Barts Health NHS Trust

The Royal London Hospital

Quality Report

Whitechapel Road, Whitechapel
London E1 1BB
Tel: 020 7377 7000
Website: http://www.bartshealth.nhs.uk

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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	
Accident and emergency	
Medical care	
Surgery	
Intensive/critical care	
Maternity and family planning	
Services for children & young people	
End of life care	
Outpatients	

Summary of findings

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Overall summary

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

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

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

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

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

Summary of findings

The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

Are services safe?

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

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

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

Are services effective?

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

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

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

Are services caring?

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

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

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

Are services responsive to people's needs?

Generally services were responsive to people's needs. In some areas of the hospital, patients' needs were not being met. While some improvements had

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been made in some areas, essential checks on patients did not always happen. There were problems with patient flow through the hospital, bed occupancy and discharge planning. This was having a negative impact on patients' experiences.

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

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

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

Are services well-led?

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

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

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

Accident and emergency

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

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

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

Medical care (including older people's care)

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

Surgery

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

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

There were systems in place for patients to provide comments and complaints about their care and treatment. However, the information regarding how to

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provide feedback was not readily available. Complaints were logged and a response was provided, however, not all staff were encouraged to participate in resolving the complaint and there was limited evidence of learning from complaints.

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

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

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

Intensive/critical care

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

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

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

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

Maternity and family planning

At the time of our inspection, the maternity and neonatal intensive care unit (NICU) were providing safe, effective care and were responsive to the needs of people who used the service. Most of the women we spoke with were pleased with the antenatal and maternity care they received. They felt they had been

given sufficient information and support. Women were particularly complimentary about the care they had received during labour and from the breastfeeding team. However, we found that some people had had some negative experiences on the postnatal ward.

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

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

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

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

Services for children & young people

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

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

The staffing levels were perceived by nursing staff and parents to be safe but did not always meet national guidelines for staffing in children's services. The quality of the service was monitored by managers and a number of risks to patient care had been identified and escalated to the trust Board. We also saw

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that a number of improvements had been introduced, for example, the introduction of a new paediatric early warning bedside documentation system. However, it was evident that some aspects of clinical governance and learning from incident reporting was not embedded in the children's services. We identified a significant incident that had not been reported.

End of life care

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

Outpatients

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

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

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What people who use the trust's services say

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

Areas for improvement

Action the trust MUST take to improve

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

Good practice

Our inspection team highlighted the following areas of good practice:

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

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Detailed findings

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

Our inspection team

Our inspection team was led by:

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

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

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

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

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

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

- Accident and emergency (A&E)

Detailed findings

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

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

During the inspections we:

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

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

Are services safe?

Summary of findings

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

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

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

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Patient safety

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

Staffing

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

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

Learning from incidents

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

Equipment

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

Hospital infections and hygiene

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

Are services effective?

(for example, treatment is effective)

Summary of findings

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

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

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

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Clinical management

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

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

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

Staff skills

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

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

Collaborative working

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

Are services caring?

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

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

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

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Patients' views and feedback

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

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

Privacy and dignity

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

Food and drink

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

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

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

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

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

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

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Patient flow through the hospital

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

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

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

Discharge planning

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

Information

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

Complaints

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

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

Are services well-led?

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

Summary of findings

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

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

Our findings

Leadership and clinical governance structures

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

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

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

Organisational culture and staff morale

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

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

Accident and emergency

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

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

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

Summary of findings

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

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

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

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

Accident and emergency

Are accident and emergency services safe?

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

Patient safety

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

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

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

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

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

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

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

Caring for children

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

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

Staffing

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

using agency staff, the department aimed to use the same agency nurses, who were trained in accident and emergency. Also, all agency staff received an orientation on arrival in the department for the first time.

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

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

Equipment

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

Learning from incidents

The department demonstrated a strong commitment to improving practice through learning from incidents. It had a high level of incident reporting. Since 1 October 2012, 908 incidents had been reported in the department. Staff told us this was reflective of the open learning culture of the department. Incidents were reviewed by senior staff in the department to identify any learning that needed to be implemented. Staff we spoke with were able to clearly describe learning points that had been identified from recent incidents and how these were being actioned to prevent similar things happening again. We were told that when an incident was reported, an e-mail was automatically sent to other staff in the department so they were aware of the incident and any safety implications.

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

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

Are accident and emergency services effective?

(for example, treatment is effective)

Patients were seen and treated effectively by appropriate staff.

Clinical management/guidelines

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

The department was in the process of developing a number of 'care bundles' for set conditions. Conditions for which bundles had already been developed included radial fractures, fractured neck of femur (hip joint) and renal colic. This project aimed to take national guidelines and use them to develop key standards that the department would

aim to meet. It would also look at how best to ensure that these standards were delivered and performance audited on an ongoing basis. We saw the example of a new patient information page that was being used for patients who arrived with a fractured neck of femur. This information sheet included key stages to be completed within timescales, such as delivery of analgesia. A formal audit was being undertaken of the quality of care for patients with this type of fracture and staff were confident it would show an improvement in care.

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

Communication

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

Staff development

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

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

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

Links with local GPs

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

Are accident and emergency services caring?

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

Patients' views and feedback

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

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

The department was gathering patients' opinion through the NHS Friends and Family test. No other formal method was being used to collect patient feedback. Since April 2013, patients attending hospital wards and A&E departments have been asked: 'how likely are you to recommend our ward/A&E department to friends and family if they needed similar care or treatment?' Their responses to this are used to calculate a score about

satisfaction with the service. So far, the A&E department has received an overall score of 56 out of a possible top score of 100, which is better than the A&E average for England which is 52.

Privacy and dignity

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

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

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

Food and drink

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

Information availability

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

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

(for example, to feedback?)

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

Waiting times

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

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

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

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

Pathway of care

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

Accident and emergency

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

Responding to the needs of children

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

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

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

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

Caring for people with mental health needs

The department had a dedicated 'place of safety' room for people who arrived under section 136 of the Mental Health Act 1983 or those who may have mental health needs. There were plans to develop a second, 'ligature-free' room to decrease the risk of self-harm for patients with mental health problems. Members of staff from the local mental health trust were situated on the department 24 hours a day. The team gave patients access to medical staff, mental health nurses and approved mental health professionals. This arrangement facilitated the prompt mental health assessment. Staff told us they felt they had a good working relationship with the wider department.

Working with the ambulance service

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

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

Paperless department

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

Complaints

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

Are accident and emergency services well-led?

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

The department was jointly managed with the emergency departments at the trust's other hospitals. We saw evidence that, following the trust merger in 2012, the

departments had begun to work more closely together. We were told that recent cross-department appointments had been made, with consultants employed to work in all the trust's A&E departments.

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

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

Medical care (including older people's care)

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

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

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

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

Summary of findings

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

Medical care (including older people's care)

Are medical care services safe?

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

Patient safety

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

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

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

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

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

The wards were using safety briefing books, these were updated at each staff handover and recorded the beds of patients with specific needs, such as those requiring support with eating, or those at risk of falls. They were also used to record any problems with equipment. We noted that these books had been completed and that, on each shift, 'safety briefings' were held where staff discussed these issues.

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

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

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

Staffing

There were not always sufficient numbers of nursing staff on the medical wards. The trust was in the process of reviewing nursing staffing levels and we were told that the new staffing structure would be put in place by the end of December 2013. Senior nurses told us that staffing levels were based on the patients' dependency needs. However, there was no formal assessment tool in place to allow

nurses to assess patients' level of dependency. Senior nurses told us that any additional nursing staff had to be authorised by one of the senior managers. Staff said that sometimes there were delays in approving additional staff, which meant that some of the shifts remained uncovered. Nursing staff on the medical wards told us that sometimes there were not enough staff on duty to enable them to deliver good and safe care.

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

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

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

Managing risks

Patient records showed that the risk of developing blood clots, pressure sores, catheter and urinary tract infections were managed in most cases. However, due to staff shortages on some of the wards, documents were not always being completed, therefore there was not always a record of how these risks had been managed. The trust had 'intentional rounding' in place, a system where staff walk around the ward or clinical area to check on the welfare of patients at a minimum of every two hours. Patients' files we looked at showed that staff did not always complete each person's chart. This meant that there was no written evidence that two-hourly checks were being carried out. One of the ward managers told us that staff did not always see the value of completing documentation, however, efforts were being made to ensure that staff understood the purpose of recording all types of care offered and care delivered, as well as any refusals by the patients. We noted that records of two-hour intentional rounding on the AAU were being completed.

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

Hospital infections

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

Medical care (including older people's care)

Safeguarding procedures

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

Patient records

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

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

Medical equipment

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

Are medical care services effective? (for example, treatment is effective)

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

Staff skills

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

Learning from past incidents

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

Are medical care services caring?

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

Patient feedback

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

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

Patient treatment

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

Food and drink

We received mixed comments about food offered in the hospital. Some patients told us they were unhappy that

there were no microwave ovens or toasters on the wards. This meant that meals brought in by relatives could not be reheated. Also, people told us that if a patient was not on the ward during meal times, they would not be able to be served a warm meal.

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

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

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

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

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

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

Management of flows
Some nursing staff told us that some beds were being occupied by patients who were physically fit for discharge, but were staying in the hospital because they were waiting for arranged services, such as packages of care, or for suitable housing. As some of the patients did not live in the local area, there was a risk that delays may occur because of the complexity of dealing with different local authorities.

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

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

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

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

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

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

Staff told us they used LanguageLine, a telephone translating service for patients and relatives who did not

speak English. Interpreters could be booked, however, there were sometimes reported delays in making bookings and using interpreters. For example, an interpreter had been booked for the family of an unconscious patient so that medical staff could discuss treatment options and other issues with the person's family, however, there was a delay in arranging the meeting. We were also told that some staff working in the hospital would translate on behalf of patients.

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

Are medical care services well-led?

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

Leadership

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

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

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

Staff morale

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

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

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

Surgery

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

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

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

Summary of findings

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

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

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

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

There were staffing and equipment issues in theatre and a significant number of cancelled operations. There was

reliance on bank (overtime) and agency staff to cover shifts in both theatres and on the surgical wards. They were sometimes inexperienced and this was impacting on the department's efficiency

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

Are surgery services safe?

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

Patient safety

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

The high risks associated with the management of pre-operative patients were not always effectively managed. The surgical wards used standard criteria to identify high-risk patients. Once identified, these patients, about 10% of all surgical patients, were all seen by consultant anaesthetists pre-operatively to ensure they were fit for surgery. However, it was identified that high risk cardiac patients, who could deteriorate while undergoing their pre-operative assessment – for example, undergoing a stress test – could not be safely transferred to the A&E or Coronary Care Unit CCU if their condition became unstable. While some staff had completed resuscitation training, the lift linking the two departments was inadequate as it could not safely accommodate a patient trolley. The arrangement of undertaking these tests on the second floor placed patients at risk in the event of an emergency.

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

There was a trust-wide strategy for the management of pressure ulcers that included specific roles and responsibilities, such as a dedicated Tissue Viability Nurse (TVN) team. We were told that the number of patients

coming into hospital with a pressure ulcer and those acquiring one while in hospital was increasing. Some patients told us that they had acquired a pressure ulcer during their stay in hospital. Staff said that they requested specific equipment such as a pressure-relief mattress, but there weren't enough available which resulted in delays delivering this equipment to the ward.

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

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

Managing risks and incidents

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

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

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

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

Equipment

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

We also found that the theatre department did not have sufficient paediatric bronchoscopy equipment; this placed

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

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

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

Hospital infections and hygiene

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

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

Staffing

There were not always appropriate numbers of skilled theatre staff to provide safe care in theatres. We were told that the lack of permanent nursing staff in theatre was impacting on patient care, as a high number of agency staff (in some cases inexperienced) in specialist surgery theatres were being used to cover vacancies and staff absences. This arrangement was reported to be very stressful in emergency situations when teams had to rely on agency staff who may not know where to find equipment that was needed. In specialist surgical theatres this was also reported to be leading to delays in surgery and in setting up equipment as these staff was unfamiliar with the specialist surgical equipment. This resulted in patients' operations taking longer than they would if permanent staff were present. This inappropriate additional time in theatre was unnecessary and, at times, reduced theatre capacity. The staffing rotas that we saw confirmed that a high number of bank and agency staff had been used and there were several unfilled shifts. For example, on 10 October 2013, there were six unfilled staff nurse shifts. Staff in theatres had escalated this issue and we noted that it was included on the department's risk register.

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

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

Surgery

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

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

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

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

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

Are surgery services caring?

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

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

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

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

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

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

Patients' feedback and complaints
Patients' experiences and complaints were used to improve the service and the effectiveness of treatment. Some matrons we spoke with were clear about the trust's complaints procedure and were able to provide examples

of how they had responded to patient feedback. For example, extending the opening hours of the infusions service for neurology, meaning that patients could go into work for half of a day then to go and have their infusions, losing half a day rather than a whole day's wage.

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

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

Responding to patients' needs

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

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

Discharge of patients

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

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

Accessible information

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

Are surgery services well-led?

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

Leadership

Staff in surgery told us that they felt well supported by the matron and consultants. Ward staff in many areas felt their wards were well managed by the ward sister, for example, ensuring there were always some permanent staff on duty to supervise and work with the agency staff. There was effective team working between the nursing and medical

staff who worked well together and supported each other. However, we did witness an incident of bullying in theatre when an individual's behaviour towards a junior member of staff was unacceptable. We were also informed of incidents of bullying of clinical staff by middle managers.

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

The trust is currently in consultation with nursing staff regarding the re-banding of some clinical posts. Nursing and medical staff raised concerns about the impact on patient care of these changes and, while they had had an opportunity to comment on the proposal, they did not feel listened to and had no confidence that the managers would take their views into account. Staff felt disempowered and demoralised by these changes, stating that for some posts, several nurses were competing for the same post, the trust was using online assessments rather than face-to-face interviews. Staff felt this approach was unfair. Some staff groups, for example, the laboratory and nursing staff, reported a lack of promotional opportunities. Some students told us this would influence their decision about if they would apply for a post in the trust when they qualified. While others were very keen to secure a post in wards they had worked in because they stated the ward was well-led and they felt valued.

Managing quality and performance

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

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

Intensive/critical care

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

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

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

Summary of findings

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

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

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

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

Intensive/critical care

Are intensive/critical services safe?

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

Patient safety

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

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

Critical Care Outreach Team

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

Staffing

The unit had completed a quality and safety audit in July 2012, which found that there were enough qualified medical and nursing staff available to meet patients' needs. However, during our inspection, we noted that there were not always enough appropriately trained staff to meet patients' specialist needs. The critical care unit had reduced their vacancy rate from 25% to 11%, which had reduced the unit's need to cover vacant posts with agency staff, who may not be familiar with the unit layout and patients' needs.

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

The environment

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

Hospital infections and hygiene

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

Medical equipment

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

Intensive/critical care

Are intensive/critical services effective? (for example, treatment is effective)

Services were generally effective and followed national guidelines.

Clinical management and guidelines

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

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

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

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

Patient mortality

A national independent survey by the Intensive Care National Audit &Research Centre (ICNARC) highlighted that the numbers of unplanned readmission was relatively low. The comparative figures showed that the Royal London unit had a higher number of delayed discharges and out-of-hours (after 10pm) transfers to the wards. A similar number of people died in ITU than would be expected, given the area, age and health of the population the hospital serves. A monthly mortality meeting with medical and nursing staff took place to monitor and understand why people might die on the ward so improvements could be made.

Staff skills

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

Are intensive/critical services caring?

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

Feedback from patients and relatives

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

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

Patients' privacy and rights

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

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

Intensive/critical care

Are intensive/critical services responsive to people's needs?
(for example, to feedback?)

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

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

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

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

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

Are intensive/critical services well-led?

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

Leadership
The critical care unit was well-led. Senior managers and clinicians had a good understanding of the performance of their department. Staff we spoke with stated that there was effective team working which promoted a team approach to care delivery. The unit held weekly consultant meetings to discuss mortality. Nurses were encouraged to attend these meetings and their opinions were sought.

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

Maternity and family planning

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

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

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

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

Summary of findings

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

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

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

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

Maternity and family planning

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

Are maternity and family planning services safe?

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

Patient welfare and safety

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

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

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

Maternity and family planning

Equipment

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

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

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

Safeguarding

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

Managing risk

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

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

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

Infection control

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

Staffing levels

At the time of our inspection, there were sufficient staff to meet the needs of women on the unit. However, some staff raised concerns about capacity to cope at busy times, especially when there were unexpected absences. We were told that there was a directive not to use agency staff, but shifts could not always be covered by the services' internal bank staff. The trust's midwife-to-birth ratio was one

midwife for every 32 births, which was fewer than national recommendation of 1:28. Staff told us there were times when they were unable to provide one-to-one care to women in established labour.

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

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

Are maternity and family planning services effective?
(for example, treatment is effective)

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

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

Benchmarking and national guidelines

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

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

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

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

Research

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

Collaborative working

We observed a staff handover on the labour ward and postnatal ward. Both were well attended. On the high-risk labour ward, handover was attended by consultants and doctors in addition to the midwives. NICU and maternity, including fetal medicine, worked closely together to ensure that any potential admissions to NICU were identified as earlier as possible. At the time of our inspection MCAs were excluded from handover on the postnatal ward. We were

told that this was so they could clean the ward. The provider may find it useful to note that some of the MCAs we spoke with told us this was a challenge as it meant that they did not know what the women under their care might need unless a midwife told them.

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

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

Staff skills

Midwives had statutory supervision of their practice and access to a supervisor of midwives for advice and met them formally on an annual basis. Midwives told us the service provided good development opportunities and that they were supported to attend mandatory training. Midwives rotated throughout the service to prevent their skills from becoming limited to one area. The provider may find it useful to note that some maternity care assistants (MCA) we spoke with felt they had a lot of responsibility. While they confirmed they had received appropriate training to carry out tasks, they felt it was beyond their salary grade.

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

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

IT and administrative support

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

Are maternity and family planning services caring?

Maternity services at the Royal London Hospital were caring.

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

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

Privacy and dignity

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

Maternity and family planning

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

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

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

Are maternity and family planning services responsive to people's needs? (for example, to feedback?)

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

Accessible services

People felt that their needs had been met at each stage of their pregnancy and no concerns were raised about accessing the service. The MFAU was open seven days a week and there was a maternity triage operating 24 hours a day. In response to a high number of emergency caesareans, the service had allocated five delivery rooms to induction of labour procedures to improve the process for women. There was also an "early labour lounge" for people who were in the early stages of labour and did not need to be admitted, but who felt anxious about returning home. There was a good flow of women through the maternity pathway and we found no evidence of delayed discharges.

In the year preceding our inspection, services had been suspended twice due to bed shortages. We were told that this was a result of other services in the area having to close and their patients being transferred to Royal London Hospital.

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

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

Accessible information

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

Maternity and family planning

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

Continuity of care

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

Patients' feedback and complaints

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

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

Are maternity and family planning services well-led?

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

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

Leadership

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

Service culture

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

Managing quality and performance

The service monitored the quality and safety of care. The service was part of the women's and children's clinical academic group (CAG), which was responsible for the service. Each CAG was assigned a lead for risk and clinical governance who was responsible for monitoring progress along with ward management. Risks specific to the service had been identified and action plans put in place. There was a performance dashboard for the service produced monthly and included indicators such as, delivery rates, complaints and staffing levels. We found evidence that lessons were learned from audits and root cause analyses following incidents, which were shared with staff effectively. However, the risk register for the women's and

children's directorate, which had not been updated since July 2013, did not easily identify risks associated with maternity and did not include the trust's high level or emergency caesarean sections.

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

Services for children & young people

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

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

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

Summary of findings

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

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

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

Services for children & young people

Are services for children & young people safe?

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

Managing risks

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

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

Communication and handover

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

Critical care

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

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

Staffing

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

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

ward; the challenges of caring for children and families who were long-term inpatients and the physical layout of the wards which were spacious but had limited sightlines in places.

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

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

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

Safeguarding children

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

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

Hygiene

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

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

Security

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

We saw that confidential patient records were stored in an open trolley on the wards near the nurses' station. The

station was not continuously manned and the records were not properly secure. Staff told us they had reported their concerns about the lack of lockable storage for patient records but this had not yet been addressed.

Are services for children & young people effective?
(for example, treatment is effective)

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

Clinical management and guidelines

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

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

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

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

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

Staff skills and support

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

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

Are services for children & young people caring?

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

Patient feedback

Parents and children said the staff were kind. One parent said, "they are compassionate, they really want to help get [my child] better and well". Another said, "It's been a really positive experience". Most parents told us communication was good, and their child's treatment was explained to them in a way they could understand and they were kept informed. One parent said, "We were encouraged to ask questions, as many as we needed and to repeat them if necessary". Another parent whose child had been in hospital for some time said, "Staff listen and ask for my observations. I have become part of the team". Parents of children with longer-term conditions consistently said they worked "in partnership" with the hospital staff.

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

Services for children & young people

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

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

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

Are services for children & young people responsive to people's needs?
(for example, to feedback?)

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

Facilities for children and young people

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

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

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

Accessible information

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

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

Are services for children & young people well-led?

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

Leadership

Paediatric services are part of the women's and children's CAG which was still under development. The senior managers and paediatric matrons from all the hospital sites within the trust met monthly to review quality and performance and we saw the notes of recent meetings. Quality issues were communicated to staff through a variety of methods, including handover meetings and

'purple folders' which were available on every ward and unit. Some of the nursing staff said they would like to have more opportunities to meet as a team and discuss ideas for improvement.

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

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

Managing quality and performance

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

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

End of life care

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

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

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

Summary of findings

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

End of life care

Are end of life care services safe?

Patients received safe end of life care.

Patient safety

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

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

Patient records and end of life decisions

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

Staffing

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

Are end of life care services effective? (for example, treatment is effective)

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

Clinical management and guidelines

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

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

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

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

Are end of life care services caring?

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

Patient feedback and support

The two relatives who we spoke with told us that they were satisfied with the quality of care offered by the staff. One person told us that medical staff explained the process and they felt involved in the decision-making process. One of the relatives told us, "We are quite happy with the care provided and we are happy with the hospital. Staff are very

End of life care

welcoming. I can see there are shortages of staff, I can't fault them though. The doctor came to discuss what was happening and explained everything, including medication, to me".

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

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

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

Staff feedback

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

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

(for example, to feedback?)

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

Patients' rights and wishes

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

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

Patient records and end of life decisions

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

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

Patient information

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

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

End of life care

Are end of life care services well-led?

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

Leadership

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

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

Managing quality and performance

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

Outpatients

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

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

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

Summary of findings

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

Outpatients

Are outpatients services safe?

Patients received safe and appropriate care.

Patient safety

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

Safeguarding patients

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

Hygiene and the environment

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

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

Patients told us the outpatient services were generally effective.

Clinical management

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

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

Staff skills

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

Are outpatients services caring?

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

Patient feedback

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

People were often positive about the advice and care they received during their consultation or the course of diagnostic tests. However, some people told us they waited a long time to receive an appointment. This particularly affected the spinal fracture clinic with six of seven patients we spoke with reporting problems accessing the clinic.

Outpatients

Staff told us this was an ongoing problem with this service. Senior outpatient managers were aware of the issues and said they worked with each clinical team to identify the root cause of problems.

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

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

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

Patients' privacy

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

Are outpatients services responsive to people's needs?

(for example, to feedback?)

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

Patients' feedback

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

Waiting times

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

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

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

Outpatients

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

Meeting patients' needs

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

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

Accessible information

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

Are outpatients services well-led?

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

Leadership

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

Managing quality and performance

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

Good practice and areas for improvement

Areas of good practice

Our inspection team highlighted the following areas of good practice:

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

Areas in need of improvement

Action the hospital MUST take to improve

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

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records. The registered person must ensure patients are protected against the risks of unsafe or inappropriate care and treatment by maintaining an accurate record of the care and treatment provided to patients. Regulation 20.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment. The registered person must protect patients who may be at risk from the use of unsafe equipment by ensuring equipment is properly maintained, suitable for use and available in sufficient quantities to meet patient need. Regulation 16 (1)(a)(2).

This section is primarily information for the provider

Compliance actions

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services. Patients were not protected from the risks of receiving care or treatment that is inappropriate or unsafe in such a way as to reflect published good practice guidance from professional and expert bodies. Regulation 9(b)(iii).