients and out patients. The results highlighted that awareness amongst medical staff of patients approaching end of life was low and that further work was needed to be undertaken to help staff. Two areas for priority were: Identify patients who were approaching end of life; and have discussions with patients approaching end of life.

End of life care

- The end of life CQUIN audit undertaken in August 2016 looked at 17 deceased patient notes. The end of life CQUIN focused on key aspects that included 100% of expected deaths to have a CCP in place. The audit demonstrated that the trust was not meeting this target. (The Commissioning for Quality and Innovation (CQUINs) payments framework encourages care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare).
- These showed that: 7 cases (41.1%) had been admitted within the last 28 days of life; 13 cases (76.5%) could not have been managed in the community but 11 cases (64.7%) had a coordinated care plan in place; a Coordinated Care Plan was used in 4 cases (23.5%) and documented to be used in a further 2 cases (11.8%); there was documentation relating to the communication of dying in 13 cases (76.5%); a DNACPR form was included in 13 cases but was incomplete in 8 cases (61.5%), and in nearly all cases there was no nurse signature; a preferred place of care (PPOC) was documented in 6 cases (35.3%), however, it was not always clear that a death was expected; 1 patient was transferred to their PPOC, and 14 patients (82.4%) died or deteriorated too rapidly to transfer them to their PPOC.

Competent staff

- There were no nurse prescribers in the NUH SPC team.
- The SPC team had annual appraisals and access to clinical supervision to develop within their role.
- We saw that the hospital had recently introduced 'End of Life Care' Wednesdays; a series of one hour interactive workshops led by the SPC team for all clinical staff which covered the following: Improving communication at the end of life; holistic care planning at the end of life; compassionate care at the end of life; improving bereavement care; recognising the dying patient; improving communication at the end of life.
- However, staff informed us that it was not always possible for the wards to release staff for the training so on occasions no staff attended.
- End of life care was covered as part of the induction programme for medical and nursing staff. End of life care was also covered in the preceptorship programme for new nurses.
- The hospital ran a rolling training programme for nursing staff in the use if the McKinley T34 syringe pump. Information provided by the trust showed that only 50% of the SPC team had been trained in the use of the Mckinley T34 syringe pump. Across the wards information received from the trust shows that a total of 58% of the nursing staff had been trained. It was not mandatory for all registered practitioners working on the wards to be trained to use the T34 Syringe pump.
- The hospital had recently introduced a link nurses training programme in Foundations in Palliative Care which was a six module programme. To support the link nurses who were based on the wards end of life care link nurse group meetings had been planned for 2016 and 2017.
- Porters were trained in transportation of the deceased and were also trained to arrange viewings of the deceased. This enabled viewings of the deceased out of hours.

Multidisciplinary working

- There was a weekly hospital palliative care multidisciplinary team (MDT) meeting. Medical staff, nurses, social services and the chaplaincy attended this meeting. All palliative and end of life, cancer and non-cancer, patients were reviewed in relation to their care. This included the appropriateness of medicines. Patients who were discharged or had died were also reviewed, including ongoing support to their families.
- As part of the hospitals safety week a MDT end of life care ward round was undertaken to review patients who were approaching end of life across the hospital on different wards. Staff we spoke with felt that the MDT session had been useful and enabled some challenging discussions around patients approaching end of life.
- We saw that referrals to the SPC team came from the wards across the hospital and the team promoted referrals for both cancer and non-cancer referrals. The SPC team told us they worked hard to build good working relationships with all ward teams. They told us staff on all wards have been supportive of the SPC team.
- The bereavement office's main professional contacts were: doctors, nurses, mortuary technical staff, SPC team, coroner's officers, police, registrar of births, deaths and marriages, hospital chaplains and funeral directors.

Seven-day services

- The SPC team provided a face to face 9am to 5pm service Monday to Friday. NICE guidance (QS13)

recommends that palliative care services should ensure provision to: visit and assess people approaching the end of life face to face in any setting between 9am and 5pm, 7 days a week.
- Palliative care consultants delivered a 24 hr consultant advice line across Barts NHS trust sites, another NHS hospital and a local hospice.
- The Chaplaincy provided a Muslim and Christian 24 hr on call service. If other religious or spiritual needs were required the lead chaplain would source this.
- The mortuary service was open from 8am until 4pm Monday to Friday. Out of hours viewing was provided by porters.
- The bereavement office was open 8am until 4pm Monday to Friday. Arrangements were in place to issue death certificates out of hours on the grounds of religious or cultural needs.
- Out of hours the clinical site managers who were registered senior nurses supported the release of bodies assisted by the portering staff.

Access to information

- The DNACPR forms were stored at the front of the patients' notes. They were easily identifiable, this allowed easy access in an emergency.
- Staff had access to national guidance on ward computers which could access internet sites. They told us this was invaluable for accessing NICE guidance and other key reference documents.
- The SPC team nurses visited the wards on a daily basis to review patients at the end of life and to support ward-based medical and nursing staff in planning and delivering care to patients.
- There were end of life resource folders kept on some of the wards, offering staff information on where they could obtain additional support or advice and details of aspects of symptom management and care at the end of life.
- If patients required support, staff could access palliative support through the out of hours service.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw that verbal consent to treatment was recorded in all the patient records we reviewed. We observed staff explaining procedures, giving patients opportunities to ask questions, and seeking consent from patients before providing care or treatment.
- Staff were clear about their roles and responsibilities regarding the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS). Staff had received Mental Capacity Act training and various resources were available on the trust intranet, if staff needed more support.
- The trust had a core policy in place for Do Not Attempt Cardio Pulmonary Resuscitation that had been approved in January 2014 and was due for review in 2017.
- We reviewed 16 DNACPR forms throughout the ward areas. All were signed by a consultant and kept at the front of a patient's notes, allowing easy access in an emergency. However, in five of the forms reviewed we found there was no discussion recorded as having taken place with the patient or their relative and on four of forms there was no record of the patients' mental capacity assessment when the form indicated that the patient did not have capacity.
- We saw the trust carried out routine DNACPR audits. Between January 2016 and October 2016 303 DNACPR forms were reviewed which showed 66.6% (201) forms had been completed incorrectly. The main reasons identified were no record of a discussion with the patient and or relatives, no record of any advance decision and no mental capacity assessments.
- Staff informed us the DNACPR forms were not unified, which meant that a DNACPR form written in hospital becomes invalid when the patient is discharged. The trust advised that that their transport providers have confirmed that that DNACPR forms are valid until a patient is discharged from the Trust. This includes the last leg of a journey either to home or another destination, such as a hospice or nursing home. The patient remains under the trust's care until the transport provider has completed a handover to the receiving destination. Once in the community the patients GP needs to issue a community DNACPR which means that if there is a delay a patient could be at risk of being readmitted.

Are end of life care services caring?

Requires improvement

We rated caring as requires improvement because:

End of life care

- The hospital did not prioritise side rooms for patients requiring end of life care.
- There were no designated facilities on the hospital site for overnight accommodation; wards could provide chairs for relatives who wished to remain at their relatives' bedsides.
- Patients' privacy and dignity was compromised.
- The results from the bereavement survey undertaken between January and September 2016 showed that only 8% (1) of the respondents rated their overall experience as excellent, and only 15% (2) rated their experience as good.

However

- Relatives we spoke with told us that the staff communicated with them and their relative in a way that helped them understand their care, treatment and condition. They told us discussions with staff had been handled very sensitively.
- We saw staff carrying out care with a kind, caring, compassionate attitude. Staff spoke to patients politely and respected their privacy and dignity, asking for consent to proceed with tasks.
- The chaplaincy service visited patients on a daily basis to provided support for patients and their relatives irrespective of their individual faith, and they could be called upon 24 hour a day seven days a week.

Compassionate care

- We spoke with five patients and their relatives, they were positive about the end of life care provided at the hospital. A patient we spoke with said "staff were very kind" and the doctors take time to talk to him and his wife. Another patient told us that the care has been good. Relatives told us they had been kept informed of what was happening by the medical team. They told us discussions with staff had been handled very sensitively.
- One relative (female) we spoke with had been staying overnight in a six bedded ward with their father. The family had not been moved into a side room so had little privacy. In another patients record we saw that notes on three consecutive days stating that 'no side room was available' and one of the entry stated 'no side rooms available for palliative care patients in whole trust'. The record was unclear if the patient was moved into a side room before being transferred to a hospice.
- Staff told us that palliative care patients were not prioritised for side rooms. There was a lack of facilities for dying patients and their relatives. This meant that patients' privacy and dignity was compromised.
- Staff spoke to patients politely and respected their privacy and dignity, asking for consent to proceed with tasks. We saw that staff spent time talking to patients and those close to them.
- The hospital had a chaplaincy service. Staff we spoke with told us that not all the wards were good at contacting the chaplaincy service for patients. Staff we spoke with were aware of the chaplaincy service and how to refer patients to them. Staff told us that the chaplaincy team were easy to access.
- The bereavement officer told us they arranged visits for relatives who wished to view the deceased. They ensured that people could take the time they need and did not rush people so that they can say goodbye to their relatives and ask any questions they may have.

Understanding and involvement of patients and those close to them

- Patients we spoke with told us they felt involved in their care and understood their treatment and care plans. Patients described conversations with the doctors and consultants; they had been able to ask questions and had been told how their illness might progress.
- The SPC team and chaplaincy team provided support for patients and those close to them at end of life. Relatives we spoke with told us that the staff communicated with them and their relative in a way that helped them understand their care, treatment and condition.
- The trust provided information on the bereavement survey undertaken between January and September 2016. The survey was given to friends and relatives to complete at the time of their relative death and was collected from them when the relatives collected the death certificate. A total of 13 responses were returned.
- The results showed that: 77% (10) of respondents felt staff were approachable. 54% (7) of respondents felt they had been given choices in the care around the time of death and immediately afterwards. 46% (6) of respondents felt they had been given accurate information before the death and that it was given in a sensitive manner. 46% (6) of respondents felt that their relative/friend's religious/spiritual and cultural beliefs were considered by the staff caring for them. 31% (4) of

respondents felt they receive enough helpful and supportive information after the death of their relative. 8% (1) of the respondents rated their overall experience as excellent, 15% (2) rated their experience as good and 76% (10) did not respond to the question.
- The trust advised that to improve response rate, since October 2016 the trust bereavement survey was sent to next of kin six weeks following death
- In records we reviewed we saw that patients were involved in their own care and relatives were kept involved in the management of the patient with patient consent. We saw documented discussions with patients and their families regarding care and treatment.

Emotional support

- Ward, nursing and medical teams offered emotional support in addition to the SPC team.
- Support for carers, family and friends were also provided by the chaplaincy and bereavement services.
- The chaplaincy service was provided with a list of patients on a daily basis by the SPC team and visited patients on a daily basis to provided support for patients and their relatives irrespective of their individual faith, or if they did not follow a faith. They could be called upon 24 hour a day seven days a week. If patients were discharged the chaplaincy would contact the local parish priest or Imam.
- The chaplaincy team held worship services in the hospital's multi faith rooms which patients and or their relatives could attend.
- The patients and visiting family members we spoke with told us they felt emotionally supported by all the staff involved in their care.

Are end of life care services responsive?

Requires improvement

We rated responsive as requires improvement because:

- The trust did not routinely audit their fast track process; without this information, the trust was unable to monitor their progress or improve.
- The trust was not routinely auditing patients' preferred place of care (PPOC). Without this information, they were unable to monitor their progress or improve.
- There were no reported complaints between January and October 2016 about end of life care. However, we noted in the minutes of one meeting that end of life complaints were not easy to identify. This meant that the trust were unable to review complaints that may be related to end of life care.

However

- Between April and October 2016, 97% of the patients had been seen by the SPC team within 24 hours of referral.
- There were no visiting time restrictions for family and friends visiting a patient in the last days or hours of life. This allowed family and friends un-limited time with the patient.

Service planning and delivery to meet the needs of local people

- For all in-hospital deaths at NUH between April 2015 and March 2016, there were 377 referrals to the SPC team: 56% were non-cancer patients and 44% cancer patients. Between April 2016 and October 2016 there were 223 referrals: 58% were cancer and 42% non-cancer patients.
- For the period April and October 2016 97% of the patients referred had been seen by the SPC team within 24 hours of referral.
- The trust had a process to fast track patients to their preferred place of care (PPOC). This process aimed to support the timely discharge of patients at the end of life to enable them to die at home or in their place of choice. The trust was not routinely auditing the effectiveness of the fast track process, without this information, the trust was unable to monitor their progress or improve.
- However the trust provided information for the period January 2016 to October 2016 which showed that 50% patients on a fast track were discharged home or to another care facility (for example, residential or nursing home). 21% were discharged to NHS Continuing Care Beds. 1% (1 patient) was discharged to the Hospice. At least 19% of patients died in hospital. The hospital advised that they needed to explore if there were any issues that prevented the patients being discharged to their preferred place of death.

End of life care

Meeting people's individual needs

- There were no dedicated 'end of life' beds at the hospital. Patients who required end of life care were mostly nursed on general medical and surgical wards. The hospital did not prioritise side rooms for patients requiring end of life care. Staff we spoke with told us those patients recognised as being in the last hours or days of life were, where possible, nursed in a side room to protect their privacy and dignity. However, patients at the end of life were mostly cared for on open wards, as the use of single rooms were prioritised for patients who required isolation.
- Where patients were nursed in a side room, relatives were able to stay in the room with them and wards had access to appropriate facilities for relatives, for example, chairs and hot drinks.
- Nursing staff told us there were no visiting time restrictions for family and friends visiting a patient in the last days or hours of life. This allowed family and friends un-limited time with the patient.
- Whilst there were no designated facilities on the hospital site for overnight accommodation, wards could provide chairs for relatives who wished to remain at their relatives' bedsides. Some wards made their day room available for relatives to use on such occasions.
- The trust produced a leaflet called 'Coping With Dying'. This leaflet contained information about what was available to relatives and what to expect during the dying phase. The leaflet was available in other languages and large print on request.
- Staff told us interpreting services were available through a telephone service. Staff told us there were generally no delays in accessing this service when needed.
- There was a chaplaincy service at NUH. The team provided spiritual and pastoral care and religious support for patients, relatives and staff across the trust. Patients could refer themselves or staff alerted the chaplaincy team if a patient had asked to see them. A member of the chaplaincy team visited the wards daily; patients usually contacted the service during these visits.
- There were two multi-faith rooms on site, these were quiet spaces where people could pray or reflect. The multi-faith rooms were open 24 hours a day and were used by patients, relatives, carers and staff. Regular services were held in the multi-faith rooms.
- In the multi-faith rooms we saw that patients and their relatives were able to access a variety of religious books and literature in various faiths such as Hindu, Sikh, Buddhist, Judaism and Christian. The multi-faith rooms were also equipped so that different faiths were able to utilise the rooms for example, there was a sink for washing, shoe rack and the direction of Mecca was marked on the ceiling.
- The bereavement officer liaised with bereaved families and co-ordinated the issue of the medical certificate so that the death could be registered and the funeral arranged. The bereavement officer could book appointments with the registry office for relatives.
- The hospital had a mortuary and viewing area and there were washing facilities. There were no religious artefacts. Staff were available to answer questions and signpost relatives to appropriate people if they had any questions or queries. When we visited there had been a viewing overnight and the used sheets and blankets had been left on a chair. Relatives were able to view the deceased by appointment Monday to Friday between 9.00am and 4.00pm. Out of hours and at the weekends porters were able to facilitate viewing of the deceased.
- The hospital had a Macmillan Cancer information centre. It provided people affected by cancer access to comprehensive, appropriate information and support.
- The hospital had a dementia team to support people living with dementia and we observed that patients living with a learning disability where highlighted at the morning safety brief.

Access and flow

- There was a telephone referral system for the SPC team. Informal triaging took place throughout the day and any urgent referrals, for example where a patient was in pain, were prioritised.
- The SPC team had received 377 referrals between April 2015 and March 2016 and 223 referrals between April 2016 and October 2016. The number of referrals to the hospital specialist palliative care service appeared to be consistent over the 19 month period.
- Between April 2015 and March 2016 165 (44%) and April 2016 and October 2016 130 (58%) of the patients who had been referred to the SPC team had a diagnosis of cancer.
- Between April 2015 and March 2016 212 (56%) and April 2016 and October 2016 93 (42%) patients who had been referred had a non-cancer diagnosis.

End of life care

- The SPC team were visible on the wards. Nursing staff knew how to contact them. Referrals were made by telephone contact. Ward staff told us there were no delays for patients to be seen.
- The trust was not routinely undertaking patients' preferred place of care/death audits. Without this information, they were unable to monitor progress or improvement.
- The porters told us that they were able to respond to calls made requesting deceased patient transfer promptly. The hospital expected the porters to transfer deceased patients within 20 minutes.

Learning from complaints and concerns

- A review of seven end of life steering group meeting minutes held monthly between January and October 2016 indicated that there were no reported complaints about the end of life care. However, in the minutes of one meeting end of life complaints were not easy to identify and that clearer wording would be required to enable the correct coding of complaints. This meant that the trust were unable to review complaints that may be related to end of life care.
- We saw Patient Advice and Liaison Service (PALS) leaflets available around the hospital.
- Staff in the bereavement office told us that they try to resolve any concerns from relatives in a timely way to avoid escalation to a formal complaint.

Are end of life care services well-led?

Requires improvement

We rated well led as requires improvement this was because:

- The Newham University Hospital (NUH) senior management team had little oversight of the mortuary as the mortuary was managed centrally from Royal London Hospital by the Clinical Support Services which operated trust wide.
- The trust had an 'End of Life Care Strategy 2016 - 2019,' this had been ratified by the trust on the 19th October 2016. However staff we spoke with were not aware that the strategy had been ratified by the trust and many nursing staff knew nothing about it.
- The trust had a draft business case to 'increase staffing to improve end of life care and specialist palliative care across Barts Health NHS Trust'. However, this business case had not taken into consideration other services such chaplaincy and therapy and how they would link in to the overall vision of end of life care.
- The trust had developed a Compassionate Care Plan (CCP) to replace the Liverpool Care Pathway. We did not see evidence that this document was embedded.
- The hospital did not routinely collect information of the percentage of patients who died in their preferred location. Without this information, the trust was unable to monitor if they were honouring patient's wishes or if they needed to improve this.
- There were no risks identified on NUH or multi-site risk register related to end of life care. However the 'end of life care key line of enquiry report' presented to the quality assurance committee meeting in September 2016 highlighted two risks. These related to the recruitment to of additional staff for end of life care.
- The trust carried out surveys for patient and staff satisfaction, although these did not specifically identify end of life care results.

However

- The trust had a defined management and governance structure for end of life care. The trust's Chief Medical Officer (CMO) and a Non-Executive Director had specific responsibility for end of life care on the trust board.
- The trust had an end of life strategy which identified priorities to improve care and treatment delivered at the last stages of life.
- The SPC team attended the trust wide palliative care team meetings which were held monthly.

Leadership and culture within the service

- The trust had a defined management and governance structure for end of life care. The trust's chief medical officer (CMO) and a non-executive director had specific responsibility for end of life care on the trust board. There was also an identified site lead for end of life care at NUH that reported into the end of life steering group which reported into the trust board.
- Chaplaincy and bereavement services were line managed across the trust by the deputy chief nurse who is a member of the corporate nursing team. The head of chaplaincy and bereavement services also worked across the trust and was responsible for the

bereavement officer and the mortuary attendant. When we visited, the mortuary attendant had been absent for six weeks and there was no identifiable person to take a lead in their absence.
- The mortuary was managed by the 'clinical support services trust wide clinical academic group' that was overseen centrally from Royal London Hospital; this meant that NUH senior management team had little oversight of the mortuary or the standards it was being maintained to.
- The SPC team reported on its performance through their annual report. We saw a copy of the Specialist Palliative Care Annual Report 2015 – 2016 dated October 2015.
- All staff we spoke with were aware of who their immediate managers were and they were aware of the roles of the senior management team.
- Staff we spoke with told us the SCP team worked collaboratively with staff on the wards in providing end of life care. Staff were positive about the support provided by the SPC team.
- Staff we spoke with on the wards told us of their commitment to provide safe and caring services.

Vision and strategy for this service

- The trust had an 'End of Life Care Strategy 2016 - 2019,' which was based on the '5 priorities of care for the dying'. This had been ratified by the trust on the 19th October 2016. However staff we spoke with were not aware that the strategy had been ratified by the trust and many nursing staff knew nothing about it.
- The trust had a draft business case to 'increase staffing to improve end of life care and specialist palliative care across Barts Health NHS Trust'. A programme manager had been employed to manage the planning and eventual delivery of the business case and strategy. The business case was linked to the trust's priorities, objectives and plans and included the provision of a 24/7 palliative care consultant on call rota and 7 day working or nurses across all hospital sites. However, this business case had not taken into consideration other services such chaplaincy and therapy services how they would link in to the overall vision of end of life care. This highlighted that the trust had not clearly thought out how this agenda would link to all aspects of the trust work.
- The trust's values and behaviour statements were displayed on notice boards around the hospital, as well as on the trust's intranet and internet. Most staff we spoke with told us the trust's vision and strategy was publicised on the trust's intranet and on emails. Staff said they incorporated the trust's values and behaviours into their practice.

Governance, risk management and quality measurement

- Newham University Hospital contributed to the trust wide National Care of the Dying Audit (NCDA).This meant that the hospital was unable to be measure its performance to against clinical and organisational indicators.
- The trust had an end of life strategy, which identified priorities to improve care and treatment delivered at the last stages of life.
- The SPC team attended the trust wide palliative care team meeting which were held monthly.
- The trust had developed a care-planning tool, the Compassionate Care Plan (CCP), to replace the Liverpool Care Pathway. We did not see evidence that this document was embedded across the trust.
- The hospital had an end of life steering group which met on a monthly basis. We saw that it had a standardised agenda and had multidisciplinary representation.
- The hospital had a programme for end of life training and ad-hoc teaching sessions that was provided on the wards for staff.
- The hospital did not routinely collect information of the percentage of patients who died in their preferred location. Without this information, the trust was unable to monitor if they were honouring patient's wishes or if they needed to improve this.
- There were no risks identified on NUH or multi-site risk register related to end of life care. However the 'end of life care key line of enquiry report' presented to the quality assurance committee meeting in September 2016 highlighted two risks. These related to the recruitment to of additional consultant and nursing posts and the appointment of a lead nurse for end of life care.

Public and staff engagement

- The trust carried out surveys for patient and staff satisfaction, although these did not specifically identify end of life care results.

End of life care

- The hospital held regular patient forum meetings; however these were not just for patients and their relatives who were receiving palliative or end of life care.
- Patients and relatives were able to access the Macmillan cancer information centre which would provide information, support and signpost community groups and bereavement support.

Innovation, improvement and sustainability

- As part of the hospitals safety week a multidisciplinary team (MDT) end of life care ward round was undertaken to review patients who were approaching end of life across the hospital on different wards. Staff we spoke with felt that the MDT session had been useful and enabled some challenging discussions around patients approaching end of life.
- The hospital had an 'end of life grand round' which presented the outcome of recent audits and surveys related to end of life care. Grand rounds are an important teaching tool and help doctors and other healthcare professionals keep up to date areas which may be outside of their core practice.

Outstanding practice and areas for improvement

Outstanding practice

Medical care

- Safeguarding practices in the Greenway Centre were highly specialised and staff proactively developed these to meet the increasingly complex needs of the local population. This included multidisciplinary specialist input and monthly tracking of patients with specific needs, including through the provision of advocates who spoke Romanian or Portuguese.
- Staff took innovative steps to improve engagement with patients living with diabetes. For example, to improve the care of young people with diabetes, staff introduced remote video chat appointments. This reduced the number of wasted appointments and patients gave very positive feedback about the flexibility this afford them, including the reduced need to miss university lectures and the ability to 'attend' an appointment from overseas.
- Staff introduced innovative measures to improve access and flow, particularly at a weekend. This included the implementation of consultant-led discharge ward rounds and a new patient flow coordinator post. In addition staff had negotiated 24-hour, seven-day-a-week access to a social worker that meant complex discharges could be planned outside of the previous Monday to Friday model. This also meant vulnerable patients had faster access to professionals who could establish a package of care without the need to delay their discharge.
- An overseas team provided dedicated support to patients cared for on an inpatient basis who had complex needs relating to immigration, asylum or refugee status. This meant patients could be safely discharged with appropriate care and support in place, including for their legal status.
- There was a clear, sustained focus on offering opportunities to student nurses and medical trainees. Feedback from site visits by sponsoring universities were consistently good with continuous levels of compliance against quality markers for developmental education.

Areas for improvement

Action the hospital MUST take to improve

Importantly, the trust must:

Outstanding practice and areas for improvement

Services for children

- The trust must ensure incidents are investigated in a timely way and in accordance with published guidance. 12 (2)(b)

Maternity

- The trust must ensure steps are taken to provide additional consultant posts to mitigate the risks and meet the care and treatment needs for women and babies at NUH. 18 (1)
- The trust must ensure that measures to ensure the security of babies in maternity services are implemented. 15 (1)(b)
- The trust must ensure the backlog of incidents awaiting review are addressed; and serious incidents are correctly identified. 17 (2)(a)(b)(f)
- The trust must ensure learning from incidents, complaints and peer reviews is used for the purposes of continually evaluating and improving services.17 (2)(e)(f)
- The trust must ensure staff are clear about their roles and responsibilities under legislation around capacity and deprivation of liberty. 11(3) & 13(5)

Outstanding practice and areas for improvement

End of Life Care

Action the hospital SHOULD take to improve

- The trust must ensure that reporting processes are able to identify, review and learn from information that relates to the end of life care it provides such as through complaints, incidents and satisfaction surveys. 17(1)(2)(a)(b)
- The trust must ensure that the Compassionate Care Plan it has developed is embedded across the hospital. 9(3)
- The trust must ensure that it meets the national guidance ['Commissioning Guidance for Specialist Palliative Care: Helping to deliver commissioning objectives' (Dec 2012.)] which recommends a minimum requirement of 1 whole time equivalent consultant in palliative medicine per 250 hospital beds (NUH has 344 beds). 18(1)
- The trust must ensure that systems and processes are in place to enable proper management and oversight of the mortuary to be assured. 17(1)
- The trust must ensure that standards of cleanliness and hygiene are maintained in the mortuary. 15(1)(2)
- The trust must ensure that the premises and equipment within the mortuary are properly maintained and fit for purpose. 15(1)(c)(e)
- The trust must ensure there are systems in place to determine appropriate transfer of deceased patients in the event of a fridge breakdown. 17(1)
- The trust must ensure that pain for patients at the end of life, is properly assessed and treated. 9(3)(a)(b)
- The trust must ensure that Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms are completed correctly. 9(1)(a)(b), 11(1)
- The trust must ensure that due consideration is given to the privacy and dignity of patients at the end of life in relation to facilities available for them and their relatives. 10(1)(2)(a)
- The trust must ensure that systems are in place to effectively monitor the effectiveness of services provided to the dying patient in relation to its fast track process and patients' preferred place of care. 17(1)(2)(a)

Outstanding practice and areas for improvement

In addition, the trust should:

Medical care

- The trust should ensure learning from infection prevention and control audits is communicated to all staff.
- The trust should ensure interpreting services are readily and proactively provided to reduce the safeguarding risk associated with relying on relatives and friends to interpret clinical care.
- The trust should ensure the nutritional and hydration needs of patients are met. This includes patients with complex needs including dementia, co-morbidities and where they are cared for as a medical outlier.
- The trust should ensure premises and equipment are clean and secure in relation to the control of substances hazardous to health.
- The trust should ensure staffing levels are actively monitored and reflected accurately in daily safer staffing meetings. This means the senior nurse in charge on each ward should agree with the staffing level reflected by the site manager in the safety briefing.
- The trust should ensure staff are supported to work safely and effectively through the provision of consistent and structured support.
- The trust should ensure nurses have access to training and professional development in line with their career plans and/or professional development plan.
- The trust should ensure staff who wish to undertake additional qualifications relevant to their role are supported to do so.

Outstanding practice and areas for improvement

Surgery

- The trust should ensure there is clear differentiation between adult and paediatric resuscitation equipment on the resuscitation trolley.
- The trust should ensure there is good compliance with all steps of the World Health Organization surgical safety checklist.
- The trust should ensure that referral to treatment time is evidenced.
- The trust should ensure that all staff have level 2 safeguarding training and safeguarding children.
- The trust should ensure all staff have training in Mental Capacity Act and Deprivation of Liberty Safeguards.
- The trust should ensure that there is better feedback about incidents to surgery staff and that there is shared awareness of the top three departmental risks.
- The trust should ensure sluice room doors on surgical wards are kept locked and all chemicals are locked away in a cupboard.
- The trust should endeavour to recruit to anaesthetic staff grade vacancies.
- The trust should improve upon data collection of appraisal rates.
- The trust should improve upon Patient Reported Outcome Measures (PROMs) measures.

CYP

- The trust should ensure infection prevention and control on Rainbow Ward always complies with the trust's policies for infection prevention and control.
- The trust should ensure expressed breast milk is stored separately from other products.
- The trust should address maintenance issues in a timely way, ensuring thorough investigation and repairs.
- The trust should ensure CYP services should have a robust plan and system of clinical audit in place to monitor adherence to evidence based practice.
- The trust should ensure staff on the NNU make themselves aware of the UNICEF Baby Friendly accreditation programme, a global accreditation programme to support breast feeding.
- The trust should ensure Rainbow Ward delivers adequate post-operative pain management of children.
- The trust should ensure there are facilities for parents to prepare or purchase food.
- The trust should ensure there is a range of information leaflets for children and their parents or carers across both Rainbow Ward and the NNU.
- The trust should improve recovery facilities in theatres to ensure areas for children are child friendly with appropriate décor.
- The trust should improve on emergency readmissions for non-elective patients under the age of one year and children between the age of one and 17 years.
- The trust should develop a long-term local strategy for CYP services.
- The trust should ensure the agendas for governance meetings always reflect the governance meetings terms of reference.
- The trust should ensure identified risks are always included on the trust's risk register in a timely way, and record actions the service is taking to mitigate risks clearly on the risk register.

Outstanding practice and areas for improvement

Maternity

- The trust should ensure further recruitment to providing sufficient number of appropriately skilled midwives to meet the needs of the service.
- The trust should consider funding for staffing a second obstetrics theatre to improve waiting times for caesarean
- The trust should ensure better working relationships across the maternity service; fostering better communication and morale.
- The trust should ensure that midwifery staff are supported to attend the role specific training programme.

End of Life Care

- The trust should ensure that medical and nursing files are easy to navigate and in order.
- The trust should give consideration to all services that link in to the overall vision of end of life care, such as chaplaincy and therapies, in its draft business case to increase staffing.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Services for children 12 (2) (b) Incidents were not always investigated in a timely way and in accordance with published guidance.

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care End of life care 9 (3) The trust had developed a Compassionate Care Plan to replace Liverpool Care Pathway for end of life care patients. However, we did not see evidence that this document was embedded across the trust. An audit of the use of the Compassionate Care Plan (CCP) undertaken by the specialist palliative care team showed that only 8 (28.6%) out of 28 sets of patient notes had a documented CCP in their notes. 9(3)(a)(b) Not all the patient records we reviewed had pain assessments recorded, despite having diagnosed conditions which often cause pain and discomfort.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect End of life care

This section is primarily information for the provider

Requirement notices

10 (1)(2)(a)Palliative care patients were not prioritised for side rooms and there was a lack of facilities for dying patients and their relatives.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment End of life care 15 (1)(2) We found that infection control procedures were not followed for safe storage of deceased patients in the mortuary (deceased holding unit). We found that the mortuary area was dirty and there were no daily cleaning check lists available for completion by staff. 15 (1)(c)(e) Within the mortuary we found that there was a hole in the wall exposing electrical cabling. Staff told us this had been reported in early October 2016.

Regulated activity	Regulation
Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance End of life care 17 (1) The mortuary (deceased holding unit) fridge temperatures were not checked between 11 October and 1 November 2016. There was no policy to determine correct transfer of deceased patients in the event of a fridge breakdown. 17 (1)(2)(a) The end of life CQUIN audit undertaken in August 2016 looked at 17 deceased patient notes. These showed that only 6 patients (35.3%) had their preferred place of care (PPOC) documented and only one patient was transferred to their PPOC.

This section is primarily information for the provider

Requirement notices

17(1)(2)(a)(b) The trust must ensure that reporting processes are able to identify, review and learn from information that relates to the end of life care it provides such as through complaints, incidents and satisfaction surveys.

Maternity

17 (2)(a)(b)(f) Not all incidents had been correctly identified as a SI. We saw examples where similar outcomes had been categorised differently and the reason given by the trust did not follow their own guidance on categorisation as it was stated in the trust's adverse incident policy. In another incident we saw it met the trust criteria for a SI however it had not been recorded as such. There was a backlog of more than 150 incidents waiting to be reviewed, which had led to a delay in learning. The trust were working closely with commissioners to review overdue incidents and SI's with a plan for completion by December 2016.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing End of life care 18(1) The trust must ensure that it meets the national guidance ['Commissioning Guidance for Specialist Palliative Care: Helping to deliver commissioning objectives' (Dec 2012.)] which recommends a minimum requirement of 1 whole time equivalent consultant in palliative medicine per 250 hospital beds (NUH has 344 beds).

Regulated activity	Regulation
Maternity and midwifery services	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Maternity

This section is primarily information for the provider

Requirement notices

13 (5) Most staff we spoke with were not clear about their roles and responsibilities under legislation around capacity and deprivation of liberty. Staff responses were variable and several staff thought it was about health and safety issues.

Regulated activity	Regulation
Maternity and midwifery services	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Maternity 15 (1)(b) At the previous inspection, security had been identified as a risk because of insufficient staff to monitor access out of the unit. Visitors were admitted without checking their names or who they were visiting, which was a potential risk to women and babies. On the labour ward, a visitor log was kept by the person at the reception desk. The only mitigation was continuous recorded CCTV in the main reception, observable by security staff. However, there were only two site security staff. At this inspection we found a similar situation. We observed members of the public being let into wards without any checks about who they were.

Regulated activity	Regulation
Maternity and midwifery services	Regulation 18 HSCA (RA) Regulations 2014 Staffing Maternity 18 (1) There was insufficient consultant cover resulting in less than 50% of women in labour with a consultant present on the labour ward. Staff told us this meant patients were waiting longer for pain relief and treatment. Out of hours medical cover at all levels was overstretched, leading to delays in care. The trust had not approved the proposal to fund additional consultant posts at the time of our inspection.