

Barts Health NHS Trust

The Royal London Hospital

Quality Report

The Royal London Hospital
80 Newark Street
London
E1 1BB

Tel: 020 7377 7000

Website: <http://www.bartshealth.nhs.uk/our-hospitals/the-royal-london-hospital/>

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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	Inadequate	
Urgent and emergency services	Requires improvement	
Medical care	Requires improvement	
Surgery	Inadequate	
Critical care	Good	
Maternity and gynaecology	Requires improvement	
Services for children and young people	Inadequate	
End of life care	Inadequate	
Outpatients and diagnostic imaging	Requires improvement	

Summary of findings

Letter from the Chief Inspector of Hospitals

The Royal London Hospital in Whitechapel, East London is part of Barts Health NHS Trust and provides acute services to a population of approximately 242,000 living in Tower Hamlets and surrounding areas of the City of London and East London. The hospital serves a highly deprived population with a higher than average proportion of ethnic minority population, with Bangladeshi being the largest single group with 30% in Tower Hamlets.

The trust employs around 15,000 staff with approximately 1703 nursing and midwifery staff based at the hospital.

We inspected this location in a direct response to the concerns we found at Whipps Cross University Hospital, another hospital run by the trust and concerns raised by a number of sources including members of the public and commissioners. We spoke with approximately 150 patients and relatives and over 350 members of staff.

Overall, we rated this hospital as 'inadequate'. The critical care service was rated as good however we found that urgent and emergency care, medical care including care of older people, surgery, maternity and gynaecology services and outpatients and diagnostic imaging all required improvement. We found that services for children and young people and end of life care was inadequate and significant improvement is required in these core services.

In order to provide safe, effective and responsive care that is well led to the needs of patients, this hospital requires significant improvements.

Our key findings were as follows:

- The organisational structure of the Clinical Academic Groups did not always facilitate robust and effective governance arrangements and visible local leadership.
- Hospital specific performance information was not always available and senior leaders did not have the information they needed to be assured about the quality and safety of the service being provided.
- There was a culture of bullying and harassment and we have concerns about whether enough is being done to encourage a change of culture to be open and transparent.
- The trauma and emergency service provided excellent outcomes for patients.
- Staffing was a key challenge across all services. there was a high use of bank and agency nursing staff and locum medical staff who were not always familiar with the hospitals policies and processes and did not always have access to IT systems that held patient information.

Safe

- There was not always enough nursing and medical staff to ensure safe care. However there was a high fill rate on bank and agency which meant when it was identified that staff were needed they were provided. Whilst some areas were displaying safety thermometer information, they were not displaying planned and actual nursing and nursing assistant/healthcare assistant staffing numbers and who was in charge for each shift in the clinical area that was accessible to patients, their families and carers, in line with NHS England guidance.
- There was not sufficient information documented in patients records to ensure safe quality of care.
- Patients needs were not always assessed and responded too.
- Safeguarding arrangements were in place and were followed in most circumstances, although we identified some instances where this was not the case.
- Most staff were familiar with the incident reporting system. However lessons learnt were not always known or widely shared with staff. Within surgery there had been three Never Events relating to wrong site surgery within a three month period and not all staff were aware of the learnings from these incidents. At the time of our inspection there were 100 incidents overdue for investigation in the children's and young people service.
- The WHO Surgical Safety checklist was not sufficiently audited.
- Medicines management was variable, but overall was safe.

Summary of findings

- Infection control principles were adhered to and monitored in most areas apart from hand hygiene auditing in some surgical theatres.

Effective:

- Most staff lacked an understanding of the Mental capacity Act 2015 and Deprivation of Liberty Safeguards (DoLs) and how it applied to their roles.
- Evidence-based care and treatment was provided. However some guidelines and policies were out of date regarding children and young people and end of life care.
- There was lots of multidisciplinary working, and seven-day working was in progress across all disciplines. The services had good joint up working with mental health specialists.
- Patient outcomes were at or better than the national average across most medical and surgical specialties.
- Overall pain relief was well managed.
- The nutrition and hydration needs of patients were met.
- Patients were largely given sufficient information about their treatments and had the opportunity to discuss any concerns.

Caring:

- Staff were caring and compassionate and interacted well with patients.
- Most patients and relatives were satisfied with the care and support they received and felt that staff listened to them and were compassionate.
- Patients had their privacy and dignity respected.
- Information was available to people and shared with them so they could be fully informed about their care.
- Chaplaincy and bereavement services demonstrated a caring and compassionate approach to working with people.

Responsive:

- The average bed occupancy from April to December 2014 was 95%. This impacted on the flow of patients throughout the hospital. Patients were cared for in recovery, or transferred out of critical care for non clinical reasons.
- The emergency department was not meeting the national four-hour waiting time target. This target was introduced by the Department of Health for NHS acute hospitals in England, and sets a target that at least 95% of patients attending emergency departments must be seen, treated, admitted or discharged in under four hours.
- The hospital was persistently failing to meet the national waiting time targets. Some patients were experiencing delays of more than 18 weeks from referral to treatment (RTT). The trust had suspended reporting activity to the department of health and had started a recovery plan.
- Patients well enough to leave hospital experienced significant delays in being discharged because of documentation needing to be completed.
- Operations were often cancelled due to a lack of available beds.
- Complaints were not always managed in a timely or appropriate manner.
- Bereavement services were well organised and responsive to people's needs.
- Plenty of information was available to patients in written form; however, this information was only provided in English, and not in the language of the predominant population served by the hospital.
- Translation services were available when required.

Well-led:

- Performance dashboards and information was unreliable. Senior staff did not always have the information they needed to have oversight of the services they led.
- There were some examples of good local leadership, and most staff felt supported by their immediate line managers. However, the trust-wide senior managers did not support local managers well.
- Governance and risk management was monitored in some instances, but improvements were not consistently made.

Summary of findings

- Innovation was prevalent in the trauma and emergency centre.
- The financial position of the trust impacted on the volume of innovation, improvement and sustainability initiatives of the services.

We saw several areas of outstanding practice including:

- Senior staff were trialling the Multidisciplinary Action Training in Crises and Human Factors initiative (MATCH). This was a framework within which Never Events and Serious Incidents could be discussed in an environment characterised by mutual respect and in which lessons learnt could be quickly introduced without damaging personal relationships. It was reported that initial results had been very promising. However, staff reported that whilst there had previously been plans to introduce this across the Trust, the financial pressures meant this was on hold.
- The hospital is a pioneer in trauma care. 25% of the patients attending the trauma service as an emergency had penetrative wounds, which is significantly higher than any other UK trauma centre. However, the survival rate at the hospital was better than the national average and the service had regular national and international visitors wanting to learn from the service. The service had worked with the Armed Forces whilst on combat operations and had taken specific learning from this and applied it to the service.
- In particular, the Trauma service in conjunction with military colleagues had developed the concept of the 'platinum ten minutes' based upon techniques used to help save the lives of soldiers in combat situations. Through the use of fluid, plasma, active surgical intervention and rapid assessment at the scene more patients were arriving at hospital alive.
- The Royal College of Physicians audit of stroke care rated the hospital as 97.5% for patient experience from diagnosis to rehabilitation - the highest result in London.
- A surgeon had become the first in the UK to broadcast online a live surgical procedure using a pair of Google Glass eyewear. The procedure was watched by 13000 surgical students around the world from 115 countries and they also had the opportunity to ask the surgeon questions.
- In the week following the inspection the service was running an initiative entitled "Stepping Into the Future". This was a trial run of a new operating model that, it was hoped, would help relieve some of the flow and access issues in the service. Initiatives that would be tried would include ring fenced surgical elective beds, no non-clinical cancellations on the day, surgery not starting without an available ITU/HDU bed, and trauma and orthopaedics to concentrate on emergency admissions only.

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

Importantly, the hospital must:

- ensure safety is a sufficient priority in all services.
- ensure all services are well-led.
- take further action to improve and address the perceived culture of bullying and harassment.
- address the capacity issues across the hospital.
- ensure performance dashboards and information are reliable and service specific. Senior staff must have the information they need to have oversight of the services they lead.
- address the lack of data specific to services at the hospital.
- ensure governance and risk management processes are robust and embedded throughout the hospital.
- ensure incidents are investigated promptly and the learning from incidents, complaints and never events is shared across the services.
- ensure audits are carried out to identify areas for improvements and implementation is monitored.
- ensure all policies are based on current and best practice guidelines.
- urgently improve security in the maternity services.
- ensure staff carry out and document assessments of patient's needs to ensure the planning and delivery of care meets their needs.

Summary of findings

- ensure nursing records are completed fully and accurately to ensure patient safety.
- ensure there are sufficient numbers of suitably qualified, skilled and experienced medical staff to meet the needs of patients. In particular in maternity and children's services.
- ensure there are sufficient numbers of suitably qualified, skilled and experienced nursing staff to meet the needs of patients. Staffing levels must meet the Royal College of Nursing staffing guidelines and the Core Standards for Intensive Care Units.
- take definitive action to reduce the Referral to Treatment Time and ensure accurate reporting.
- reduce the number of cancelled procedures and operations.
- ensure the induction process for agency staff working in critical care needs to be consistent and monitored.
- ensure all staff have an understanding of their responsibilities under the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards. Staff in Urgent and emergency services clearly understood their role however other services were not clear.
- ensure there is enough surgical equipment for children.
- ensure the do not attempt cardio-pulmonary resuscitation (DNA CPR) form and the new DNA CPR policy are clear and in keeping with any recent ruling or guidance.
- ensure that all relevant ward staff receive training specific to managing patients at the end of their lives.
- ensure there is a policy on the consistent use of opioids.
- reduce patient waiting times in outpatient clinics.

The trust should:

- ensure all staff follow infection prevention and control guidance in all medical services.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Urgent and emergency services

Requires improvement

Rating



Why have we given this rating?

The service was not consistently meeting national targets, some patients had longer waits because there was not enough beds in the hospital. Staffing levels were managed well, and recruitment arrangements were on-going. The service had been proactive in developing courses to increase the number of children nurses within the department. The environment was clean and there was consultant cover 24 hours a day, seven days a week because it was a trauma centre. Patients felt well cared for and staff told us they were supported by their peers and management. Patients received evidence-based care and treatment. However the governance structure was not robust and meetings lacked detail and incidents, complaints, risk and audits were not consistently discussed in a meaningful way. We saw evidence that clinical audits had been planned for the year, but we were not provided with evidence that they had been undertaken or reported on. Feedback and learning from incidents were limited and improvements were needed to ensure accurate records were maintained and that there were suitable prompts for staff to follow to ensure all patient needs had been met and recorded.

Medical care

Requires improvement



We found areas of good performance. However, there were aspects of the services that demonstrated variable, average or worse than average performance. The safety of medical services was compromised by the frequent occurrences of staff shortages, inconsistency in following trust infection prevention and control measures and poor recording of patient risk assessments. Patients experienced good outcomes and where performance was worse than average the trust had worked with stakeholders to improve. Policies and procedures were written to meet national guidance, but staff reported there were limited local protocols available to them. Patients' pain relief and nutritional needs were mostly met. Seven-day working was partly in place and there were plans in

Summary of findings

progress to make further improvements. Multidisciplinary working was embedded throughout medical services and most areas reported excellent team working. Patient feedback was positive and the Friends and Family Test response rates, although variable, showed some improvement. We observed interactions with patients that were professional, compassionate and caring. There was appropriate patient flow from admission to discharge and recent changes to improve the assessment of patients with complex needs or requiring continuing care were having positive effects. Patients living with dementia were supported adequately, particularly in the stroke and elderly care wards. However, there was a need to ensure patients with dementia received appropriate care in every area of the trust. Leadership at a local level was visible and supportive, but many staff were still unaware of the CAG senior managers. Many staff reported a culture of bullying and harassment and reported behaviours that could be characterised as such.

Surgery

Inadequate



There was no department wide learning from incidents or complaints and the service did not accurately monitor the number of Never Events that occurred. There had been four Never Events and a small proportion of the WHO surgical safety checklist were audited. There was a heavy reliance on bank and agency staff who did not always have access to the electronic patient records and local policies and protocols. The service was not confident in the data for 'Referral to Treatment Times' and were not reporting externally. Internally the service reported that the 18 week target was not being met and operations were frequently cancelled. There was minimal senior leadership across the service and limited vision for the service. However, the department achieved good surgical outcomes for patients. Staff provided treatment and support in a caring and compassionate manner. There were some good examples of local leadership and innovation. The trauma centre was effective and innovative.

Critical care

Good



Patients and relatives who we spoke with were positive about the care they received and the

Summary of findings

support from the staff that looked after them. The ACCU was a consultant led service which provided cover in accordance with the Intensive Care Standards (ICS). There was a clear vision about the service that the staff wanted to provide a quality service. There was a commitment to delivering a multidisciplinary collaborative approach to care and treatment which was evidenced based and followed national and best practice guidance. The unit had a daily safety huddle meeting which staff were encouraged to attend: the purpose was to ensure that staff were aware of any quality improvement strategies, changes and dissemination of information.

Recruitment of new nursing staff had seen the vacancy rate decrease from 25% to 8%, there had been a reduction in the use of agency and bank shifts. During the inspection patient acuity was high; the unit was utilising higher numbers of staff to meet the increased needs of the patients.

There was a positive culture about incident reporting, the investigative process was clear and transparent with lessons learnt clearly identified. However, one of the areas identified in lessons learnt was about safety checks being 'signed-off' on critical care observation charts by the nurse responsible for patient care. During the inspection we identified at least five critical care observation charts that had not had the safety checks signed-off. The unit had a system in place to verify the identity of agency and bank nurses but this was not being used consistently or recorded.

Maternity and gynaecology

Requires improvement



The accommodation was clean and high quality and we saw some excellent team working and some innovative initiatives. However there were not enough medical and midwifery staff and there was evidence that this compromised the care offered to some women. Women in labour were prioritised but this meant that other areas were often short-staffed with an impact on waiting times for other women. We also had some concerns about security of mothers and babies because of the high number of visitors at all hours. We had no significant concerns about safety or security in gynaecology.

Summary of findings

There was a systematic approach to clinical governance which included process for reviewing and learning from serious incidents, complaints and a programme to update guidelines to promote consistent practice across the trust.

Midwifery staff and trainee doctors spoke highly of their training. A values and behaviour programme had been launched in maternity services across the trust to improve the way staff interacted with women and with each other and to improve the standard of care. There were positive comments about this programme from staff and from many women who had used the service, although women made some adverse comments about waiting times in antenatal clinics and for discharge. Bereaved women were sensitively supported.

The hospital took part in national audits and carried out some local audits to assess and evaluate the effectiveness of care provision. The results of these were presented to staff although audit data was not always benchmarked against other hospitals other than those within the trust.

Outcomes for women and their babies in maternity services were similar to other hospitals.

Leadership for maternity and gynaecology services was provided by the women's and children's health clinical academic group (CAG). This did not appear to provide an effective route from ward to board and neither doctors nor midwives felt that their concerns about safety, or the sustainability of working under pressure were acknowledged by management. Data to support management of the service was of variable quality and could not be generated through the IT system.

Services for children and young people

Inadequate



There were significant nursing shortages in paediatric surgery, and no acuity tool was used to determine staffing numbers. In the neonatal unit there was a risk to child safety because of the low numbers of nurses qualified in the specialty. Staffing levels on the paediatric critical care unit did not meet Royal College of Nursing staffing guidelines.

Audits were not routinely completed, local and national guidelines were out of date and senior staff told us that performance data was unreliable. Patient outcome information was limited because

Summary of findings

of a limited audit programme. We found effective multidisciplinary working across children's services at the hospital. A range of weekly, multidisciplinary meetings took place that allowed staff from across the various services to discuss, plan and reflect on patients whose care needs did not fit a standard treatment pathway.

Throughout our inspections on all wards, we saw staff treat patients and their parents with dignity and respect. All of the parents and relatives we spoke with were positive about staff, who they referred to as caring and friendly. They said the care they and their child received was kind, compassionate and supportive.

There was limited service provision for adolescents and inadequate support for children and young people with learning disabilities.

There was no voice, vision or strategy for children's services at an executive level. Local clinical and nursing leads showed a passion and vision for the future of the service, but they were not engaged in shaping the future of the service. Performance data to monitor the quality of the service that was being provided was unreliable. Several local and senior leaders told us that they had given up trying to get their voice heard by the executive, and that they just did what they were told.

There was a 'them and us' separation conveyed between staff and the executive team. We were told by many staff that there was a punitive culture. There was a culture of not reporting incidents in paediatric surgery because staff did not feel that it was a useful process, as they had not seen changes made when they had reported previous incidents. Despite these failures of executive leadership, staff had a strong bond at a local level, and felt supported by their immediate colleagues.

End of life care

Inadequate



The service lacked clear leadership and strategy - it had no influence within the clinical academic group (CAG) structure. The service was not able to understand how complaints or incidents might relate to end of life care, the hospital was not measuring the quality of services delivered to patients receiving such care. Limited action had been taken in response to the 2013 review of the Liverpool Care Pathway (LCP)

Summary of findings

and at the time of the inspection the pathway had not been replaced. 50% of 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms we reviewed had not been fully completed. Staffing shortages had an impact on the service's ability to provide good care and we found examples where patients receiving end of life care were not being properly supported.

Outpatients and diagnostic imaging

Requires improvement



The service was not always responsive to the needs of their patients. The hospital was persistently failing to meet the national waiting time targets for non admitted patients and had stopped reporting. Appointments were cancelled more often than the national average and clinics frequently ran late. Patients were not always informed about the reasons for delays.

Performance and monitoring data which would have assisted the department to develop and improve its services was not collected and available to staff. Action had not been taken to address identified issues raised by staff.

Staff were caring and compassionate and patients were involved and understood their care and treatment.

Medical records storage was not fit for purpose; and there were issues with tracking and prepping of medical records at the hospital.

There were several speciality clinics such as cardiology and breast surgery as well as one-stop clinics for maternity and gynaecology specialities at the hospital run by clinical nurse specialists. This meant patients could be seen quickly, assessed and treated at the same time without the need to go home and come back for treatment or a follow-up appointment after initial consultation.

The Royal London Hospital

Detailed findings

Services we looked at

Urgent and emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and gynaecology; Services for children and young people; End of life care; Outpatients and diagnostic imaging

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Background to The Royal London Hospital

The Royal London Hospital in Whitechapel, East London is part of Barts Health NHS Trust and provides acute services to a population of approximately 242,000 living in Tower Hamlets and surrounding areas of the City of London and East London. The hospital serves a highly deprived population with a higher than average proportion of ethnic minority population, with Bangladeshi being the largest single group with 30% in Tower Hamlets.

The private finance initiative (PFI) Royal London Hospital opened on 1 March 2012. It 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. It is a trauma and emergency centre and a hyper acute stroke unit (HASU). The hospital also provides specialist tertiary care services and is the base for the London air ambulance.

The hospital has 671 beds across 31 wards.

Royal London Hospital is part of Barts Health NHS Trust established in 2012. It is the largest NHS trust in England. It has a turnover of £1.25 billion, serves 2.5 million people and employs approximately 15,000 staff. The trust comprises 11 registered locations, including six hospital sites in east and north-east London (The Royal London Hospital, Newham University Hospital, Mile End Hospital, St Bartholomew's Hospital, The London Chest Hospital and Whipps Cross University Hospital) as well as five other smaller locations.

Our inspection team

Our inspection team was led by:

Chair: Diane Wake, Chief Executive, Barnsley Hospital NHS Foundation Trust

Head of Hospital Inspections: Siobhan Jordan, Care Quality Commission (CQC)

Inspection Lead: Hayley Marle, CQC

The team of 40 included CQC inspectors, a planner, analysts and a variety of specialists: consultants in

emergency medicine, medical services, gynaecology and obstetrics, palliative care medicine, anaesthetist, physician and a junior doctor; midwife; surgical, medical, paediatric, board level, critical care and palliative care nurses; physiotherapist, an imaging specialist, outpatients manager, pathologist, child and adult safeguarding leads, a student nurse; and experts by experience.

How we carried out this inspection

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

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

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

- Urgent and emergency services (A&E)
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and gynaecology
- Services for children and young people
- End of life care
- Outpatients and diagnostic imaging

Before our inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included

Detailed findings

the clinical commissioning groups (CCGs), NHS Trust Development Authority, Health Education England, General Medical Council (GMC), Nursing and Midwifery Council (NMC), Royal College of Nursing (RCN); NHS Litigation Authority and local branches of Healthwatch.

A number of organisations, members of the public and current staff raised concerns about the quality of the service being provided at the hospital.

In November 2014 we carried out an announced inspection to Whipps Cross University Hospital, where we rated the hospital as inadequate and had concerns about the other hospitals run by Barts Health NHS Trust. We carried out an announced visit between 21 and 23 and unannounced visits on Saturday 30 January 2015, Wednesday 4 and Friday 6 February 2015. We observed

how people were being cared for and talked with patients, carers and/or family members and reviewed personal care or treatment records of patients. We held focus groups with a range of staff in the hospital including doctors, nurses, midwives, allied health professionals, and administration staff. We interviewed senior members of staff at the hospital and at the trust. A number of staff attended our 'drop in' sessions to talk with a member of the inspection team.

The CQC inspection model focuses on putting the service user at the heart of our work. We held a listening event in Whitechapel on 14 January 2015, when approximately 15 people shared their views and experiences of the Royal London Hospital.

Facts and data about The Royal London Hospital

1. Context

- The site is the largest standalone acute hospital building in Europe. It is one of six hospitals run by Barts Health NHS Trust which is the largest NHS Trust in the country.
- The main commissioner of the acute services is Tower Hamlets clinical commissioning group (CCG).
- It serves a population of more than 2.5million from Tower Hamlets. The population of Tower Hamlets is statistically worse than the national average for deprivation, under 16s in poverty, statutory homelessness, violent crime, long term unemployment, obese children (year 6), drug misuse, recorded diabetes, incidence of tuberculosis (TB), acute sexually transmitted infections, life expectancy for male and female, infant mortality, smoking related deaths, killed and seriously injured on the roads and under 75 mortality rate for cardiovascular and cancer diagnosis.
- The population of Tower Hamlets is statistically close to the national average for alcohol-specific hospital stays, under 18s conception, smoking prevalence, percentage of physically active adults, hospital stays for alcohol related harm and hip fractures in people aged 65 and over.
- The population of Tower Hamlets is statistically better than the national average for GCSE achieved 5 A*-C,

smoking status at time of delivery for women, breastfeeding initiation, obese adults, excess weight in adults, hospital stays for self-harm, excess winter deaths (three years).

- The hospital has a total of 671 beds - 65 maternity beds, 44 critical care beds.
- The hospital employs 1703 nursing and midwifery staff. The workforce was supported by 9.4% bank and agency staff against a national average of 6% in the last financial year.

2. Activity

- Inpatient admissions: 270,258 (2013/14)
- Outpatient admissions: 443,173 (Dec13-Nov 14)
- Emergency attendances
 - 08/06/13 – 31/05/14 – 129,176
 - 07/06/13 – 16/12/14 – 69,594
- MIU attendances
 - 08/06/2013 – 31/05/2014 – 22,168
 - 07/06/2014 – m 16/12/014 – 12,509
- Births: 4,352 (2013/14)
- Deaths in hospital: 573 (Apr 14 – Nov 14)

3. Bed occupancy

Detailed findings

- Ranged from 90% to 94.5% (2013/14). It was 95% during our inspection.

4. Incidents

Four never events reported between January up to 31 December 2014.

- January 2014 in Neurosurgery - wrong site surgery
- February 2014 in Dental Surgery - wrong site surgery
- March 2014 in Dental Surgery - wrong site surgery
- September 2014 in theatres - surgical error
- Between October 2013 and September 2014 the hospital reported 183 Serious Incidents (SIs). They consisted of 68 grade 3 pressure ulcers, 16 Maternity services unexpected admissions to neonatal care unit (NICU), 11 unexpected admissions to neonatal care unit, 10 maternity services unplanned admission, 9 delayed diagnosis and 69 others.

5. CQC Inspection history

- CQC has inspected the Royal London Hospital three times since 1 April 2012.
- The hospital was inspected as part of Barts Health NHS Trust inspection in November 2013 under the CQC's new inspection methodology. The trust was not rated. We issued five compliance actions:
 1. Care and welfare of people who use services. Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. 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.
 2. Assessing and monitoring the quality of service provision. Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010. The provider did not have an effective system to regularly assess and monitor the quality of service that people receive and did not always implement the required changes to ensure improvements were made.
 3. Safety, availability and suitability of equipment. Regulation 16(1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. 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.

4. Records. 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.
5. Staffing. Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010. 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

6. Key Intelligence Indicators

Safe

- Four never events reported between January up to 31 December 2014.
- Between October 2013 and September 2014 the hospital reported 183 Serious Incidents
- Clostridium difficile: 10 cases for trust as a whole
- MRSA: 1 case for trust as a whole – target of 0
- Data not available specific to the hospital

Effective

- Hospital Standardised Mortality Ratio (HSMR) indicator – no evidence of risk for the trust as a whole
- Summary Hospital-level Mortality Indicator (SHMI) – no evidence of risk no evidence of risk for the trust as a whole.
- Data not available specific to the hospital

Caring

- NHS Friends and Family test (July 2014) – average score for urgent and emergency care was 46, which was worse than the national average of 53. The response rate was 41.8%, which was better than the national average of 20.20%.
- The average Friends and Family score for inpatients was 61, which was worse than the national average of 73. The response rate was 27.60%, which was worse than the national average of 38%.
- The average Friends and Family score for maternity (antenatal) was 50, which was worse than the England average of 62 but only 4 responses were recorded. The

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average score for maternity (birth) was -33, which was worse than the England average of 77. The average score for maternity (postnatal) was 18, which was worse than the England average of 65.

- Cancer Patient Experience Survey (2013-14)– the trust as a whole had a 82% rating for 'Patient's rating of care' as 'excellent'/'very good'. This was same as the threshold for the lowest 20% of trusts.
- CQC Adult Inpatient Survey – One risk was identified in the trust as a whole to the question 'Did nurses talk in front of you as if you weren't there'.

Responsive

- A&E, four-hour target – Met the 95% target for the period 08/06/20113 – 31/05/2014 – 96.40% and for the period from 07/06/2014 – 16/12/2014 – 95.19%

- Referral-to-treatment times – the trust stopped providing this data beyond August 2014, so no up to date reliable data is available.

Well Led

- Staff survey 2013 overall engagement score (trust as a whole): 3.63. Slightly worse than the England average of 3.73.
- The response rate for the staff survey was lower than the national average with a response rate of 46% compared to 49% national average. The results of the 2013 NHS Staff Survey demonstrated that for Bart's Health NHS Trust, the majority of scores were as expected in line with the national average over the 28 key areas covered in the survey, which included:
 - as expected in 24 key areas
 - better than average in 2 key areas
 - worse than average in 2 key areas

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Inadequate	Good	Good	Inadequate	Requires improvement	Inadequate
Critical care	Good	Good	Good	Good	Good	Good
Maternity and gynaecology	Inadequate	Good	Good	Good	Requires improvement	Requires improvement
Services for children and young people	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate
End of life care	Requires improvement	Inadequate	Requires improvement	Requires improvement	Inadequate	Inadequate
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate

Notes

We are currently not confident that we are collecting sufficient evidence to rate effectiveness for outpatients and diagnostic imaging

Urgent and emergency services

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

Information about the service

The emergency department (ED) provides a 24-hour service, seven days a week to the local population. The department sees around 165,000 patients a year and is one of London's four regional trauma and emergency care centres. The department has a helipad and severely injured patients are received into the department via air ambulance each day. Patients present to the department either by walking into the reception area or arrive by ambulance via a dedicated ambulance-only entrance or via Helicopter Emergency Medical Service. Patients transporting themselves to the department report to the reception area, where they are booked in and await triage by a nurse or GP. The department consists of a cubicles (majors) area, minor injury and urgent care as well as a resuscitation area for up to eight patients, including two dedicated children bays. The hospital has one of the busiest A&E's for children in the country. The ED has its own children area with a separate waiting area for children, cubicles and an observation area. The ED has its own x-ray department, including dedicated use of two CT scanners. Patients attending the ED should be expected to be assessed and admitted, transferred or discharged within a four-hour period in line with the national target. If an immediate decision cannot be reached, a patient may be transferred to the Clinical Decision Unit (CDU) for up to 12 hours or admitted to the Acute Assessment Unit (AAU), for up to 48 hours. CDU forms part of the ED, while AAU is part of the medical speciality.

The service is within the Emergency Care and Medicine (ECAM) Clinical Academic Group (CAG).

Summary of findings

The service was not consistently meeting national targets, some patients had longer waits because there was not enough beds in the hospital. Staffing levels were managed well, and recruitment arrangements were on-going. The service had been proactive in developing courses to increase the number of children nurses within the department.

The environment was clean and there was consultant cover 24 hours a day, seven days a week because it was a trauma centre. Patients felt well cared for and staff told us they were supported by their peers and management.

Patients received evidence-based care and treatment. However the governance structure was not robust and meetings lacked detail and incidents, complaints, risk and audits were not consistently discussed in a meaningful way. We saw evidence that clinical audits had been planned for the year, but we were not provided with evidence that they had been undertaken or reported on. Feedback and learning from incidents were limited and improvements were needed to ensure accurate records were maintained and that there were suitable prompts for staff to follow to ensure all patient needs had been met and recorded.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement 

Incidents were reported however, not all staff were aware of the incidents or learning and actions taken as a direct result. Suitable arrangements were in place for managing medicines, although these were not always consistently followed. Cleanliness and infection control procedures were followed. Documentation was inconsistent and not all staff had access to the most up-to-date information relating to patients conditions on the IT system. Vital signs were monitored for children, but an early warning tool to manage their condition was not in place.

Incidents

- Between July and December 2014 over 500 incidents were reported by staff, which indicates a good reporting culture. We were told that all staff were copied into incidents which had occurred at the hospital with details of action taken. The staff said they received regular emails about incidents and that they were discussed at handovers as well as their team meetings. However, although staff confidently talked through the process followed for receiving information about incidents, most of the staff we spoke with were unable to explain what lessons had been learned from incidents.
- We saw from review of the incidents between these periods, the action taken had been detailed for some, but this was not always the case, over a quarter of these incidents did not have a recorded action and for some others action taken was recorded as, 'appropriate action taken' for example and there was no further description outlining what action been had been taken.
- Between February 2014 and early January 2015 a total of 11 Serious Incidents had been reported, with the exception of two of these, all were downgraded to low or moderate harm following discussion at the Serious Incident committee. The committee requested that internal investigations were still conducted for these incidents. Some investigations were in progress, one incident classified as moderate harm had been closed

without evidence of an investigation. The committee highlighted an investigation was required for this particular incident because it was anticipated that lessons could be learned.

- We reviewed the investigation reports for two serious incidents. Both reports included a clear chronology of events, a narrative of what could have been improved with recommendations and an action plan. One of the Serious Incidents had occurred approximately 11 months ago. All actions were recorded as completed, the second Serious Incident had occurred just over two months ago and some action was still ongoing.
- We talked to staff about both Serious Incidents, some of the staff were able to tell us about one of the Serious Incidents They told us that a new protocol had been put in place as a direct response to this incident. However, the majority of staff we spoke with were not aware of the second incident and the staff who were aware, had not been informed of the outcome of the investigation. We were told that during the inspection, senior nursing staff had only just been briefed on the incident, two months after the event which demonstrates that prompt learning does not take place.
- The ED fed into a number of Mortality and Morbidity meetings. We reviewed a sample of meeting minutes and saw that discussions had taken place regarding outliers and incidents reported on unexpected deaths.

Cleanliness, infection control and hygiene

- There were policies and procedures in place to reduce the risk of cross-infection. Staff knew how to access these through the intranet.
- We observed that the department appeared visibly clean on the day of our inspection and the staff we spoke with did not report any infection control issues.
- We saw staff wash their hands and use hand gel between attending to patients 'Bare below the elbow' policies were adhered to. Staff wore minimal jewellery in line with the trust's policy.
- Infection control audits demonstrated that increased compliance had been achieved in recent months (data provided was up to and including November 2014), although it was noted that some areas of A&E, in particular the CDU had not consistently completed the audit data.
- Staff were aware of the trust's aseptic non-touch technique guidance which aimed to reduce infection.

Urgent and emergency services

- The overall completion rate for infection control training among clinical and non-clinical staff was 54%, significantly lower than the trust's 90% target. .

Environment and equipment

- The ED had a dedicated radiology department, which included dedicated x-rays and scanners, which helped minimise the delay for patients who required certain diagnostic tests. An MRI scanner was available for use on the next level, although it was not dedicated for the ED. The department also had their own laboratory to analyse blood and blood gas test results promptly.
- We observed that staff had access to medical equipment required for an ED and specialist trauma centre and the staff we spoke with reported that there were no concerns regarding equipment.
- We reviewed the incidents reported between July and December 2014 and noted that a small number of incidents relating to equipment had been reported, but there were no themes emerging.
- We observed that resuscitation trolleys had the required items and that these had been checked daily.
- We were told that there were enough computers for staff to access as required, including one in each cubicle. Some of the staff we spoke with reported to us that although there was a computer in each room to record nursing observations, it was time-consuming logging in and out of each computer. Patient observations were frequently recorded on a piece of paper for a few patients at a time before being transferred to their electronic record. This increased the risk of information being incorrectly recorded in a patient's record.

Medicines

- Medicines including controlled drugs were stored correctly in locked cupboards. Storage arrangements met legal requirements.
- A controlled drugs register was maintained to record their receipt and administration and had been signed as received or administered in line with requirements. We saw that the controlled drug register was regularly audited. We reviewed a sample of controlled drugs, the balance recorded in the register agreed with the actual stock. However, we noted that in a recent medicines audit, the department was not consistently compliant with recording and signing of controlled drugs.

- We were told that all controlled drugs incidents were reported to the trust's Controlled Drug Accountable Officer.
- We reviewed of a sample of patient files and found medication had been prescribed and administered in line with policy and requirements.
- Staff had access to the British National Formulary to refer to the medication prescribed or taken by patients to ensure medication was safely prescribed.

Records

- Patient records in the ED were electronic and staff were issued with 'smart cards' to enable them to access and update patient records on the IT system. We were told that all staff had their own smart card and that agency nurses and locums were issued with a card that was signed out and in for each shift worked.
- The staff we spoke with all told us that there were technical issues with the computer system, which on occasions delayed access to vital patient information and caused delays in updating patient conditions. As patient conditions changed rapidly, staff did not always have access to up-to-date information, which could impact on patient care.
- We noted through general review of the notes that the nursing records were not always easy to follow because standard risk assessments were not used. For example, it was not always possible to determine if the relevant checks had been undertaken to assess patients' pressure areas. Free text fields were used to record information about a patient's pressure area care, Waterlow score or nutritional needs.
- An audit of nursing records had been completed in 2014. It was unclear when the audit was undertaken or when data was gathered and there was insufficient detail in the report.
- The audit only included notes for cubicles (majors) and resuscitation. The audit highlighted a high proportion of patient records without nursing notes. Recommendations from the audit included: dissemination of the results, creation of nursing notes, development of healthcare assistants and emergency department assistants to include documentation as well as easier access to computers. There were no timescales or ownership for the actions and it was unclear how the report would be shared or followed up to ensure appropriate actions had been taken and had resulted in improvements.

Urgent and emergency services

Safeguarding

- Almost 100% of nursing staff had completed their safeguarding training levels 1 and 2. However, this was much lower at 73% for level 3 training and 82% of medical staff had completed level 3 training. All clinical staff working with children are required to complete level 3 training.
- There were systems in place to make safeguarding referrals if staff had concerns about a child or vulnerable adult. The staff we spoke with talked confidently about the types of concerns they would look for and what action they would take. We did note that none of the staff we spoke with knew who the safeguarding adult lead for the trust was and only one member of staff we spoke with was able to name the safeguarding children's lead, although all staff knew they could find this out from the intranet if they needed to.
- We reviewed a sample of patient records and saw that safeguarding referrals had been made where it was appropriate to do so. However, two of the children records we reviewed related to children who had suffered an injury; neither of these notes documented sufficient detail which should be routinely documented under such circumstances. Safeguarding referrals were not made for these two children, but it was unclear from the information available whether it would have been appropriate.
- A separate incident had also been reported regarding a child who had been discharged from ED with a head injury where safeguarding protocols had not been followed, despite the child being on another local authority's child protection register.
- We were told that safeguarding and domestic violence concerns regarding adult patients and their children or children patients were discussed at the weekly psychosocial meeting to consider the action that had been taken and whether this was appropriate. We saw examples of this happening.
- Training on domestic violence was available to staff and the staff we spoke with had an understanding of the procedures they needed to follow.
- The trust did not have a chaperone policy and we did not see any posters throughout the department advising patients how to access a chaperone if they wished to do so.
- Statutory and mandatory training requirements were listed in the training manual. Requirements were generic and were not listed according to the role of different staff members.
- We saw that the combined ED staff had achieved a completion rate of 77% for statutory and mandatory training for the year to date against a target of 90%. Compliance with some training sessions was much higher than others; for example, dementia awareness had been well attended by all nursing staff, but less well attended by medical staff.
- All new staff temporary or permanent were provided with an induction summary sheet which outlined the flow of the department as well as key contact numbers. We were told that all new staff had an orientation period and that permanent staff would also be required to attend the trust's induction programme.
- Once in post, staff were required to complete mandatory training in accordance with agreed timeframes.
- Statutory and mandatory training included, but was not limited to, privacy and dignity, reporting of incidents, infection control, safeguarding, dementia awareness and information governance.
- The hospital had also set up their own development programme for band 5 nurses. The course aims to expedite children nursing specialist training to reduce the vacancy rate for band 6 and 7 nurses. The programme has been accredited by the Royal College of Nursing.

Assessing and responding to patient risk

- Patients who transported themselves to the ED were required to report to reception and book in. A brief summary of the patient's condition was recorded on the system, which could be accessed by staff. Patients were initially triaged and/or treated by an emergency nurse practitioner if they had a minor injury or by a GP if they had reported to reception with a minor illness. The streaming arrangement formed part of the urgent care pathway and patients could be referred on to be seen within the cubicles (majors) area in the ED if it was considered appropriate.
- Patients who had not been injured could also be seen by a patient navigator. There were three navigators employed by the ED. Navigators performed a non-clinical role, assessing a small group of low-risk

Mandatory training

Urgent and emergency services

patients who needed to be diverted to their GP or a walk-in centre. Patient navigators could select certain patients out of the list or were assigned patients considered appropriate by GPs.

- We were told that this system worked well and was effective at redirecting patients; all patients seen by the navigators were either booked an appointment with their GP or referred to a walk-in centre before leaving the department. The navigators we spoke with were able to describe the types of patients they would see and refer on, but there were no set criteria documented to support this function. There is an increased risk that if a patient is not seen by a clinical member of staff, they could be incorrectly referred on from the service, although there were no examples that patient welfare had been affected.
- There was a rapid assessment process in place for patients who arrived by ambulance or patients who were referred to cubicles (majors).
- Patients who arrived by ambulance were taken directly to the Emergency Assessment Area within the cubicles area. There was a process in place to assess all patients arriving by ambulance within 15 minutes. We spoke to some paramedics who were in the department, who told us that this process generally worked well but there could be delays if the department was busy.
- We reviewed the ED dashboard, which reported on the percentage of patients who arrived by ambulance being assessed within 15 minutes. We saw that for the year to date, the hospital had achieved 54.9% against a national target of 85%; 92.6% of patients were assessed within 30 minutes against a target of 95%. We were told by the service manager and matron that there had been no patients waiting longer than an hour for their assessment. However, the dashboard reported this had occurred on six occasions during the year. We were informed that the dashboard was incorrect, but an explanation could not be provided.
- There was a Clinical Decision Unit (CDU) which formed part of the ED. The CDU accepted patients who met specific criteria and were expected to stay no longer than 24 hours. However, during our inspection we noted that one patient did not meet the criteria for CDU and remained in the department for at least 48 hours. Some of the staff we spoke with told us that patients do stay longer than the agreed timeframe because of waiting for a specialist team or for a bed on a hospital ward.
- Children patients had their own reception and waiting area; patients were initially assessed by a children's nurse or by a doctor.
- During our inspection we observed that patients were managed safely, although some patients had long waits on the department and were not always transferred onto a bed.
- We saw that the ED had a suitable system in place to monitor adult patients to ensure timely escalation if they deteriorated, although this was not the case for children. For adult patients, observations were recorded using the moderated early warning score, a tool produced to monitor for any deterioration. However, although vital signs for children were monitored, there was no paediatric early warning score (PEWS) used for children. Therefore reliance was placed on professional judgement and manually reviewing patient observations.
- We were told that there were procedures in place for identifying and reporting pressure ulcers as part of the assessment process. However, we noted that the IT system did not include a standard risk assessment for pressure sores and reliance was placed on staff recording 'free text' information. We were told that patients with an identified pressure sore were ordered a bed promptly.
- Some of the elderly frail patients we observed had been ordered hospital beds and we observed them being cared for appropriately. However, we saw other examples of patients being cared for on hospital trolleys for long periods of time. One patient we saw had been on a trolley for approximately 10 hours. This patient was elderly frail and did not have details of any risk assessment recorded in their notes as to whether they were at risk of developing a pressure ulcer. We also saw evidence of another patient where the notes did not contain the appropriate pressure area risk assessment. We spoke with a member of staff who informed us that assessments should have been performed for both patients, but because there are no 'prompts' or pre-formatted risk assessment on the system that this was overlooked on occasions.
- There was no systematic process in place that was consistently used to assess patients' needs and their risks, such as risk of pressure ulcers or falls or nutritional and fluid requirements.

Nursing staffing

Urgent and emergency services

- We were told that the vacancy rate was higher for children nurses than adult nurses. We asked management what the vacancy rate was during the inspection and after the inspection, but we were only provided with data for the previous year. We were told that there was a higher vacancy in children because of the national shortage of children's nurses.
- The CAG had developed a retention strategy, dated January 2014, which set out the issues faced by the trust, potential causes of attrition rates as well as solutions. There was a plan in place and actions were recorded as being discussed at appropriate committees. It was unclear if its effectiveness had been reported on.
- It was noted through review of a sample of rotas that not all shifts were filled. Staff we spoke with told us that although some shifts were short, it was manageable and that cover was always arranged wherever possible and that patient safety was always a priority.
- We reviewed the number of shifts unfilled for the period April–December 2014 and saw that there had been a significant reduction in unfilled shifts since the beginning of the year, but there had been a rise in December 2014 with 86 shifts unfilled compared with 45 in the previous month. We were told that typically more shifts were unfilled because the required staffing levels had been increased to deal with winter pressures.
- We were told that it was harder to fill shifts in the children's ED because of the national shortage of children nurses. When shortages occurred in the children ED, agency nurses hired would work on the adult ED and an adult nurse from the main ED would fill the shift vacancy on children.
- Agency cover was provided by nurses who often worked in the department whenever possible; agency nurses who had not previously worked in the department were given a brief orientation and induction.
- The staff we spoke with told us that the skill mix worked very well. Junior nurses told us they felt well supported by the senior nurses and they always had confidence in how the shift was managed.
- We observed some multidisciplinary handovers and found these to be effective. Each patient in the department was discussed to ensure staff taking over the next shift had a clear insight into the patient's condition, tests undertaken and plan of care.
- Consultant cover was provided 24 hours a day, seven days a week because the department is a regional trauma unit.
- We requested details of the vacancy rate for medical staff but were only provided with data for the previous year.
- The staff we spoke with told us that although some shifts were short, it was manageable and that cover was always arranged wherever possible and that patient safety was always a priority. The department worked with other departments to improve flow and senior clinicians expedited discharges for patients who were fit.
- We reviewed the number of shifts unfilled for the period April–December 2014 and saw that unfilled shifts peaked in June and July, but reduced significantly until December 2014 with 69 shifts unfilled compared with 28 the previous month. We were told that typically more shifts were unfilled because the required staffing levels had been increased to deal with winter pressures.
- Locum cover was provided by medical staff who often worked in the department whenever possible.
- We observed some multidisciplinary handovers and found these to be effective. Each patient in the department was discussed to ensure staff taking over the next shift had a clear insight into the patient's condition and tests undertaken so far.

Major incident awareness and training

- The trust had a major incident plan, which was last updated in September 2014. The latest version included an update on lessons learned from previous exercises. The plan set out roles and responsibilities; example scenarios had been included within the plan.
- We were told that regular major incident training took place and the majority of staff we spoke with told us that they had attended major incident training. All of the staff we spoke with talked confidently about what to do for certain major incidents and where they could access equipment and clothing. Overall 83% of staff had completed training in emergency planning against a target of 90%.
- We were provided with a copy of a debrief report for a recent major incident exercise. The report outlined the event, what worked well and what could be improved. An action plan had been developed. Each action had a

Medical staffing

Urgent and emergency services

deadline and nominated person/team responsible for implementation; however, confirmation of the date each recommendation had been achieved was not recorded.

- There was a designated room to store equipment for major external incidents; items were boxed and boxes clearly labelled to correspond to the 'type' of incident which could occur.
- We noted that some decontamination equipment was stored in the corridor next to the ambulance entrance of the ED. Equipment was placed behind a screen, but this had the potential to restrict access as well as equipment being stolen or tampered with. This was recorded as a risk on the department's risk register. It was unclear when this was identified as a risk and therefore how long equipment had been stored there or what action was planned to address this and when.
- The department had a decontamination room near the reception area, in case anyone presented with symptoms/signs indicating they may need to be isolated and/or decontaminated.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good



There were processes in place to ensure patients received evidence-based care and treatment. However, there was limited evidence that these processes were audited and being complied with. The unit was a specialist trauma centre and hyper-acute stroke unit. National guidance was incorporated into local policies and were followed. Staff said they were well supported by their peers and colleagues and the management team as well as receiving good support from other departments, for example, pharmacy and the specialist stroke team. There was multidisciplinary working, putting patients first. Most of the staff we spoke with had a good understand of supporting and assessing patients who lacked capacity.

Evidence-based care and treatment

- Clinical pathways had been developed for a number of conditions; they made reference to national guidance as appropriate and were available on the intranet, which staff could access as required.
- We reviewed a sample of patient notes for people who had attended the ED. From the sample we reviewed, patients had received care in line with national guidance. For example, patients who had a suspected injury to their neck of femur or suspected stroke had been treated in line with the relevant National Institute for Health and Care Excellence (NICE) guidance.
- We observed one patient had been in the CDU for longer than expected and that the admission was not in line with trust policy.
- We noted that some patients had received sub-optimal care, but these examples had been reported as incidents and the patient outcome recorded. Action taken was recorded for some, but not all, of these cases.

Pain relief

- The ED had an electronic scoring tool to record patients' pain levels. Pain was scored from 0 to 10. Adult patients were asked (when possible) what their pain rating was. This was documented by the nurse on behalf of the patient because hard copy tools were not available.
- There was an age-appropriate tool for children to score their pain and assessments were recorded electronically.
- The patients told us that they had received pain relief if necessary and we saw evidence of this happening through review of patient notes.

Nutrition and hydration

- The cubicles area of the ED had a healthcare assistant who was responsible for ensuring a food and drinks round was undertaken twice each day. In between these dedicated times, the healthcare assistant and/or nursing staff regularly asked patients if they required food or drink.
- The patients we spoke with were all satisfied that their nutrition and hydration needs had been met.

Patient outcomes

- The trauma and emergency centre was an important component of patients who had experienced trauma. The latest Trauma Audit and Research Network outcome data showed the actual survival rate was similar to expected survival rate following a trauma.

Urgent and emergency services

- 25% of the patients attending the trauma service as an emergency had penetrative wounds, which is significantly higher than any other UK trauma centre - the survival rate at the hospital was better than the national average.
- A total of 31 clinical audits were planned for 2014/15. Audits were considered for inclusion if they were a trust core audit priority, local priority, part of a national audit or part of the National Institute for Health and Care Excellence audits. The majority of audits had been assigned to a project lead and had a proposed start and end date, but not all. It was unclear from the plan which audits had been started or completed.
- We requested a copy of two completed audits for 2014 and 2015, along with corresponding minutes where they had been presented. This information was not provided; we were given a completed audit from the previous year as well as a pre-audit presentation for an audit scheduled for this year. We were provided with example agendas where other audits had been presented.
- We also requested a copy of the nursing audit plan for the year as well as example nursing audits. We were provided with a copy of the nursing record audit, but not an audit plan.
- We saw that unplanned reattendance rates were significantly below the national average. The national performance is 5%. The trust's reattendance rate for the year to date as at 11 January 2015 was 1%. We asked if reattendances had been audited to understand why the reattendance rate was much lower than the expected average; however, an audit had not taken place to ensure confidence in this data.

Competent staff

- The trust had systems in place to ensure professional registration of permanent employees was maintained and up to date and we saw evidence of this.
- The staff we spoke with told us that they had received an appraisal within the last year and had found this process helpful. We saw that most medical staff had received an appraisal in 2014. The data provided for nursing staff was not presented in a meaningful way and therefore conclusions could not be drawn about the numbers who had received an appraisal.
- We requested details of appraisal data for medical staff, but the data provided was not specific to the hospital.

- The junior and middle-grade doctors we spoke with told us that they felt supported by the consultants and that their 'door was always open' if they wished to discuss any issues/concerns with the consultants.

Multidisciplinary working

- The staff we spoke with told us that multidisciplinary arrangements work well most of the time, although there were delays in patients being allocated beds because of delays in other specialities' teams coming to see patients, in particular neurosurgery.
- The trust had arrangements in place for attendance and admission avoidance. There was a team of navigators whose role it was to divert patients to primary care if their attendance was not an accident or emergency. The trust maintained a record of the number of patients diverted back to primary care by the navigators. There was a clear admission avoidance pathway in place. The team aimed to reduce admissions and also to reduce the length of stays for patients who were medically fit to return home by ensuring care packages and/or the environment was a safe. We were told that the team did their best but that it could take some time to ensure necessary arrangements were in place without compromising the patient's social and support needs.
- There were strong links with the medical team who formed part of the ED.
- Patients who presented at the ED with mental health needs were treated for their immediate clinical needs and a referral was also made immediately to the in-house crisis team for adult patients. Children and adolescents were referred to the Children's and Adolescent Mental Health (CAMH) team during office hours. Out of hours, advice was sought from a specialist at Great Ormond Street or the in-house paediatrician, depending on the circumstances. Children were admitted and referred to the CAMH team during office hours for mental health concerns.
- We reviewed a sample of adult and children records and saw evidence that patients had been referred to the in-house psychiatric team or CAMH team within a reasonable timeframe. We also saw evidence of advice being sought and documented when a child with mental health needs attended the ED out of hours.

Urgent and emergency services

- Data provided by the trust demonstrated that during September and October 2014 there were only two patients who remained in the department for more than four hours because they were waiting for a mental health bed.

Seven-day services

- Pharmacy services were available during the day, seven days a week and on-call arrangements were in place out of hours.
- The ED had their own radiology department complete with x-ray machines and CT scanners. An MRI was available on the next floor.
- Blood tests were also done in-house and results available promptly both in and out of hours.
- The trust had a specialist stroke team who attended to patients in the resuscitation room who required thrombolysis. However, this was a small team and when they were not available the ED team would cover this role if necessary and were trained to do so.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Most of the staff we spoke with had a good understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards. Some nursing staff told us that they would seek advice from medical staff and that this worked well.
- There was no specific training provision for the Mental Capacity Act 2005 or Deprivation of Liberty Safeguards. We were informed that the Learning Disability training as well as the dementia training included an element of mental capacity, but this did not include competency or capacity assessment for children or for people who were incapacitated other reasons, for example if they were unconscious or intoxicated.
- Through review of patient records, we saw examples of patients whose capacity had been assessed as well as patients who had needed to be restrained. We saw that the security guards had been involved and that processes had been documented well and followed policy.
- We were told that assessments were completed on hard copy forms if necessary.

Are urgent and emergency services caring?

Good



The majority of patients and relatives we spoke with told us that they were satisfied with the care they received and felt that staff listened to them and were compassionate. This was supported by our observations.

Compassionate care

- Most of the patients we spoke with told us that staff were kind and caring and that they felt well looked after. One of the patients who had waited in the department for a long period of time was dissatisfied with the level of communication from staff because he was unsure what was happening with his tests and whether or not he was moving to another department and when. However, most were complimentary. One patient told us, "The care here has been excellent, I was seen quickly and I cannot fault them. I am allergic to penicillin and the staff here made sure I spoke with my GP before prescribing me antibiotics".
- There was no intentional rounds for patients to ensure their needs had been met, such as to provide toileting assistance or to ensure patients were positioned comfortably. However, we observed staff supporting and treating patients in a kind and caring manner.
- The Friends and Family Test is a method used to gauge patients' perceptions of the care they received and how likely they would be to recommend the service to their friends and family. Positive feedback from patients through the Friends and Family Test was above the England average. We noted that the trust had switched to obtaining information by use of a 'token' system. Patients were given a token and asked to place the token in the relevant box, as to whether they would recommend the hospital to their friends and family. This meant that some of the qualitative data was lost because patients no longer had the opportunity to record comments. The response rate fluctuated greatly each month; response rates were high in September and October at 25.7% and 32.4% respectively, but dropped considerably in November and December at 0.6% and 8.1%. The majority of patients who completed the survey reported that they would be likely or very likely to recommend the ED to their friends and family.

Urgent and emergency services

Understanding and involvement of patients and those close to them

- Most of the patients we spoke with told us that they were satisfied with the level of involvement and communication from staff. One person reported dissatisfaction regarding communication from staff, which had left them feeling frustrated waiting for information.
- We saw through review of complaints over the past six months that communication from staff was a common theme in complaints. We were told that staff were constantly reminded of the need to ensure they communicated information well with patients and their relatives.

Emotional support

- We were told by staff that they provided regular updates to relatives who were in a critical condition.

Are urgent and emergency services responsive to people's needs?
(for example, to feedback?)

Requires improvement 

Some patients had long waits in the department with the primary cause being lack of available beds across the hospital. Translation services were used and staff had a good understanding of how to support people with dementia or a learning disability, although communication could be improved for people who were unable to talk. Leaflets were not available in other languages, despite a high proportion of patients speaking Bengali as their first language. Complaints were not always responded to in a timely manner.

Service planning and delivery to meet the needs of local people

- Access and flow was monitored continuously. In January 2015 a trust-wide summary report had been produced that outlined strong performance as well as underperformance and plans in place to improve the service for patients.

- An improvement scheme had been introduced to meet the needs of patients. It specified agreed actions under three separate streams: inpatient processes, effective discharge and ED assessment. Each stream was supported by specific actions and details of the current position were reported on. The report was high level and did not include detail of timescales, responsibilities or ownership.
- The main waiting area was large and had adequate seating and a separate waiting area for children.

Access and flow

- The national target for patients attending ED to be admitted, discharged or transferred within four hours is 95% of all patients. For the year to date, as at 11 January 2015, the Royal London Hospital's achievement stood at 90.80%. This was similar to the national performance.
- We were told by senior staff that there had been no delays in excess of one hour for ambulance handovers, although the dashboard stated there had been six ambulances that had waited longer than one hour to hand the patient over to the ED. The national target was set at 0% and therefore the ED had not met this target. The management team did not provide an explanation.
- The longest wait time in ED before being admitted, transferred or discharged for the year to date was 11 hours and 28 minutes. For the year to date, 5% of patients waited more than eight hours in the department. This was similar to the national average.
- The data provided indicated that 1% of patients left the department without being seen, which is significantly lower than the national target of 5%. Data reliability was a recognised issue at the hospital and an audit had not taken place to verify the accuracy of the data.
- The staff we spoke with told us that the department was frequently very busy but that they worked as a team to ensure the best care was provided. Some staff told us that care could be rushed at times, but that the department was managed safely. There were rare occasions when the pressure was overwhelming.
- We reviewed the breach reports provided by the trust, which recorded the reasons patients had exceeded the four-hour wait in ED during September and October 2014. The reasons for patients remaining in the department for more than four hours were bed availability (including in the Clinical Decision Unit (CDU)), clinical need delays in A&E assessment and delays in speciality review.

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- The CDU formed part of the ED; patients could be admitted to the CDU for up to 12 hours. The CDU accepted transfers from the ED for short-stay patients as well as accepting GP referrals directly. Specific criteria had to be met for patients being transferred to the CDU. We saw that for the majority of patients who were in CDU, it was appropriate for them to be there.

Meeting people's individual needs

- Most of the staff we spoke with had a good understanding of how to care for patients with dementia and/or a learning disability. The design and layout of the building was also helpful, particularly in cubicles where patients had their own room; this helped to ensure patients were in an environment that was quiet and relaxed as far as possible.
- The staff we spoke with told us that patients with a learning disability had a 'passport' that they carried with them and this provided useful information regarding their physical health and relevant contacts. We were told that most people with a learning disability or dementia were accompanied by a carer who was able to communicate on their behalf. If the patient was unable to communicate and was unaccompanied, the member of staff would contact the learning disability team during office hours, although there were no specific arrangements out of hours.
- The department did not have picture books or other simple tools to aid people who had difficulties communicating.
- The staff we spoke with were unable to tell us who the hospital lead was to support patients with a learning disability. Staff were aware that there was a hospital lead and where they could find contact details if they needed to, but they clearly had not used this resource.
- A translation telephone service (Language Line) could be accessed for patients who were unable to communicate adequately in English and staff reported that this worked well. We saw examples recorded in patients' notes when interpretation services had been used.
- There were information leaflets about specific accidents/injuries/emergency conditions within the department. However, leaflets were in English only.
- We were shown information for parents who presented to the ED with a child suffering from diarrhoea and

vomiting. The CD was available in many languages. We were told that this had been made by the trust because of the high number of children who attended the department reporting these symptoms.

- We observed that there was a quiet, private room within the ED for relatives who needed time to themselves or for staff to discuss bad news with relatives.
- We were told by staff that they provided regular updates to relatives on patients who were in a critical condition.
- The children ED waiting area contained toys to play with for children who were waiting for an assessment.

Learning from complaints and concerns

- There was a central Patient Advice and Liaison Service (PALS) based at hospital. Patients had the opportunity to contact PALS by telephone, email or in person. We were told that patients could also be given the number of the governance team and that this information was available to patients on the PALS leaflets.
- A total of 55 complaints had been received between April and November 2014. Almost half of the complaints took more than 40 days for a response to be sent and the complaint closed, seven of the complaints had taken in excess of 60 days and some up to 83 days for closure. Ten of the complaints had not yet been closed.
- The information we were provided with did not record details of whether the complaint had been upheld or not. A significant proportion of complaints related to communication issues or long waits in the department.
- We were told that complaints were communicated to staff at their daily handover meeting and/or to individual staff members as appropriate.
- We asked for examples of changes the department had made as a direct result of a complaint, but these were not provided.

Are urgent and emergency services well-led?

Requires improvement 

There was no clear vision and strategy for the service. Governance and risk management was being reviewed however the meetings were not always minuted or detailed for actions to be taken forward. The CAG structure was not visibly supporting local leaders. Local leadership worked well and staff reported that they were supported by their

Urgent and emergency services

immediate management team, who were approachable and led the department to ensure staff remained calm under pressure. Patients and staff were given the opportunity to provide feedback about the service, although it was not clear how feedback was acted on.

Vision and strategy for this service

- During the inspection, we asked management about the vision and strategy for the department and were told about segments of work that had been or were being undertaken to improve flow, but we were not told about a cohesive strategy. We requested a copy of the department's annual business plan, but this was not provided. Instead we were sent a performance report prepared in January 2015, which included an extract of an improvement scheme. We had not previously been told about the improvement scheme.
- The extract of the improvement scheme outlined the department's performance and underperformance as well as plans in place to improve the service for patients. It considered progress made with the improvement scheme.

Governance, risk management and quality measurement

- A committee governance structure was in place, with local meetings held as well as ECAM CAG meetings.
 - The directorate held quarterly cross site governance meetings to monitor and discuss performance, incidents and complaints as well as other issues arising. We requested copies of the monthly governance meetings, but we were told that these were not minuted. We were told these meetings fed into the monthly ECAM Quality and Safety Committee and similar matters were considered.
 - A Serious Incident Committee met weekly and reviewed all ECAM CAG Serious Incidents and made decisions about whether they had been correctly categorised as well as receiving updates on investigation reports and action taken. We were provided with two sets of minutes for the Serious Incident Committee and confirmed that there had been discussion about Serious Incidents that had occurred. One of the incidents had been investigated and was due to be downgraded and closed, the other was ongoing.
- We reviewed the most recent set of minutes available for the ECAM Quality and Safety Committee (December and November 2014) and found that the numbers of incidents reported on and dealt with were recorded. The top three incidents were listed for ECAM CAG as a whole, but this was not reported on by location or for the ED separately. Complaints were discussed at a weekly complaints meeting, but this meeting was in its formative stage, and information was not broken down by location or department. There was no evidence that complaints had been discussed in any meaningful way.
 - The risk register was discussed at one of the meetings and the team was unsure whether "the risk sub-committee was still meeting"; no response was noted in the minutes.
 - It was highlighted that some risks needed to be added to the risk register, but it was unclear which risk register they needed to be added to, for example ED or medical, and for which locations, or whether the risk affected all risk registers.
 - We requested minutes for the ED risk management committee, but these were not provided.
 - We reviewed the ED/AAU meeting minutes for September and saw that discussions were held around example cases and related NICE guidance as well as other issues, for example, ongoing issues with IT.
 - The ED maintained a risk register. High-level risks were transferred to the trust-wide risk register. We reviewed the risk register for the ED, which had a total of 11 risks recorded. The highest risk currently on the register was access to the children ED; this was last reviewed in December 2014. The control measure in place was a temporary door, but it was unclear whether this was adequate and when the replacement door would be fitted. Some of the risks had been clearly defined with control measures adequately recorded. However, control measures for other risks were not always clear, and it was unclear whether the control measures had reduced the level of risk because a residual risk score was not calculated. For example, one of the risks related to the transfer of more than one baby who required ventilation and the lack of equipment if multiple transfers were required. The control measure was recorded as 'patient assessment'. It was unclear what was meant by the control measure or whether further action was required to further reduce the level of risk posed.

Urgent and emergency services

- We noted that four of the risks had been last reviewed in November or December 2014, four did not have a review date and the remainder had not been reviewed since summer 2014. Some risks identified during the inspection process had not been recorded on the register, for example, the risk of children nursing shortage.

Leadership of service

- Cascading of information for emergency care at a senior level had been defined. Information was cascaded via the trust-wide CAG Group Director to the Clinical Director, Service Head, General Manager, Clinical Lead as well as the Matron. It was unclear from the structure chart provided what the reporting lines were.
- Local leadership worked well. The clinical management for medical and nursing was well established and the staff we spoke with reported that they had good relationships with their immediate manager and that they would feel comfortable in talking to more senior management within the ED if they needed to. The service manager was new in post, but had developed a strong understanding of how the department ran and we observed a good rapport between management and staff.
- Within the ED there was a nurse in charge of the shift who oversaw nursing needs for the department. Each separate area within the ED, for example urgent care/ children, was overseen by the most senior nurse in that area; this nurse reported to the overall nurse in charge, who in turn reported to the matron.
- Medical staff reported to the consultant or a senior registrar.

Culture within the service

- The staff told us that the ED was a wonderful place to work and they felt supported by their peers and management. We observed positive interaction between all staff groups and a team spirit at all times.

Public and staff engagement

- Patients were given the opportunity to provide feedback through the Friends and Family Test. The response rate for the test had declined in recent months, but feedback received had been consistently positive and in line with the England average.
- An annual staff survey took place each year to gauge staff perception on a range of matters and was collected at a trust level.
- We requested a copy of the survey findings along with an action plan; we were told that there was no specific action plan for the ED but that this was factored into a CAG-wide report. We were told that staff contributed to team meetings and could raise issues as part of their annual appraisal. We saw an example of the band 7 meetings where general discussions had taken place.

Innovation, improvement and sustainability

- The children area of the ED had designated play worker week days. This helped to minimise the boredom and frustration children could feel while waiting for long periods in the department.
- The design and layout of the environment took into account the needs of patients and enabled staff to carry out their duties with limited restrictions.
- There was an arrangement with local youth workers, who were brought in to help disperse crowds. They were contacted for support, particularly when a gang-related incident took place.

Medical care (including older people's care)

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

Information about the service

Medical care services are managed within the Emergency Care and Acute Medicine (ECAM) Clinical Academic Group (CAG). There are six medical clinical divisions in the CAG comprising Older People and Stroke Services; Rheumatology, Dermatology, Immunology and Sexual Health; Neurosciences; Renal and Diabetes; Respiratory Medicine; and Gastroenterology. We visited 18 wards, including the acute admissions unit (AAU), older people's wards and the stroke unit, and we spent time in the discharge lounge. We spoke with 34 patients and five relatives, 73 staff covering a wide range of clinical and non-clinical staff including doctors, nurses, therapists of all disciplines, health support, domestic and portering staff. We reviewed 60 patients' medical and nursing records and attended nursing and medical handover meetings, multidisciplinary board rounds and bed management meetings. We observed staff carrying out their duties and their interactions with patients and others. We previously inspected medical care services in November 2013 and found the trust did not always have sufficient staff to meet the needs of patients on the elderly care wards. We also required the trust to take action to improve patient care plans and clinical risk assessments.

Summary of findings

We found areas of good performance. However, there were aspects of the services that demonstrated variable, average or worse than average performance. The safety of medical services was compromised by the frequent occurrences of staff shortages, inconsistency in following trust infection prevention and control measures and poor recording of patient risk assessments.

Patients experienced good outcomes and where performance was worse than average the trust had worked with stakeholders to improve. Policies and procedures were written to meet national guidance, but staff reported there were limited local protocols available to them. Patients' pain relief and nutritional needs were mostly met. Seven-day working was partly in place and there were plans in progress to make further improvements. Multidisciplinary working was embedded throughout medical services and most areas reported excellent team working.

Patient feedback was positive and the Friends and Family Test response rates, although variable, showed some improvement. We observed interactions with patients that were professional, compassionate and caring. There was appropriate patient flow from admission to discharge and recent changes to improve the assessment of patients with complex needs or requiring continuing care were having positive effects. Patients living with dementia were supported

Medical care (including older people's care)

adequately, particularly in the stroke and elderly care wards. However, there was a need to ensure patients with dementia received appropriate care in every area of the trust.

Leadership at a local level was visible and supportive, but many staff were still unaware of the CAG senior managers. Many staff reported a culture of bullying and harassment and reported behaviours that could be characterised as such.

Are medical care services safe?

Requires improvement 

We found the wards visited were all visibly clean and equipment was available and ready for use. However, staff did not always follow infection prevention and control measures and there had been a higher rate of MRSA and C.difficile than expected. Staffing on some wards was not always sufficient to meet the needs of patients and shifts were not always filled as requested. Patients were not always routinely reassessed for the risks of potential harm and nursing documentation was reported by staff as confusing and was not always completed.

Incidents

- The trust had reported 248 serious incidents between October 2013 and September 2014, of which 185 related to grade 3 or 4 pressure ulcers. The hospital reported 65 of the serious incidents, of which 36 related to grade 3 or 4 pressure ulcers.
- The majority of staff were aware of the reporting system and demonstrated how to report an incident through the trust intranet page. Most staff told us they received an acknowledgement email when they submitted an incident report. We heard examples of staff receiving feedback on incidents as part of ward handovers. However, not everyone we spoke with automatically received feedback on the outcome of the investigation. Ward managers were responsible for investigating incidents in their ward/department. Some ward managers were able to show us all of the incidents related to their ward and the number that were closed or still under investigation. The incidents included details of lessons learnt and remedial actions taken such as training, supervised working and disciplinary action. However some ward managers had difficulties accessing the incident management system to demonstrate the process to us.
- We saw information displayed in wards to remind staff of the need to discuss incidents with patients, offer an apology and explain the actions taken to prevent another occurrence. The incident reporting system also required staff to confirm such discussions had taken

Medical care (including older people's care)

place and if staff were unable to speak directly with the patient or relative then a letter was sent. This showed that duty of candour requirements were being complied with.

- The ECAM CAG held a weekly serious incident meeting, chaired by the Group Director, to review all potential serious incidents across the CAG. Incidents that met the serious incident threshold were assigned to an investigator and timescales for reporting were agreed at the meeting. The outcomes of incident reviews were discussed and reported as part of the governance meetings.
- Staff told us the weekly chief executive briefing contained examples of learning arising from serious incident investigations across the trust.
- Each medical speciality held mortality and morbidity meetings monthly or bi-monthly. Junior doctors attended, and the minutes and presentation slides provided by the specialist medical teams showed the meetings were used to share learning arising from patient deaths and incidents. The gastroenterology team maintained a register/summary log to document clinicians attending, case learning, clinical incidents and audit outcomes for the team.
- We saw in ward meeting minutes incidents such as falls and pressure ulcers were discussed and staff were involved in the remedial actions to improve clinical practice. Staff were able to tell us when the last fall or pressure ulcer had occurred in their ward and told us this type of incident was discussed at ward meetings.

Safety thermometer

- Safety thermometer results were visible at the entrances of every ward we visited, with colour-coded safety crosses to indicate how many falls, pressure ulcers (admitted with and acquired in hospital), infections, incidents and inadequate staffing episodes had occurred. On one ward the safety thermometer noticeboard had not been updated for two days, which staff told us was because of a lack of staff.
- The safety thermometer results for all pressure ulcers were worse than the national average. There was a higher incidence of pressure ulcers on the stroke and care of the elderly wards. One ward had reported between 1 and 3 new pressure ulcers in 10 out the last

12 months. Another had reported between 1 and 4 new pressure ulcers between April and August 2014, but this had reduced to zero with a slight increase in October 2014.

- Patients assessed as being at risk of pressure ulcers were provided with appropriate pressure-relieving mattresses and staff used the pressure ulcer prevention bundle of care (known by the acronym SSKIN) to document their care. Nurses told us there was little delay in getting the mattresses and profiling beds.
- Nurses said they were supported by tissue viability nurses and we saw records of their interventions with patients.
- Reporting of urinary tract infections (UTIs) was better than the national average and the majority of wards reported zero UTIs for the last 12 months. Four wards had reported between 1 and 3 new UTIs on the safety thermometer over the same period.
- Reporting of falls with harm showed a decreasing trend, with most wards having between seven and 11 months free from falls. All falls with severe or moderate harm were discussed at both the weekly ECAM CAG serious incident meeting and the weekly falls meeting. Patients at risk of falling were given non-slip socks to wear and several wards had bought crash mats and sensor alarms to help prevent falls.
- Patients were assessed for the risk of developing a venous thromboembolism (VTE) on admission to hospital. Doctors recorded the assessment score on the electronic patient record. The patient medication chart also had a section for documenting the VTE score and prescribing prophylaxis such as anticoagulants and anti-embolism stockings. However, there were no VTE scores documented in the medication records we looked at and medical staff told us that only the electronic record needed to be completed.
- The percentage of staff who had completed four harms training (catheter infections, falls, pressure ulcers and VTE) to prevent patient harms was 94%, higher than the trust 90% target.

Cleanliness, infection control and hygiene

- Wards and departments were visibly clean and free from dust. There were cleaning schedules available, staff used colour-coded equipment to carry out their duties and cleanliness audits conducted between October and December 2014 were rated green, scoring between 97% and 100%.

Medical care (including older people's care)

- Patients were screened for MRSA on admission to the hospital and those transferring from other hospitals were isolated until a clear screen was obtained.
- The trust was above the national average for MRSA, Clostridium difficile and methicillin-sensitive staphylococcus aureus. There were four cases of MRSA bacteraemia and 19 of C. difficile which was more than the hospital's target of zero.
- We saw patients with an infection were usually isolated in single rooms. However, on one ward (3E) the infection control team were involved in managing several patients with C. difficile who were brought together into one four-bedded bay to enable their isolation and help meet their complex care requirements.
- Infection control policies and procedures were on the trust intranet and all staff told us the infection control nurses were visible around the wards and responded to requests for assistance. There were link infection control nurses on all wards who carried out infection prevention and control audits and monitored staff practice.
- We observed variable compliance with trust infection control policies and procedures. We saw examples of good hand hygiene practices on most wards; however, we also saw that some domestic, nursing and phlebotomy staff did not wash their hands or use hand sanitiser between patients, and observed three occasions when they did not use protective gloves and aprons when entering and leaving isolation rooms.
- There was overall good compliance with the trust's uniform policy and bare below the elbow guidance. However, we observed on one ward that staff were not following the policy and saw a member of staff wearing a cardigan in the clinical area and some staff wearing rings on their fingers that had embedded stones. We notified the infection control team on the ward of these observations at the time of the inspection.
- We observed there was variable signage outside or on entering wards to remind staff and visitors to use hand sanitiser before entering and leaving the ward. The dispensers were stocked and refilled as needed. Audit results showed most wards were achieving 100% in the monthly hand hygiene audits.
- The percentage of staff who had completed infection control training was 79%, which was lower than the trust's target of 90%. This meant that staff were not always up to date with their training to ensure they followed appropriate infection control guidance.

Environment and equipment

- Wards and corridors were mainly free from clutter.
- Resuscitation equipment was checked daily and a record was kept of the checks and actions taken when equipment needed to be replaced. We looked at the resuscitation trolleys in every ward we visited and found them to be clean and stocked in accordance with the equipment list. All trolleys were security tagged and a record was made of the number daily.
- Other equipment in wards was clean and labels were attached to show who had cleaned it and when. There were labels showing when equipment had been serviced or safety tested.
- Sluices were clean and clinical waste was appropriately bagged and disposed of at regular intervals.
- Sharps bins were dated and signed when made up and put into use.
- Staff reported that there were not enough terminals available for staff to access the IT systems and the Wi-Fi connection to the computers on wheels was problematic on some wards. Medical staff could not always access patient information during ward rounds and were unable to update the electronic record at the patient bedside.
- We observed physiotherapy equipment on the stroke ward was stored in an unused bathroom. Staff told us the gym was situated on the 11th floor of the hospital and was not easily accessible so equipment was brought to the ward. Patient point-of-care equipment such as infusion pumps were left in clinical store rooms waiting for collection. We saw six broken patient televisions stored in the day room on a care of the elderly ward because the ward staff had been unable to find who was responsible for their repair or removal.

Medicines

- Medicines were stored appropriately in locked cupboards within locked clinical rooms.
- Lockable drug fridges were available and there were records of the daily minimum/maximum temperature readings.
- Controlled drugs were checked twice daily and we looked at several registers that showed drugs were dispensed by two staff and spot checks of the registers showed they were fully completed.

Medical care (including older people's care)

- We saw intravenous fluids were stored in an unlocked clinical room and were accessible by anyone entering the ward. We raised this with the ward and senior manager at the time, who took action to have a lock installed.

Records

- We reviewed 60 sets of patients' records, of which 27 were multidisciplinary records of medical, allied health professional and nursing daily records, and 33 were nursing records. The patient records were a mixture of electronic and paper documentation.
- Nursing risk assessments for skin, nutrition and falls were not always completed in full for all patients. We found in 10 point of care records that there were many examples of assessments not being completed in full or showing evidence of reassessment on wards across medical care services.
- After a serious incident investigation, the clinical commissioning group (CCG) had carried out an audit on the standard of documentation for assessing patients' risks of pressure ulcers. Nursing documentation needed to improve. The audit action plan included clear actions, timescales and responsibilities to achieve the required improvements.
- There were various documents available for nursing staff to record risk assessments. Some patients had a nursing inpatient booklet, others had individual risk specific forms and others had care bundle documentation to record nursing actions and reassessment of risks. Nurses told us the documentation could be confusing and bank or agency staff were not always sure which to complete. Ward managers told us they carried out daily reviews of documentation to try to improve standards of record keeping and provided immediate feedback to staff. On ward 10E we saw the daily spot checks of the SSKIN bundle of care by the ward manager was displayed on the white board as a visual reminder to staff of their progress or where improvements were needed. The graph showed a wide variation in completion according to the time of day and nursing staff told us it correlated to the patient acuity/activity and staffing on the ward.
- We were told records audits were carried out. We asked for but did not see evidence of the results, other than staff telling us record keeping needed to improve. Medical records were stored in ward offices and nursing point of care records were in folders at the patient

bedside. We observed patient records kept in the stroke unit for audit purposes were stored on open shelving in a room with unrestricted access. On a return visit to the unit we saw a lock was being installed on the door.

- We found the majority of notes were stored appropriately and saw examples of good practice on ward 13E, where all patient-identifiable records were always securely stored in locked cabinets. However, we observed one incident where a patient's medical record had been left open and unattended in a corridor during a ward round; this was addressed immediately by the doctors involved.
- Seventy per cent of staff had completed information governance training, which was lower than the trust target of 90% and meant that staff were not always up to date with their training to ensure they followed appropriate guidance.

Safeguarding

- Nursing and therapy staff were aware of the safeguarding team and how to raise concerns. There was a safeguarding information poster displayed in most wards that listed the actions to be taken and how to escalate concerns and to whom.
- Nursing and therapy staff reported they had attended safeguarding vulnerable adults and children training as part of their mandatory core competencies. Training rates were high, with 96% of staff overall having completed safeguarding training for adults and children at levels 1 and 2.

Mandatory training

- Staff accessed mandatory training, which was predominantly annual and was a mixture of study days and e-learning. Some training, such as moving and handling and dementia awareness training, was attended every two or three years.
- The overall mandatory training rate for medical care services was 89%, just below the trust target of 90%. Managers tracked staff attendance on the staff e-rostering system to enable scheduling of training. The majority of staff we spoke with were up to date with their training and local records confirmed this. The lowest rates of training were in infection control (79%), information governance (70%) and medicines management (85%).

Assessing and responding to patient risk

Medical care (including older people's care)

- Patients' physiological recordings such as temperature, pulse and respiration rates contributed to the early warning system or patient at risk score, which was used to continually monitor patients and had clear guidance and trigger points to escalate based on the score. However, we observed not all triggering scores were escalated in accordance with the guidance and staff could not always give a reason for the decision.
- There was an intensive therapy unit (ITU) outreach team available for advice and support to manage patients with a deteriorating condition on the wards during the day. The Hospital at Night team undertook the outreach function from 8pm because their principle role was to manage patient safety at night and assess and support the management of deteriorating patients.
- Agency use figures showed the highest use was in care of the elderly at 20% and in stroke at 23.3% from April to November 2014. Staff reported vacancies overall had reduced for a time with the trust having monthly recruitment drives. However, nursing and healthcare assistant vacancy rates were high at over 10% in some specialties and managers in elderly care and stroke reported a high turnover of staff within the first year of employment.
- Staff numbers were increased to provide 1:1 care for patients with mental health needs and to assist in the monitoring and care of mobile confused patients. Staff expressed concerns that the patient dependency and acuity, particularly on the older people's wards, required additional staff to meet their needs and they were not always available.

Nursing staffing

- Staffing levels for each ward had been set following a nursing and patient acuity review. We saw in AAU the staffing levels were set at a nurse to patient ratio of 1:2 for monitored beds and 1:6 for the rest of the ward. In other wards the ratio was set between 1:6 and 1:7. However, this was not always met.
- Electronic staff rostering was used to plan staffing for a four-week period and ward managers identified the shifts needing to be covered to meet vacant posts and long-term absence in advance.
- Nursing staff reported concerns regarding staffing levels and we found many wards during the inspection were working with below planned numbers of staff to meet the needs of patients because of short notice staff absence and/or shifts that had not or could not be filled by bank/agency staff. Almost every ward we visited had documented in the safer staffing tools that they had experienced below planned numbers during December and January. This was especially noticeable on the stroke unit and wards for older people. The stroke unit did not have enough staff on 11 occasions and on ward 10E there were 16 occasions in January 2015 when they had not had the planned numbers of staff to meet the needs of a highly dependent group of patients.
- At the time of the unannounced visit, which began at 8.30pm, we found there were two wards (AAU and 10E) that were short of at least one health support worker at the start of the shift. Staffing was discussed at the bed meetings and we saw clinical leads and site managers trying to reallocate staff across the hospital to address the most acute shortages.

- We saw examples of the weekly acuity tool that staff completed. Acuity was assessed daily but staffing was not always adjusted in response to the outcome. We were also told the wards had completed a similar tool for an extended period of time in 2014 but had not had any feedback. Senior managers told us on several wards with high acuity and dependency the data showed there was a need to increase staffing but no action had been taken because of financial constraints.
- Nursing handovers were conducted at the change of shifts. We observed morning nursing handovers on two wards. The structure of handovers was standard but varied in quality and the amount of detail provided. Staff were given a printed patient list with information on each patient. The nurse in charge provided a report on each patient from the previous shift, and this was followed by a bedside handover.

Medical staffing

- ECAM CAG had 723 whole time equivalent (wte) medical staff in post: 29% were consultant grade (below the national average of 33%), 4% were middle career doctors (below the national average of 6%), 46% were in the registrar group (above the national average of 39%) and 22% were junior grade doctors (the same as the national average).
- There was permanent consultant cover for AAU from 8am to 5pm and there were plans to recruit to increase consultant numbers from 4.3 wte to 7wte by September 2015. All specialist medical teams reviewed patients in A&E requiring admission during on-call and covered the wards on a rotational basis. Although this meant the

Medical care (including older people's care)

AAU was not always covered by a consultant in acute general internal medicine, all consultants were trained in general internal medicine. Senior leads told us work was in progress to review consultant job plans to improve consultant cover across all the specialties.

- Locum cover was arranged to fill vacant posts and cover special leave requests and there was a 14.5% usage rate. Some vacant consultant posts were covered by locum staff. Staff gave examples where consultant posts had been kept vacant due to cost pressures. However, we were told the posts were now being covered by locum staff and recruitment was in progress. The risks of insufficient staffing was noted on the risk register.
- At night there was a medical registrar and three junior and middle-grade doctors to cover the assessment of patients coming in through A&E, the AAU and medical wards, except the stroke unit which had a dedicated senior house officer to support the thrombolysis service and was supported by a consultant on-call at home with a remote telemedicine system.
- Consultants in the hyper acute stroke unit/stroke unit provided 24/7 on-site and on-call cover with a middle-grade doctor on duty out of hours to provide the thrombolysis service.
- Junior doctors were ward based and there were arrangements for other medical members of the team to see patients on all wards. Nursing staff told us they did not have any problems contacting the medical staff.
- We saw examples of specialist team rotas that listed the consultant of the month in the diabetes/haematology/gastroenterology teams. We were told these were planned for the year and other commitments such as outpatient clinics were organised around this.
- The majority of patients were admitted directly to the AAU. The unit consultant carried out an early morning ward round before the consultant-led medical handover at 9am, which was attended by specialist medical consultants and junior doctors of all grades and nursing staff to transfer patients' ongoing care to the appropriate specialist team. The handover was appropriate and provided a full medical history, details of current health problems, diagnostic results, social history and discharge plans.
- Patient records showed patients were seen within 12 hours of admission by a consultant and daily thereafter by the medical team. However, at weekends only new and unwell patients and those potentially ready to leave hospital were seen by a consultant. We attended two

morning handovers on AAU and one night handover. Patients were discussed in detail and the system ensured a holistic and safe handover and transfer of patients' ongoing care. At night the medical staff handed over to the on-call registrar and a team of three doctors, the hospital at night team and the nurse in charge of AAU.

- We attended several ward-based medical handovers and ward board meetings, which included all members of the multidisciplinary team. Medical ward rounds were consultant led and included an overview of the patient's medical history, next steps and discharge plans. The discussions were held with the patient and were communicated in a way to ensure patient understanding. There was nursing input on the majority of ward rounds.

Major incident awareness and training

- There were business continuity arrangements and the plans graded the potential impacts if services could not be provided. There was evidence of the mitigation and procedures to deal with emergency situations such as moving staff or relocating services. However, we did not see evidence that the measures had been tested or practised.
- Arrangements were in place to improve avoidance of admissions, streamline patient pathways and improve discharge procedures. Measures taken included establishing additional bed capacity, facilitating and improving patient access to diagnostic screening, additional support to undertake care needs assessments and working with stakeholders to address non-acute discharge delays.

Are medical care services effective?

Good



There were good outcomes for patients reported in national audits for patients who had a stroke or heart failure. There had been worse-than-average outcomes in diabetes, the trust had taken action with commissioners to improve patient outcomes. We found most policies and procedures were in date but there were limited local protocols available to staff and there was a lack of local audits to assess performance. Patient pain relief and

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nutritional needs were being met overall. There was some evidence of seven-day working and we saw examples of excellent multidisciplinary working. Staff were assessed as competent to carry out their role.

Evidence-based care and treatment

- Over a third of clinical audits carried out in the clinical academic group (CAG) either suggested improvements or raised concerns about compliance with National Institute for Health and Care Excellence (NICE) guidance. Most of the issues raised were regarding dementia, epilepsy, psoriasis and delirium. In addition, only 47% of current NICE guidance had been audited, with large percentages not audited in diabetes, elderly care and emergency care (33% audited), hepatology (11%), gastroenterology (44%), neurosciences (47%), rheumatology (50%) and dermatology (56%).
- We saw examples of pathways of care in use such as the stroke integrated care pathway was based on and referenced to the NICE guidance. The stroke pathway was audited and contributed to the national audit programme. However, not all nursing staff were aware of local protocols specific to their area of work.

Pain relief

- The majority of patients told us their pain was well managed.
- Patients' pain levels were assessed as part of their regular physiological observation recordings and were prescribed analgesia as required to control their pain.
- Patients with sickle cell anaemia were admitted to the haematology ward and were prescribed hourly controlled-drug analgesia in accordance with their pathway of care. Staff told us the pain team was available to support the management of these patients' pain.

Nutrition and hydration

- Patients' nutritional status was assessed on admission using the universal malnutrition scoring tool (MUST). On AAU we observed the majority of patients' MUST scores had been calculated, but on other wards the ongoing reassessments were not always completed. We saw patients had been appropriately referred to the dietician, their food intake was monitored and they were provided with nutritional supplements in response to identified high risk of malnutrition. We requested evidence of MUST audits but these were not provided.

Patients at risk of dehydration had fluid balance charts in place, but we saw the 24-hour balance in several could not be accurately measured, with patients' urinary incontinence stated as the reason.

- Patients' rating of the choice and quality of food provided varied from good to ok. Several patients told us they didn't always get the meal they had ordered and that often the food was cold by the time it was served to them. Patients on AAU for whom food or fluids were not restricted told us they had been provided with a drink and offered a snack after being admitted.
- The wards operated protected meal times and this was observed by staff in most areas. However, we observed on ward 10E that a member of domestic staff who continued to clean the floors while patients were eating was not challenged by staff.
- Patients requiring support to eat and drink were identified with red trays and yellow cups. We observed patients' meals were all served at once and left at the patients' bedside until help was provided.

Patient outcomes

- The hospital has the best outcomes for stroke patients in London according to the Sentinel Stroke National Audit Programme.
- The hospital contributed to the Myocardial Ischaemia National Audit Programme. However, the hospital submitted no data on the two indicators for access to thrombolytic treatment because this was not provided. It had very low numbers of patients for the other three indicators, and data were insufficient to assess against the national average.
- The hospital scored better than the national average in all the 11 indicators of the heart failure audit 2012/13. In some areas of the audit the hospital far exceeded the national average such as input from a specialist, input from a consultant cardiologist, cardiology in-patient input, referral to cardiology follow-up, referral to the heart failure liaison service, and prescribing of angiotensin converting enzyme inhibitors on discharge.
- The hospital participated in the National COPD (Chronic Obstructive Pulmonary Disease) audit. We asked for, but were not provided with, the results of the most recent audit.
- The 2013 national diabetes inpatient audit results rated the service as worse than the national average in all 21 indicators. In response to the poor results, the diabetes team and commissioners had established a working

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group and a commissioning for quality and innovation (CQUIN) framework was agreed to financially support and improve services to patients. Quarterly activity and quality audits showed improvements in that all patients were seen by a clinical nurse specialist, received information about their condition, had a foot assessment and an initial plan of care developed. The trust had recently introduced a specific medication chart for prescribing diabetic medication.

- On the falls and fragility fractures audit, The hospital was better than average in 10 areas such as senior geriatric review within 72 hours, abbreviated mini mental test score, specialist falls assessment done, patient developing a pressure ulcer, mortality (both crude and adjusted), return home within 30 days (both crude and adjusted) and 30-day follow-up. The hospital scored worse than average in four areas, including patients being admitted to the orthopaedic ward within 24 hours, surgery by day after admission, best practice tariff attainment and mean length of stay.
- The trust performed worse than the national average in the dementia carers audit. Response rates across the trust were low, but the Royal London Hospital had the highest number at seven responses. We were told that the low response rate was probably due to 'questionnaire fatigue'. However, dementia champions had been made responsible to ensure that questionnaires were completed.
- The hospital results for the national learning disability audit were variable, with better than average results in 18 indicators, including identifying learning disability patients on the electronic patient system, food and drink assessments and intake being monitored, and managing challenging behaviours. However, the results were worse than average in eight indicators, such as recording the best way to communicate with the patient, epilepsy assessment and records of seizures, and staff having attended training.

Competent staff

- It was trust policy that all new staff completed a period of induction during which they were supernumerary and were supervised and supported by more senior members of staff. We spoke with several 'new starters' of various grades and disciplines who were complimentary about the induction they had been on and the supervision and support provided.

- We saw an example of a two-day ward-specific induction programme that had been developed for new nursing staff on an elderly care ward to support their learning and integration into the ward team.
- We were told there was a Care Certificate Programme for Health support workers that they were required to complete after their induction. Ward managers told us they were keen for the programme to be delivered before the new staff started on the wards because it provided staff with the core knowledge and skills to carry out their role.
- Junior doctors told us they were satisfied with the levels of supervision, training and support provided. The 2014 GMC National Trainee Survey showed educational supervision in haematology was a 'red outlier'. Quality visits by the postgraduate education quality and regulation unit in April 2014 identified teaching was available for trainees in acute medicine, but only approximately 25% of teaching was being attended. There was good induction and clinical experience in some specialties, such as rheumatology and oncology.
- Nursing staff reported they received annual appraisal and managerial supervision, but clinical supervision was not available to the majority of staff on the wards. The trust had implemented a new electronic appraisal system but staff described the implementation as 'less than robust'. Ward managers showed us the majority of their staff eligible for appraisal had been appraised or knew when they were due. The process involved discussions about professional development. Appraisal rates for medical and non-medical staff across medical specialties were over 80% and managers were actively managing this in order to achieve 100%, with rates reported monthly.
- We were told there were band 5 and 6 professional development courses to prepare staff for more senior roles, but band 7 ward managers expressed concern that staff were reluctant to apply for promotion because of the demands and pressures of senior roles.
- Therapy staff also reported they had structured appraisals by their line manager and personal development plans were developed as part of the process.
- We viewed a number of orientation records for agency staff, which were completed before they worked on a

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ward for the first time. These were a signed record that agency staff had been orientated to the ward, had been shown what to do in the event of an emergency and had been advised of key policies and procedures.

- Agency staff told us they had been given an orientation to the ward and had been given a short induction, after which they were asked to sign the orientation record.
- Core competency training was completed by staff through workbooks and e-learning, and was signed-off by their supervisor/mentor.

Multidisciplinary working

- We observed effective multidisciplinary working with therapists, social workers, nurses and medical staff, including psychology and psychiatric staff, involved in the care and treatment of patients in formal meetings, handovers and ward board handovers.
- We observed family meetings were held to discuss ongoing care and/or discharge arrangements for individual patients and were attended by social workers, therapists, medical and nursing staff.
- Therapy staff reported good liaison and working with ward teams. They told us there were some staffing challenges, such as covering vacancies, maternity leave and secondments, and that bank staff were used to cover. Speech and language therapy support to the stroke unit had been increased to ensure NICE staffing guidance was being met. Staff told us there was psychiatric support to assess patients. We were told most patients who needed a psychiatric assessment were seen within 24–48 hours.

Seven-day services

- There were no concerns raised about the availability of medical staff at weekends or out of hours. Doctors did not raise concerns about out-of-hours medical staffing levels. Some medical staff did raise concerns about the workload of the nursing workforce.
- The ECAM CAG management team were working towards full implementation of seven-day working consultant cover from September 2015. We were told there were daily speciality ward rounds seven days a week but not for acute general medicine. Consultant weekend rotas ranged from working one in five, for example in care of the elderly, to a rota of one in 18 in gastroenterology and dermatology. Staff told us in most specialist wards only new patients and patients of concern were seen routinely at weekends.

- There was seven-day working in pharmacy and imaging was described as responsive to service needs.
- Therapist support was available in respiratory medicine and on the stroke unit seven days a week.

Access to information

- Patients' medical records were available; point of care documents were at the bedside or outside of side rooms. Patient records were multidisciplinary and those we reviewed had entries by all disciplines involved in the patient's care.
- Discharge summaries were generated electronically before discharge. The documentation included the prescription for medication to take home and this was checked electronically by pharmacy staff before the medication was dispensed.
- Staff monitored when the discharge summary was generated and the drugs dispensed and also arranged transport for those patients needing it. Staff told us they completed the discharge by checking the medication against the prescription with the patient and ensuring the patient had all their belongings and documentation before leaving the discharge lounge.
- There was a turnover of patients through the discharge lounge, but we observed several patients experienced a prolonged wait. Staff reported this happened occasionally when there were delays in writing the summary or validating and dispensing their prescription.
- GPs had direct access to the on-call registrar and doctors reported it was a popular service and well used by GPs.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The majority of staff demonstrated an understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS), although some junior nursing staff were not fully aware of the procedures to follow when an application for DoLS may be required.
- Clinical staff, for example nurses and therapists, received mandatory training in the Mental Capacity Act 2005 as part of safeguarding training, but did not have specific DoLS training. Medical staff told us they had received DoLS training. We saw several appropriately completed DoLS applications and the patient records contained references to the application.

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- We saw there were appropriate assessments of patients' mental capacity and there was evidence of the involvement of independent mental capacity advocates. Best interest decisions were well documented in patient records.
- Consent policies and procedures were available and in date. Patients scheduled for surgical or interventional procedures were provided with an explanation of the risks and benefits of the procedure and signed a consent form. There were signed consent forms for any surgical procedures the patient had undergone stored in the patient record. The majority of staff were clear in asking patients for permission to carry out care tasks and procedures.

Are medical care services caring?

Good



Medical care services were caring and the Royal London Hospital was actively seeking assurance through improving response rates of the Friends and Family Test. We observed staff providing care that met the needs of patients while respecting their privacy and dignity. Patient feedback was predominantly positive and there was emotional and spiritual support available across the services.

Compassionate care

- Our last inspection found that patients told us the majority of staff were kind and caring and we found similar patient feedback during this inspection. However, some patients at the listening event felt the quality of services had deteriorated over the last few years.
- All staff groups said they received mainly positive feedback from patients, but nursing staff felt patient experiences were affected by frequent staff and skill shortages on some wards.
- We observed patients' privacy and dignity was maintained. Staff ensured curtains were drawn around beds when delivering personal care and staff interactions with patients were professional and caring. The majority of patients were happy with the care and treatment they received. Patients on the planned investigation unit told us their experience was "fabulous/amazing and the care was marvellous"; on AAU, patients told us "staff are so busy but are always polite".
- Every two hours nurses asked or checked patients to ensure they were comfortable and if they needed support with personal care. This interaction was not always recorded.
- The trust was worse than average for negative patient comments regarding medical care on NHS Choices.
- The Friends and Family Test results from April to December 2014 were variable across medical services, with most response rates ranging from 21% to 52%. One ward was recommended by 86% of patients with a 30% response rate and another scored 63% with a 52% response rate. The CAG-level reports showed some improvements in the response rate of up to 87%. The executive team told us 94% of patients would recommend services at the hospital based on the result of the inpatient survey

Understanding and involvement of patients and those close to them

- Most patients told us they were fully involved in decisions about their care. They said doctors, nurses and therapists provided them with explanations and choices if available.
- Patients had allocated named nurses who were introduced as part of the bedside handover. On the elderly care wards we saw the named nurse's name was written on a board attached to the patient locker as a reminder for patients.
- Some relatives told us they were encouraged to participate in the person's care and had attended family meetings with the multidisciplinary team. Others told us visiting times were not strictly enforced so they could spend more time with their relative during the day. Staff were keen to involve family and carers in patients' care. They told us they had recently used 'Skype' to communicate and involve relatives in the care of a patient who was not living locally.
- The majority of staff wore trust security passes for identification. We could not easily read anyone's name from them because the badges were not worn at eye level and the writing was too small. We saw that staff working in care of the elderly services wore name badges with 'My name is xxx' to ensure patients and relatives could call them by name.

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- Staff accessed language line and translation services when needed. Information about advocacy services was displayed on some wards.

Emotional support

- There was a chaplaincy service available for anyone who needed spiritual support. The chaplain visited wards and staff told us the service was easily contactable. A multi-faith room was available.
- Clinical nurse specialists were visible on the wards and staff told us they were able to refer patients for specialist continence advice and assessment, and wound and pressure ulcer management. Staff valued their advice and support. Patient records showed clinical nurse specialist advice on treatment and care was documented and communicated with the ward team.
- The care pathway for stroke patients included a mood screening assessment. The thresholds for discussions with or referral to a clinical psychologist were clearly defined and we saw appropriate referrals were made.

Are medical care services responsive?

Requires improvement



There was a high bed occupancy rate however 80% of patients received care in the most appropriate ward without experiencing multiple moves. There were effective patient handovers and the hospital had recently altered systems and roles to try to improve patient flow and discharge; however, we could not be assured this would be sustained. Patients living with dementia did not always have their needs met. There were not enough staff or volunteers available to help patients to eat and drink and there were no facilities available to keep patient meals warm. There was limited learning from complaints to improve the service.

Service planning and delivery to meet the needs of local people

- There was limited information available to show how information about the local population was used to plan and deliver services. However staff reported they worked with local commissioners to identify the needs of local people and to arrange service accordingly. There were examples of speciality-specific initiatives, for

example in diabetes where the team had access to the community IT system to access patient records and were working to set up services to identify and treat people with pre diabetes.

- Information from the clinical commissioning group indicated they were confident in the quality of care provided to stroke patients, and local patients experienced an accessible and speedy pathway with a good quality of care provided.
- We were informed by local commissioners that community services in Tower Hamlets were managed by the ECAM CAG. The commissioners raised concerns that the integration of the services had not been as effective as expected in facilitating patient admission from and discharge to the community. It had been anticipated this change would enable the CAG to exercise tighter control and free up acute beds at the hospital.
- Staff reported there were plans to relocate some wards to improve intra-speciality working and increase the effectiveness of medical staff. For example, we were told there were plans to move the elderly care wards onto the same floor, but these had been cancelled several times.

Access and flow

- There were effective patient handover arrangements through daily meetings and between ward staff at the time of transfer.
- Bed occupancy across inpatient wards was 94% for April to December 2014. Most wards were operating at over 90% occupancy despite evidence showing care can be compromised at 85%. The acute stroke unit was operating at over 100% occupancy for six out of the nine months and wards 10E and 11F were operating at similar levels for four months in the reporting period.
- The majority of patients were admitted through the AAU. There were eight beds identified on ward 10E for older patients admitted with a fractured neck of femur to ensure their care was coordinated in accordance with national guidance. Staff told us they rarely had patients admitted directly to the beds, but when they did it worked very well. Patient care was overseen by an ortho-geriatrician consultant.
- Patients admitted to the stroke unit were seen by staff from the unit in A&E, treated, and admitted to the unit in accordance with the stroke pathway of care.

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- Trust data showed that between April and November 2014 there had been a reduction in patient bed moves compared with the previous year: 57% of patients were reported as having no moves, 33% having one, 8% having two and 2% having had three moves.
- Senior managers told us the majority of patients had a maximum of one bed move, but staff reported examples of patients being moved late at night and having more than two bed moves, particularly older patients. We spoke with an older patient who told us they had been moved the previous night at midnight; they were told this was because they were due to be discharged the next day. We were also told at the listening event about a patient being moved into a ward at 3am.
- Medical teams told us they identified priority patients for transfer from AAU or in other wards into their designated wards at the daily meetings and ward rounds. However, we were told the site managers frequently overrode these priority patients and moved patients according to A&E/bed pressures. Staff told us site managers did not listen to ward staff's reasons for moving the already medically prioritised patients.
- Patient flow coordinators identified and enabled patient access to diagnostic testing to try to improve patient flow in the hospital. They attended the daily handover meeting and were tasked to ensure patients waiting for diagnostic tests to confirm diagnosis before discharge were prioritised, and they liaised with radiology/scanning and other departments to speed up requests.
- The trust was working with local partners to reduce the length of stay and to enable the assessment and discharge of patients with complex needs. An additional clinical post had been funded by winter pressures funding to ensure prompt assessments of needs. There were twice-weekly conference calls with commissioners and stakeholders to ensure access to continuing care funding and placement of medically fit patients.
- Weekly meetings were held to monitor patients with extended lengths of stay. We saw the ECAM CAG had reduced the number of these patients from 40 to 20 in the weeks before the inspection.
- The number of delayed discharges information was not available for medical care patients at the hospital. There was a ground-floor discharge lounge that was overseen by nursing staff. Patients were discharged from the ward to the lounge so that patients from AAU could be transferred. Staff were provided with the details of patients being discharged and patients were 'checked in' on arrival. Patients were provided with snacks and drinks while waiting for their take-home medication and transport.
- Renal dialysis patients reported they experienced long waits and delays for transport.
- The hospital's readmission rates for all elective and non-elective admissions were worse than the national average. Readmission rates were particularly high in both categories for nephrology. Elective readmissions for gastroenterology and pain management were worse than the national average as were non-elective readmissions for general medicine. Non-elective geriatric medicine readmission rates were better than the national average.

Meeting people's individual needs

- Translation services were available through the language line and staff could arrange for translators to be booked. However, most staff said they used families to translate for everyday conversations. The interpreting and advocacy service told us they had fulfilled requests to provide translation services for 67 languages in the last 12 months.
- Staff told us they had changed the visiting times on some of the wards to encourage families to visit at any time and particularly over mealtimes to assist in the care of their relative. We did not observe any volunteers or additional staff at mealtimes in wards that had high numbers of patients needing assistance to eat.
- Relatives told us that although some wards had fixed visiting times, staff were flexible depending on patients' needs.
- Patients with a learning disability were identified on the patient administration system. Support was available from a learning disability nurse. There was information that directed staff to contact the nurse if a patient with a learning disability was admitted. Staff were aware of the patient passport and how to access advice and support for the person.
- There was a complex discharge coordinator supported by seven band 4 staff to help discharge patients with complex needs when they were considered medically fit. An additional clinical post had been created to respond to the increased number of complex patients because of winter pressures.
- Medical staff told us there was access to psychiatric colleagues when needed. We spoke with a member of

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the psychiatric team visiting a patient, who told us there were good liaison and referral processes for patients with mental health needs. They told us they attended multidisciplinary meetings and had input into the ongoing care of the person.

- Elderly care wards had adopted the 'Forget me Not' initiative to improve care for patients living with dementia. We saw additional staff were booked to provide 1:1 care to ensure they were safe and able to move about the wards. We heard of initiatives such as 'come dine with me', where patients ate together in the dayroom rather than at their bedside. We were told patients admitted with delirium were automatically referred/transferred to the elderly care team no matter what their presenting medical condition was.
- The hospital carried out carer satisfaction audits based on the national dementia carer audit to assess progress with the implementation of dementia-friendly strategies. These included the implementation of 'Forget me Not', dementia champions, information leaflets and a care plan for patients living with dementia. We saw the Forget me Not symbol was used to identify different bays in wards, information leaflets were available, there were nominated dementia champions and there was signposting to advocacy services available on elderly care wards but not on the general wards. There was a dementia CQUIN to undertake screening assessments, but we were informed that this was not always completed by every medical team when admitting older patients.
- All wards had rooms that could be used to have private conversations with family and carers.
- Patients told us they were always accommodated in single-sex bays, and breaches were monitored and reported as part of the performance monitoring report. There had been between four and 16 breaches reported every month between October 2013 and November 2014. The CAG attributed the mixed-sex accommodation breaches to patients waiting to be stepped down from ITU and it usually related to access to the correct speciality and care-level bed. This was identified as an issue for patients under the care of neurosurgery and patients with a tracheostomy.
- There was a lack of volunteers to assist staff during busy periods such as mealtimes. On the stroke and elderly care wards over 70% of patients required some

assistance to eat and drink. There were not enough staff immediately available to help them, which meant their food was left to go cold and there were no facilities to reheat patients' food once it was served.

Learning from complaints and concerns

- Patients were aware of how to raise concerns and complaints. People were aware of the Patient Advice and Liaison Service and several told us they had found it a helpful resource. There were posters signposting people to the service on the wards.
- The ECAM CAG management team had established a system to manage complaints about medical care services and had reduced the backlog of complaints. Senior managers held a weekly meeting to discuss complaints, concerns and incidents. However, only 45% of complaints had been responded to within the required timescales in the last nine months. There was an average of 74 complaints every month, but 102 complaints were received in September 2014. The top themes from patient complaints were identified as diagnosis and treatment; appointments; security; unacceptable behaviour and communication. We observed ward managers were proactive in addressing patient and relative concerns at the time they were raised.
- We reviewed five complaint responses. There was evidence that local resolution meetings and the responses met the requirements of duty of candour when there was a serious incident. There was an apology and details of the investigation. The most recent responses showed evidence of the actions taken to improve, such as improving documentation.
- Senior managers told us the themes arising from complaints across the ECAM CAG related to delivery of care and staff listening to patients and relatives. They told us they had recognised that wards that were the 'happiest' and had less staffing pressures received fewer complaints.
- There was a lay person on the CAG governance board who provided the patient perspective and was part of the complaint review process and response.
- Staff told us they were involved in the investigation of complaints in their area and received feedback in ward meetings and handover when there were action points to be addressed.

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Are medical care services well-led?

Requires improvement 

We found local leadership within directorates was visible, supportive and ensured services were managed. An overarching vision and strategy for ECAM CAG was not in place. The clinical directorates had identified their future ambitions and developments, but these were not always explicit in every service. Senior staff engagement and visibility was not embedded and staff reported little improvement in the culture of the trust. Staff morale was low in some wards and some staff continued to report a culture of bullying and harassment. Governance, risk management and quality was monitored and some improvements were evident.

Vision and strategy for this service

- Senior clinical leads told us the vision was to develop specialist services while providing high-quality acute general medicine to the local population. Each clinical directorate lead told us their ambitions for their services and future plans, but there was no comprehensive overarching vision and strategy for ECAM CAG that had been communicated to staff.
- Ward staff were aware of the trust strategy to improve patient care, 'The Bart's Health Way', and of initiatives to improve dementia care. The majority of staff felt that the focus for everyone in senior management was to make changes to improve the financial position of the trust with little understanding of the impact the tighter financial controls were having on staff delivering frontline services.
- The hospital was planning an exercise called 'stepping into the future' where services were to be arranged and delivered as though everything was perfect. This was meant to assess where the gaps were in services and help to identify improved ways of working and patient experiences of services.
- There was a trust-wide dementia strategy from 2013 to 2018, but the majority of the actions were rated as in progress/development (amber) and a number had not started. The vision included meeting a dementia target set by the commissioners, but the results for October–December 2014 showed there was a risk of failure because the completion of dementia risk

assessments had not met the required target for all three indicators which were all emergency admissions over 75yrs with a LOS greater over 72hours were assessed for dementia/delirium; had a cognitive impairment test and were referred to the Older People's Service. The hospital consistently underperformed in the period compared with the other hospitals in the trust. The hospital rates were 66%, 81% and 100% against an overall target of 90% in October, 67%, 84% and 100% in November and 58%, 75% and 100% in December. We were told the stroke and health and care of the elderly teams were undertaking the dementia risk assessments, but there was less attention paid to them by other teams when patients over the age of 75 years were admitted by them.

Governance, risk management and quality measurement

- Risk registers were completed at directorate level for each of the specialities and the risks were incorporated into the ECAM CAG register. The high risk register identified risks such as: delayed discharge because of a lack of neuro-rehabilitation beds in London; inability to open high dependency unit beds for renal because of poor staffing/recruitment; IT integration to ensure cardiac diagnostic results were available in the patient electronic record; and VTE completion on renal wards. There was mitigation for each risk and evidence of updates and the rationale for keeping the risk active on the register. We saw most of the high scoring risks were entered onto the register in the last 18 months.
- Senior nursing staff were aware of and contributed to the directorate risk register. Ward managers identified their key risks locally but did not maintain a risk register; not all were aware of the key risks for their directorate.
- The ECAM CAG reviewed performance monthly as part of the trust's integrated monthly monitoring. The monitoring reviewed patient experience data such as Friends and Family Test, staff survey results, complaints, compliments, incidents, patient safety, harm-free care, safeguarding including DoLS and Mental Capacity Act, and staffing levels, training and appraisal rates. However, we did not see any minutes to review what actions were being taken to improve or sustain performance.
- Ward managers told us there were quarterly ward review meetings held with senior managers in the CAG to provide staff with an opportunity to discuss the

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challenges and successes of the ward and for staff to give/receive direct feedback to/from senior management. There was a standard agenda for the meetings that included challenges in patient activity, staffing, key risks, safety and quality results.

- There was evidence of escalation of clinical directorate governance and performance being escalated to the ECAM CAG board and up to the trust board. Minutes of meetings at all levels demonstrated the process followed.

Leadership of service

- The trust action plan from our last inspection included having the executive team on site at weekends and piloting the 'changing lives' programme. Staff were not aware of the executive presence at weekends but were aware of the leadership programme and we spoke with some senior managers who had attended.
- Direct line management was described as very supportive to matron and lead consultant level. Staff expressed concerns at the work pressure matrons experienced following the last staffing review, which removed many matron and senior nursing posts and extended their sphere of responsibility.
- We were told staff working in ECAM CAG had not met the senior CAG medical and nursing directors until the previous week, when there had been an inaugural 'Grand Round' meeting organised by the ECAM Director of Nursing.
- 'Back to the floor Fridays' had been re-implemented, although most staff told us there was limited value in the initiative because senior nursing staff did not spend much time on the wards.
- Ward managers were not able to be supervisory and the majority told us they were always counted in the numbers of available staff. They told us they worked additional hours to carry out their management responsibilities. They also said there had been an increase in the duplication of management information since tighter financial controls had been implemented, such as the introduction of the NHS Ready Reckoner Tool to document and justify agency staffing. Staff told us the information was available on the electronic rostering system and through the staff bank.
- Ward managers told us they were held to account for any overspend on staffing at a weekly telephone conference, which could be heard by anyone dialling in, which they found intimidating and undermined them.

- Allied health professionals told us their management was supportive and available to them because they were primarily based at the Royal London Hospital despite having trust-wide responsibilities.
- Senior staff told us investment and changes in their services were not progressed because they were stalled at directorate level waiting to be advanced through the CAG structure.

Culture within the service

- The majority of staff felt there was a culture in the trust that allowed managers and others in authority to be derogatory and undermine their colleagues in public forums.
- Most staff were aware of the trust report into bullying and harassment and several people told us "it resonated with them". However, the trust acknowledged there remained a staff perception that bullying and harassment was an issue and low morale contributed to it. We received several allegations of bullying and harassment, particularly around bed management/patient transfers, with staff feeling disempowered to refuse admissions when they were short of staff or felt unable to meet the patient's needs.
- Staff reported there was good teamwork on the majority of wards and excellent relationships with medical, nursing and therapy staff. We saw the trust had implemented recognition awards and several staff certificates were displayed on noticeboards.
- Sickness levels were variable across medical services, with an overall annual rate of 3.29% for ECAM at the Royal London Hospital in December 2014. Ward managers told us there were no long-term sickness issues on their wards and sickness absence was actively managed. We saw some staff were supported back to work in different roles until they were fully fit to undertake their usual role.
- Staff turnover was reported by the service and we found the highest turnover rates were in the medical and dental staff group at 22.84% in acute medicine (which was a reduction from 50% in the last reporting period); there was a 25.79% turnover in elderly care trained nurses and a 26.92% turnover rate in neurosciences administration and clerical staff.

Public and staff engagement

- In response to the last Care Quality Commission report, the trust committed to increasing Friends and Family

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Test responses to 20% and to give support to those areas not achieving this. Staff reported it was a constant struggle to obtain Friends and Family Test survey responses, although some medical services wards were achieving the target consistently.

- Nursing and therapy staff reported they had opportunities to attend ward and department meetings and that directorate and CAG information relevant to them was provided. Band 6 nurses attended regular meetings with senior directorate managers.
- The majority of staff felt communication had improved in the trust, although there were examples of changes to services and systems of work that were not well communicated.

Innovation, improvement and sustainability

- The diabetes service was proactive in trying to improve access and services for younger people, using technology and social gatherings to engage with them. The service was working with GPs in Tower Hamlets to improve the identification of patients with pre-diabetes, which was identified as an increasing problem in the community.
- The stroke service was involved in drug trials and research in other treatments.
- The three year older people's improvement programme started in 2014. The programme included providing study days and courses for staff in older people's services, as well as providing ongoing support programmes for staff such as staff forums, dementia training and action plans for improvement. This improvement was to be evidenced by education and training records for staff involved in older people's services, such as for those nurses with a degree, and those who had completed an older people's course. Staff told us that activities had, to date, involved ward teams spending a day away for training to help reduce falls, pressure ulcers and complaints and improve the patient experience. There had been some impact on the wards we visited.
- Other medical wards told us they had also been able to arrange away days to develop the ward team, set ward objectives and provide training.
- Each medical specialism was involved in research to improve treatments for patients and the ECAM CAG research board was responsible for monitoring activity.

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

Information about the service

The services consists of 18 theatres and 10 wards all based within the main hospital building. Each year the hospital undertakes approximately 22,000 operations which are a mixture of day cases (47%), elective procedures (21%) and emergency procedures (32%).

During our inspection we visited all 10 wards, the theatre complex and the pre-assessment unit. We spoke with 32 patients and their relatives, approximately 45 members of junior and senior staff and reviewed documentation.

Summary of findings

There was no department wide learning from incidents or complaints and the service did not accurately monitor the number of Never Events that occurred. There had been four Never Events and a small proportion of the WHO surgical safety checklist were audited. There was a heavy reliance on bank and agency staff who did not always have access to the electronic patient records and local policies and protocols. The service was not confident in the data for 'Referral to Treatment Times' and were not reporting externally. Internally the service reported that the 18 week target was not being met and operations were frequently cancelled. There was minimal senior leadership across the service and limited vision for the service.

However, the department achieved good surgical outcomes for patients. Staff provided treatment and support in a caring and compassionate manner. There were some good examples of local leadership and innovation. The trauma centre was effective and innovative.

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Are surgery services safe?

Inadequate



Safety was not a sufficient priority. Lessons learnt from incidents and Never Events were shared with staff members directly involved with the event itself or investigation of the incident but there was limited evidence of them being learnt from across the service, hospital or trust. The quality of the audit of the WHO surgery safety checklist did not provide meaningful assurance for the service.

There were no set protocols in theatres for what needed to be clean and how often. The contract with the external company had expired and in September 2013 and theatre staff undertook the tasks.

There was a heavy reliance on bank and agency staff who did not always have access to the electronic patient records and local policies and protocols.

Incidents

- Three Never Events were reported to have taken place in the service between October 2013 and September 2014. Two related to wrong site surgery and one related to surgical error. We saw a review of one of the never events which looked at the root cause and put a plan in place to prevent reoccurrence (including new protocols for when trainees can undertake particular procedures unsupervised). However, while on site we were given information that related to further never events that may not have been reported within 72 hours. There was confusion over the number of Never Events reported by the hospital and learning which did not reflect a good safety culture.
- The learning from Never Events was shared with those directly involved in the event or incident investigation, but there was limited evidence of them being learnt from across the service, hospital or Trust. Individual training was provided where needed. The department's risk register recorded if incidents (and complaints) were not learnt from across the department. This was raised in September 2013 and had not been adequately addressed.

- A record was kept of all the incidents that took place within the department. This contained details of the incident itself, remedial action taken, the investigation and lessons learned.
- Incidents were reported using the hospital's incident reporting system to which all staff had access. They would also be discussed at local governance meetings.
- On the wards the staff we spoke with were aware of how to escalate any concerns they had and how to report incidents. They were able to describe how some procedures had changed as a result of learning from incidents including how further teaching on protocols had taken place and the staffing levels had been revisited to account for different acuity levels.
- Multidisciplinary mortality and morbidity meetings took place on a monthly basis. Staff described them as useful and said there was a focus on whether they could have done anything better.

Safety thermometer

- There was a safety thermometer board on most wards. This displayed information about the ward's performance including when staffing levels had been met and infection rates.
- Analysis of submitted safety thermometer data indicated a low number of pressure ulcers, falls and catheter associated urinary tract infections reported within the surgical department.

Cleanliness, infection control and hygiene

- The rate of surgical site infections for hip and knee replacements was low.
- During our inspection we observed theatres and all ward areas we visited to be clean and tidy. Staff on the wards described their domestic staff as "responsive" to any hygiene issues or concerns. Records were kept of when cleaning took place on the wards.
- On the wards hand gel was available and we observed good hand hygiene practices from staff. Staff were 'bare below the elbow'. However, hand washing basins were not widely available across all the wards.
- Theatres were cleaned on a daily basis and between procedures. However, the contract for external cleaners within theatres had expired and not been renewed. This was placed on the departmental risk register in

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September 2013. Theatre staff were undertaking the cleaning but there were no set protocols for what to clean and how often. This issue had been placed on the department's risk register.

- There were stickers on equipment to show when it had last been cleaned.
- Sharps bins were available which were labelled and dated.
- All patients were tested for MRSA infection at pre-assessment. Between April and December 2014 there had only been two MRSA infections in the department.
- Clear signage was used when patients were being nursed in isolation.
- We reviewed the results of infection control audits that took place between April 2014 and December 2014 looking for infections. No significant issues were raised. Nursing staff undertook the Saving Lives audit to monitor infection control measures and whether they were adhered to by staff.
- We reviewed the results of the most recent audits of infection control practices within theatres and the wards. No significant issues were highlighted though normally several necessary improvements were noted and actions plans were detailed. However, it was noted that in the January 2015 audit of ward 13D significant issues were found, several of which needed to be addressed immediately.

Environment and equipment

- Staff said that equipment was readily available including beds and mattresses.
- No unmanaged health and safety risks were observed on the wards or in the theatres.
- On each ward there was a resuscitation trolley which carried appropriate equipment and drugs. These were checked regularly to ensure that they were in good working order and in date.
- Resuscitation trolleys were available in theatres and there were records of regular checks in recent months.

Medicines

- On the wards medicines were stored in locked cupboards and trolleys in the clinical rooms. Controlled drugs were checked every 24 hours and there were

records of this taking place. The temperatures of drugs fridges were checked regularly. We reviewed a selection of medications which were all in date and there was a system in place to make sure of this.

- Within theatres controlled drugs were kept in a cupboard that was not locked. Staff were aware and reported that they had plans to rectify this. We also found drugs fridges in the theatre complex that were not checked on a daily basis.
- Controlled drugs kept in the recovery area were checked regularly and stored appropriately. The amount of drugs available matched the record.
- Medical gases were accessed through wall-mounted service panels and free cylinders were not used.
- Patients were asked about any allergies they had at pre-assessment.
- Pharmacists visited the wards on a regular basis and conducted audits. Within the past six months there had been two instances where controlled drugs had gone missing on two separate wards.

Records

- On the wards, medical records were kept at the end of patients' beds. These included admission and assessment documentation, as well as pre-assessment information for elective patients. All staff involved in the care of the patient used these records.
- The majority of the records we reviewed were completed and up to date. They contained legible and relevant entries from all members of the multidisciplinary teams looking after patients.
- We spoke with staff on the wards who said that medical records were usually readily available.
- Records were kept of when cannulas and other devices were inserted and removed from patients to minimise the chances of patients leaving hospital without them being taken out.
- Agency staff did not have access to the electronic patient records and had to ask the nurse in charge to make medical requests for them. Agency staff were used routinely by the department and significant patient information was held electronically.
- In addition we found that on one of the wards the electronic records were mainly used by medical staff and the paper records by nurses and other staff raising the risk that important information could be missed by either groups.

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Safeguarding

- Staff we spoke with said they would discuss any safeguarding concerns they had with senior staff and the dedicated safeguarding team. They knew how to spot signs of possible abuse and how to report their concerns. However, it was not clear whether learning from safeguarding incidents was shared across the department.
- Since March 2014 only one safeguarding concern had been raised at the hospital which related to an incomplete discharge. This resulted in a multi-agency strategy meeting being held. However, staff spoke told us of safeguarding concerns they had reported that were not included on the overall list we were provided with.

Mandatory Training

- All staff underwent mandatory training in topics such as safeguarding, moving and handling and infection control. At the time of the inspection the majority of staff had completed their mandatory training.
- The Trust's target for completed mandatory training was 90%. Records indicated that completion rates were at 88% for safeguarding, 68% for infection control, 56% for medicines, 86% for moving and handling, 91% for health and safety and 70% for information governance in the Royal London Surgery department.
- Staff on the wards were expected to monitor their own mandatory training. Any gaps in this was picked up at appraisals and during supervisions.
- Mandatory training was available in booklet form which staff were asked to read and were tested on.
- Theatre staff told us that their mandatory training was not monitored effectively.

Assessing and responding to patient risk

- The 'Five Steps to Safer Surgery' system was used across the department. This was a process in which essential safety checks were made at five distinct points before, during and after surgical procedures.
- We were given copies of the audits that had taken place of World Health Organisation Surgical Safety Checklists which ensure that appropriate safety checks are made before, during and after surgery. These were completed and did not highlight any significant issues. The audit was not enough to provide the service with assurance that the checklist was embedded because a very small

proportion audited - between five and ten out of over 400 procedures each month. There was no increased observation or audits of the checklist following the four Never Events.

- Staff used the Patient At Risk scoring system to monitor the health of patients on the wards. If a patient's score went below a set level this triggered the calling of the medical outreach team. Where appropriate their fluid balance, nutritional intake, cannula sites and stools were monitored, amongst other relevant health factors. Staff knew how to escalate if a patient's condition deteriorated.
- During handovers the risks faced by individual patients were discussed with the multidisciplinary team present. Any relevant safety factors within the ward environment were also discussed such as pressure ulcers, falls or medication issues.
- Staff reported that there was good access to surgical doctors on the wards. However, they said that contacting non-surgical doctors to see patients who needed to be on a specialist medical ward was sometimes difficult.
- Staff were trained in how to provide emergency life support and knew how to contact the outreach team

Nursing Staffing

- There were approximately 529 nurses in the surgery department at the hospital and 112 Healthcare Assistants.
- During December 2014 bank staff were used to fill 399 nursing shifts due to vacancies.
- Staffing levels were monitored on a daily basis by senior nurses. When the establishment was not met this was recorded using the safety boards on each ward.
- Guidelines from the Association for Perioperative Practice were used to set minimum theatre staffing levels and there was also specific guidance for the orthopaedic theatres. These establishment figures and skill mix were appropriate.
- During the inspection the theatres and wards were appropriately staffed, though numerous staff reported that there were pressures on the department and that any vacancies or sickness absences could have a significant immediate impact.
- Staff confirmed that there were vacancies within theatres, in particular amongst the Operating

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Department Practitioners. They reported that they regularly used bank and agency staff, though the bank staff were often also full time employees and they tried to use the same agency employees each time.

- Nursing staff worked long days which senior staff said helped ensure patient continuity.
- Specialist nursing staff were available on the pre-assessment unit to undertake specialist assessments in a variety of surgical sub-specialities.
- On the short-stay ward the staffing establishment figure did not account for the recent introduction of 18 extra beds. Agency and bank staff were being routinely used to ensure there were enough staff on the ward. Concerns were also expressed at the level of acuity of the patients on the ward and it was considered that such acute patients should not be nursed by non-permanent staff. Staff reported that nurses were working beyond their contracted hours. The 18 extra beds and the acuity level had both been placed on the department's risk register.
- During the inspection, on ward 10F we found that there had been staffing shortages on 16 out of the preceding 22 days. There were also concerns about the acuity of the patients on the ward. Staff reported that they had escalated their concerns but these had not been responded to.
- Staff also reported that there were nursing staff pressures on wards 13D and 12F.
- Staff in theatres reported that staff sometimes worked 24 hour long shifts to cover absences.
- There was a specific induction for agency staff which included details such as emergency procedures and documentation used on the ward.

Surgical Staffing

- There were approximately 124 consultants in the surgery department at the hospital, 229 Junior Doctors and 11 career grade doctors.
- Senior staff reported that whilst they felt they had enough surgical staff, there was very little margin for error and staff absences could put the service at risk.
- There were insufficient numbers of consultants to deliver the type of on-call rota that senior staff preferred.
- Surgical cover was provided 24 hours a day seven days a week.
- Surgical trainees we spoke with were positive about the consultants and said that they were easy to access if they needed support.

- Some nursing staff expressed concerns that on occasion discharge could be delayed as doctors were not available to sign-off prescriptions for medications that patients would be taking home with them.
- On the department's risk register there were two items which related to surgical staffing. One related to a lack of orthopaedic Senior House Officers which could lead to a lack of medical cover on the wards and elective surgery having to be cancelled. This was placed on the register in May 2014 with a review to take place in January 2015. The other related to an over-reliance on locum staff in theatres which was placed on the register in December 2015.

Major incident awareness and training

- There was a written plan for what Trauma staff should do in the event of a major incident. This was available on the intranet. The specific roles for each member of the team were set out.
- Trauma staff undertook table-top simulation exercises to help them train for major emergencies.
- Staff on the main wards were aware of the major incident policy but had not taken part in any training exercises.

Are surgery services effective?

Good



The service provided evidence-based care and treatment and achieved good surgical outcomes for its patients. All staff worked well as a multidisciplinary team with appropriate professionals from both inside the hospital and external involved as necessary. The service was not yet working as a seven day service, with team members on call at the weekend rather than present at the hospital. There was a lack of understanding on the application of the Mental Capacity Act and the Deprivation of Liberty Safeguards.

Evidence-based care and treatment

- Up to date nursing guidelines (in line with NICE guidance) were available in appropriate topics. Appropriate medical guidelines on the care and treatment of patients were also available, some of which were under review at the time of the inspection. We

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asked for evidence of compliance with NCEPOD and the association of anaesthetists standards however this was not provided although medical staff said they were compliant.

- Staff in theatres were given hard copies of policies and were asked to sign a record to indicate that they had read and understood them.
- Policy updates were sent out by email and ward/theatre managers discussed them with staff.
- Set care pathways were available within the orthopaedics service for caring for patients who had undergone replacement of their hips, knees or shoulders. Further pathways were available on the intranet.
- There were specific procedures and protocols in place for the immediate management of trauma patients. However, some staff said that care pathways were not always available, particularly for trauma care.
- At the Trauma and Orthopaedics MDT meetings the x-rays of patients who had already undergone treatments were examined to ensure that optimal results had been achieved and to see if re-intervention was needed. This was considered to be good clinical practice.

Pain Relief

- The Peri-operative and Pain service (within the surgery department) undertook a full programme of their own audits of the quality of their service and outcomes to ensure they provided a high quality of care and treatment. This included looking at the effectiveness of specific methods of pain relief as well as more broad analyses of the department's work such as time spent in hospital and reasons for delays in care. Specific policies were available on the control and management of pain, including epidurals, patient controlled analgesia and adult chest trauma.
- Written documentation was available for pain scoring and we saw records of this being used by staff.
- The dedicated pain relief team visited the wards on a daily basis.
- The service asked patients to complete a patient satisfaction survey specifically about their pain management during their stay.
- A recent audit into pain relief for patients who had undergone thoracic surgery had been completed which

showed that the individual modalities of pain relief did not have a great effect on pain scores or satisfaction, but that further work did need to be undertaken to reduce patients pain on the first day after surgery.

- Not all staff on wards were trained to care for patients with epidurals or using patient controlled analgesia.

Nutrition and hydration

- Most patients were satisfied with the food provided.
- Patients nutrition and hydration was monitored on the wards, before and after surgery using appropriate tools. This was standard within patient records and it was mandatory for it to be completed within six hours of a patient's admission. Nutritional scores were then monitored throughout a patient's stay.
- Ward staff reported that they had recently invited patients' families to eat a meal with their relatives in order to get their feedback on the food provided. They said that band 7 nurses would normally collect patient stories but the vacancies at this level meant this did not happen regularly now.

Patient Outcomes

- The April 2013 – December 2013 Patient Report Outcome Measures (PROMs) for the Trust in relation to Groin Hernia, hip replacement, knee replacement and varicose vein procedures showed the trust generally achieved more positive outcomes in all procedures.
- In the Hip Fracture Audit 2013 six out of ten measures at the hospital were rated better than the England average.
- The trauma service frequently benchmarked its progress against other trauma centres and over the past ten years had received numerous accolades for patient outcomes. These included best survival rates for critically injured patients, those in shock as well as those with pelvic and vascular trauma.
- We spoke with senior staff and asked them for areas where they achieved good outcomes for patients. Staff reported that their pancreatic cancer surgery outcomes, their penetrating injuries trauma surgery outcomes, their emergency surgery and general survival outcomes, and their intestinal failure outcomes were all positive compared to national benchmarks. They were also positive about their pelvic floor surgery outcomes and their intestinal failure outcomes. We were provided written evidence of the positive outcomes by the trauma and orthopaedics service.

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- There was a dedicated pre-assessment unit. This included Cardio Pulmonary testing equipment within the department itself, the results of which could be electronically uploaded to patients records within half a day. At the time of the inspection the service was operating effectively and there was no waiting time for patients.
- In the Trauma and Orthopaedics MDT meeting, when discussing possible surgical interventions, staff were observed to make direct reference to audit results and success rates when deciding on particular procedures.
- The risk register identified patients with a fractured neck of femur were not always being operated on in under 36 hours which posed a risk to their outcome.
- For the hospital, re-admission rates for elective Ear Nose and Throat surgery and non-elective Urology surgery were higher than average.
- The performance of each individual surgical consultant was monitored for each procedure they performed.

Competent Staff

- Theatre nursing staff had a set list of skills-based competencies which they needed to achieve. They needed to spend at least eight weeks in theatres and four weeks in the recovery area to be considered competent.
- Staff had opportunities to undergo further training. This included areas such as anaesthetics and higher qualifications in nursing.
- Staff received an annual appraisal where their performance was discussed and areas for development highlighted.
- There was a policy for yearly update training to be provided to staff who cared for patients using patient-controlled anaesthesia or with epidurals and for one to one sessions to be provided to new staff. These were provided by the dedicated pain team. However, not all staff undertook this training despite their being patients with these needs on the wards where they worked.
- Staff reported that ward based training took place, such as in delivering intravenous treatments, but no records were kept of who had undertaken this.
- Surgical trainees reported that it was easy to access their educational supervisor.

- A full course of academic trauma service meetings was provided including courses in specific types of injury, violence reduction, learning from mistakes and team resource management.

Multidisciplinary working

- We observed clinical and administrative staff working well together and putting the patient first. The staff that we spoke with described a strong and supportive team atmosphere on the wards and one person told us that “everyone is here for the patients”.
- Senior staff spoke positively of the relationships the surgical team had with pathology and imaging.
- Multidisciplinary handover meetings took place daily on the wards.
- The hospital had a dedicated discharge team which the surgical wards had access to.
- Staff in the pre-assessment unit said they had good access to the full team to complete their assessments including anaesthetists and imaging staff.
- We observed a Trauma and Orthopaedics multi-disciplinary team meeting. It was well attended by both junior and senior staff, as well as multi-disciplinary professionals. The meeting was held in an open, constructive and forthright fashion during which all relevant parties could make appropriate contributions.

Seven-day services

- Nursing levels and ward clerk levels were constant throughout the seven day week.
- Surgical staff reported that interventional radiology was readily available 24 hours a day seven days a week..
- However, doctors, pharmacists and physiotherapists were only on call at the weekends and not physically present in the hospital (apart from the emergency/trauma service).

Access to Information

- Patient notes were easily accessible and contained relevant information to enable to staff to provide care and treatment.
- Written information on looking after yourself following discharge was provided to patients.
- In the records that we reviewed both the paper and the electronic care records were up to date.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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- As part of the 'Five Steps to Safer Surgery' audits that took place, staff checked to see if consent forms were completed and included in patient records. The audits that we reviewed showed that these were routinely completed and included, but a small proportion were audited.
- Patients told us they had been "kept informed" about what their treatment involved and that the information they were provided with was clear.
- When patients were unable to provide consent decisions were taken for them in their best interests. Discussions of what this was were taken in conjunction with family members and the surgeon and anaesthetist.
- However, a number of staff on the wards were unclear how the Mental Capacity Act and the Deprivation of Liberty Safeguards should inform or impact on their daily work.

Are surgery services caring?

Good



Patients were treated with dignity and respect by staff. Care and treatment was provided in a caring and compassionate manner. Patients and their families were involved in decisions about their treatment. They were given appropriate information about treatment.

Compassionate care

- Between April 2013 and July 2014, on average 64% of patients and their families using the service said they would recommend it to others.
- The pre-operative assessment service conducted a supplementary survey looking at patient satisfaction in relevant areas such as information provided and how patients were treated by staff. Patients rated the service positively in all categories.
- Patients were very positive about the quality of care that they received. They said that "everything [is] very good" and that they had been "well looked after".
- They said that any pain and nausea had been handled well and described staff as "respectful", "considerate" and "lovely".
- We observed staff caring for people on the wards. They behaved in a kind and supportive manner throughout and were helpful and considerate.

- Patients told us that their privacy and dignity were maintained and we saw this taking place.
- Meal times were 'protected' so patients were not interrupted whilst eating.

Understanding and involvement of patients and those close to them

- The patients that we spoke with said that they had been involved in decisions about their care and treatment and they understood what they involved. They said that their relatives had been involved in these decisions appropriately.
- Within the pre-assessment unit a range of leaflets for patients were available. These covered topics such as preparing for a stay in hospital, anaesthesia and specific surgical procedures. They were written in easy to understand language.
- Patients were provided written copies of their discharge summaries which included details on how to look after themselves following their procedure.
- There were written notices that told people how they could contact the PALs team though across the hospital.
- The orthopaedics department ran a 'Joint School' programme where people received information and guidance on what to expect before, during and after joint replacement procedures.

Emotional Support

- Staff were aware of the impact that people's surgery would have on them and the need to put comprehensive discharge plans in place from an early stage.
- There was a designated member of staff in the Trauma and Orthopaedic service took a lead role in speaking with patients and their relatives and helping them understand their treatment and support.

Are surgery services responsive?

Inadequate



The service was consistently not meeting the 18 week 'Referral to Treatment' target. Elective procedures were frequently cancelled, sometimes multiple times, for non-clinical reasons, and not always rebooked for within 28 days. The service did not always meet the needs of people and there was no learning from complaints.

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Service planning and delivery to meet the needs of local people

- Staff reported that they were working with local healthcare commissioners on a project called 'Transforming Services, Changing Lives'. This was an initiative at the local health economy and see how the needs of the local population could be better met.
- Staff stated that they would like to make improvements to improve the rehabilitation services at the hospital, and in particular the access to therapy support and rehabilitation personnel in general. A business case had been made for this three years previously but had not been progressed.
- It was reported that there was need for a separate rehabilitation facility that could be accessed by other Trauma units as this would significantly reduce costs (compared to having patients in an acute setting for extended periods).

Access and flow

- From April 2013 to August 2014 the hospital had not met the 18 week 'Referral To Treatment' (RTT) target in nine out of ten surgical specialities. The trust stopped reporting formally in August 2014 due to the lack of confidence in the data. Internally the data was being collected and indicated that the hospital was not meeting its admitted and non admitted pathway.
- The rate of cancelled operations that were not being rebooked within 28 days had worsened to above the England average since September 2013. Between July 2014 and October 2014, 17 cancelled operations were not rebooked within 28 days out of a total of 109 cancelled procedures (across the trust, data specific to the hospital was not available)). The main reasons for the cancellation of elective procedures reported by staff and audits were that the patient did not attend, a lack of critical care/high dependency beds or ward beds, the patient was clinically unfit, lack of access to diagnostic and imaging facilities or unavailable medical notes.
- Theatre staff told us that cancelled operations were a significant issue with some operations being cancelled multiple times and some having to be referred to the private sector.
- Senior staff reported that the organisation had recognised they would need another 25 beds to meet the demands on the service, but that the cost of this was an issue.

- The average length of stay figure for the hospital was slightly above the England average, in particular for non-elective procedures.
- The Trauma and Orthopaedic service reported that because a high proportion of their patients were homeless or had limited social support at home, their hospital stays were often extended as discharge arrangements took a while to put in place.
- We looked at the projections for waiting list sizes across the surgical specialities between January and April 2015. Some waiting list sizes were stable, and some showed reductions. However, significant specialities such as general surgery, urology and colorectal surgery showed projected increases in the waiting list sizes between January and April 2015.
- At our last inspection we raised that patients were being cared for in recovery, an area that did not meet their needs. On this inspection we found the situation was continuing. Theatre staff told us patients were kept in the recovery suite for extended periods of time as beds were not available in critical care or wards. Between November 2014 and January 2015, 48 patients were kept in recovery overnight. The longest wait in recovery for an emergency patient was 48 hours and 51 hours for an elective patient. Patients in recovery did not have access to patient toilets, there was no specific procedure for providing food to patients and pathways for receiving care such as physiotherapy were not always followed. In addition, there was sometimes a lack of appropriate medical cover. Staff said that these concerns had been reported but as yet not changes had been made. Ad hoc arrangements around food and visiting relatives were put in place where needed and extra staff could be obtained if necessary.
- Ward staff reported that discharge planning began when patients were first admitted and was a multidisciplinary effort. General managers assisted nursing staff in enabling the discharge of patients. Staff reported that they tried to start discharge planning early (including at pre-assessment) and would involve social services where appropriate. The rehabilitation needs and the timescales needed for discharge were considered by the Trauma and Orthopaedics MDT meeting prior to procedures taking place.
- The Trauma and Orthopaedics service, in an effort to manage the pressures on the department, stabilised

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some patients who attended as an emergency, then sent them home and asked them to return as a day case. This prevented lengthy hospital stays whilst waiting for their procedure to take place.

Meeting people's individual needs

- A high number of patients first language was not English. Interpreters were arranged if patients needed them however translation services were not available 24 hours a day seven days a week.
- The surgical pre-assessment unit had invited a group of patients with learning disabilities to undergo a mock surgical pre-assessment. Following this they asked them for feedback on the process which they used to make improvements so that the service would be more accessible.
- There were no mixed sex bays on the surgical wards.
- Patients had access to an 'Advocacy' team who helped with translation as well as if patients wanted to make a complaint. A PALs team was also available.
- A choice of food options were available, including specific cultural options.
- Patients had access to the hospital's religious service which included access to a Rabbi and an Imam.
- Psychiatric support was available through the medical staff.
- Staff told us that ward based training on learning disabilities was available. There was a lead learning disabilities nurse within the Trust.
- Dementia training was available and the hospital used the 'forget-me-not' system to help identify people with dementia. However, we did not see this in evidence on the surgical wards or theatres.

Learning from complaints and concerns

- Staff across the service reported that a significant proportion of their complaints related to delayed procedures or their cancellation.
- Staff that we spoke with knew how patients could complain and the support that was available to them when doing so.
- Leaflets containing details on how to complain were available on the wards.
- There was a process in place for complaints to be learnt from. However, there was an item on the department's risk register highlighting the risk of the department not taking time to learn from complaints indicating this did not always take place.

Are surgery services well-led?

Requires improvement



There was no clear vision or strategy for the service. There was minimal department-wide leadership from senior staff. However, we saw some examples of excellent local leadership in the Trauma team and the Recovery team. Outcome measures were used throughout the department to monitor quality. There were some positive examples of innovation within the department, in particular within the Trauma service.

Vision and Strategy for this service

- On the wards the majority of staff said that they were unaware of any strategy for the service and in some cases they were not aware of any plans for how the surgical sub-speciality they worked in would be developed.
- Senior staff reported that due to the current pressures on the service a significant amount of management time was given over to dealing with immediate issues and there was very limited capacity for strategic development. They said their staffing establishment figures were due to be reviewed in the near future.
- The Trauma service were aware of their strengths and weaknesses, as well as details of their strategic priorities and ideas for achieving them. They were also able to provide details of the risks to achieving the strategy, and how they proposed to mitigate these.
- Trauma staff reported that there was currently a shortage of reconstructive surgery colleagues who could take part in the Trauma pathway but long term locums were in the process of being recruited.

Governance, risk management and quality measurement

- The service kept a record of the risks it faced. However, it appeared that some of the items on the register had been there for some time without being resolved.
- The CAG met on a monthly basis, though senior staff reported that cross-CAG working and communication (between the surgical sub-specialities) could be improved. Topics discussed included incidents, risks, complaints, policies and audits. However, improvements that were made as a result of incidents

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or complaints were only implemented within individual surgical specialities and not across the department (including those relating to serious harm and never events). In addition, junior staff were not aware of the outcomes of these meetings and how they impacted on the treatment and support the service provided.

- Some staff expressed concerns about the quality of data supplied as part of the governance process, though noted that it was improving. Whilst they reported that the information was available it needed to be checked each time to ensure it was accurate.
- Theatre staff held weekly and monthly governance meetings which could be used to raise any concerns about the performance of the department. Some of the staff that we spoke with said they felt they were able to challenge senior colleagues when they had concerns.
- Within Theatres there was a specific audit programme which included regular assessments of performance around topics such as safeguarding, controlled drugs and equipment.
- The Trauma department was a member of the Trauma Audit and Research Network (TARN). This is a national group set up to help trauma services improve their performance. As part of this group the hospital's Trauma department (including the emergency surgical service) was peer reviewed by an external clinician annually and their performance was benchmarked against other trauma departments on a quarterly basis. The results for the hospital in quarters one and two of 2014/15 were mixed, with a relatively even mix of the hospital scoring above and below the national average across a range of performance measures.
- There was a programme for local and national audits to be undertaken across the department. However, a significant number of these had a 'report due' date marked next to them which had expired, and it was not clear whether they had been completed.
- The perioperative and pain governance meeting was held on a monthly basis. At these meetings they considered items such as incidents that had occurred, items on the risk register and the response to them, delays in care and any complaints.

Leadership of service

- Some staff that we spoke with said that they were under a lot of pressure, but did not feel that the senior staff supported them.

- We were told senior nursing staff were visible and they held drop-in sessions and spent time talking to staff. However, junior staff reported that across the surgical wards and theatres senior staff were not visible and did not visit the wards very often.
- On some of the wards that we visited they had vacancies at the band seven level. This meant that many routine management tasks, such as audit and clinical supervision, did not take place.
- There had been long term vacancies in General Manager posts across the CAG which had hampered the effective running of the department. This had been identified in November 2014.
- Staff on the short stay (ACAD) ward reported that they had contacted senior management about whether patients needed to be triaged for suitability before they were admitted to the ward given the level of acuity of patient they were receiving. However, they said that not had any feedback on this.
- During the inspection we saw very positive of local leadership in both the Trauma service and the Recovery service. Good teamwork was in evidence with clear support and guidance provided by leaders.

Culture within the service

- The majority of staff identified with being part of their ward's team or their surgical speciality's team, but very few staff identified with the surgical service as a whole. Staff felt they were isolated from and not supported by senior managers. They felt increasing pressure and tension, particularly around staffing and flow concerns, but did not feel that there was a plan to resolve this. There was limited communication or joint/supportive working across the department.
- It was noted that in a November 2014 report a culture of bullying and harassment had been identified at the hospital. However, whilst staff reported that they were under pressure and were not supported by senior management, very few of the staff we spoke to reported this taking place in the service.

Public and staff engagement

- Ward staff reported that they had previously used various initiatives to get feedback from patients including noting 'patient stories' about patients

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experience in the hospital, as well as inviting families to eat on the wards with their relatives. However, it was reported that capacity issues had reduced staff's opportunities to do this.

Innovation, improvement and sustainability

- A surgeon had become the first in the UK to broadcast online a live surgical procedure using a pair of Google Glass eyewear. The procedure was watched by 13000 surgical students around the world from 115 countries and they also had the opportunity to ask the surgeon questions.
- In the week following the inspection the service was running an initiative entitled "Stepping Into the Future". This was a trial run of a new operating model that, it was hoped, would help relieve some of the flow and access issues in the service. Initiatives that would be tried would include ring fenced surgical elective beds, no non-clinical cancellations on the day, surgery not starting without an available ITU/HDU bed, and trauma and orthopaedics to concentrate on emergency admissions only.
- Senior staff were trialling the Multidisciplinary Action Training in Crises and Human Factors initiative (MATCH).

This was a framework within which Never Events and Serious Incidents could be discussed in an environment characterised by mutual respect and in which lessons learnt could be quickly introduced without damaging personal relationships. It was reported that initial results had been very promising. However, staff reported that whilst there had previously been plans to introduce this across the Trust, the financial pressures the Trust faced may put this on hold.

- 25% of the patients attending the trauma service as an emergency had penetrative wounds, which is significantly higher than any other UK trauma centre. The service had regular national and international visitors wanting to learn from the service. The service had worked with the Armed Forces whilst on combat operations and had taken specific learning from this.
- In particular, the Trauma service in conjunction with military colleagues had developed the concept of the 'platinum ten minutes' based upon techniques used to help save the lives of soldiers in combat situations. Through the use of fluid, plasma, active surgical intervention and rapid assessment at the scene more patients were arriving at hospital alive.

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

Information about the service

The Adult Critical Care Unit ACCU provided both specialist and general critical care support for the local population, as well as tertiary services including trauma, neurosciences, maxillofacial and ENT, vascular, renal, hepato-biliary medicine and surgery. From January to December 2014 the ACCU admitted 2729 patients, there were 44 beds on the unit which were configured to provide 22 beds for patients requiring level 3 care with one-to-one nursing as well as 22 beds for patients requiring level 2 care, with a ratio of one nurse to two patients. There was a Critical Care Outreach Team (CCOT) who assisted in the management of critically ill patients on wards across the hospital.

The Renal High Dependency Unit had four level 2 beds and two side rooms that provided specialist care to patients with renal disorders or undergoing renal transplantation.

We talked with 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

Patients and relatives were positive about the care they received and the support from the staff that looked after them. The ACCU was a consultant led service which provided cover in accordance with the Intensive Care Standards (ICS). There was a clear vision about the service that the staff wanted to provide a quality service. There was a commitment to delivering a multidisciplinary collaborative approach to care and treatment which was evidenced based and followed national and best practice guidance. The unit had a daily safety huddle meeting which staff were encouraged to attend: the purpose was to ensure that staff were aware of any quality improvement strategies, changes and dissemination of information.

Recruitment of new nursing staff had seen the vacancy rate decrease from 25% to 8%, there had been a reduction in the use of agency and bank shifts. During the inspection patient acuity was high; the unit was utilising higher numbers of staff to meet the increased needs of the patients.

There was a positive culture about incident reporting, the investigative process was clear and transparent with lessons learnt clearly identified. However, one of the areas identified in lessons learnt was about safety checks being 'signed-off' on critical care observation charts by the nurse responsible for patient care. During the inspection we identified at least five critical care

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observation charts that had not had the safety checks signed-off. The unit had a system in place to verify the identity of agency and bank nurses but this was not being used consistently or recorded.

Are critical care services safe?

Good



Incident reporting was effective and embedded across all services. We reviewed the investigation report for incidents; there was evidence of duty of candour around the investigation and findings. The daily safety huddle meeting ensured that staff were aware of any quality improvement strategies, changes and dissemination of information. The unit utilised a patient at risk (PAR) score to identify and monitor deteriorating patients. However accurate records were not consistently kept and the management of controlled drugs needing improvements. There was an increase in staffing numbers due to a successful recruitment programme and the use of bank and agency nurses had decreased.

Incidents

- The Strategic Executive information System (STEIS) records Serious Incidents (SI) and Never Events. SIs are those that require an investigation, there were two SIs reported for critical care services in the year preceding our inspection. The investigation report for the incident that occurred in October 2014, was detailed from the incident description through to the investigative process with evidence of transparency and detailed information about lessons learnt with an effective action plan which had clear evidence of implementation. There was evidence of duty of candour around the investigation and findings.
- One of the areas identified in lessons learnt was about safety checks being 'signed-off' on critical care observation charts by the nurse responsible for patient care. During the inspection we identified at least five critical care observation charts that had not had the safety checks signed-off. We asked staff about this process and received mixed responses about completion of the checks. Another more recent SI was still under investigation and the final report was not available; but the matron told us about systems already in place on the unit to prevent a reoccurrence of the incident. Staff members that we spoke with were aware of changes instigated following on from the SI.
- Staff told us there was an open approach to reporting incidents and gave examples of incidents that they had

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reported. We reviewed incidents recorded from October 2014 to December 2014 on ACCU, there was a mixed category of incidents reported with no particular identifiable trend. Incidents reported on the RHDU for the same period related to a range of issues including staffing levels, infection control issues and medication errors.

- On ACCU once an incident had been logged an email would be sent out, with the aim to resolve within a two week timeframe. If the incident was classified as moderate to severe harm then a face to face meeting took place with staff to give feedback. The matron and lead consultant reviewed the electronic incident form within 24 hours, if categorised as severe then an investigation would be undertaken
- There were weekly Mortality and Morbidity (M&M) meetings held with across other specialities, whose patients had been admitted to the unit. Minutes of M&M meetings showed that action plans were linked with specialities.
- There was a designated critical care consultant who was the governance lead and provided feedback from M&M meetings to staff.

Safety thermometer

- Ward assurance performance information was displayed on noticeboards for all to view. However the Safety Thermometer noticeboard had results displayed, but was located away from the main thoroughfare so it was difficult for relatives and members of the public to see. The data was showing low risks, information included that it had been 33 days (December 2014) since there were no falls with harm on the unit.
- The hand hygiene compliance rate was 100%. It was 72 days since the last grade 3 pressure ulcer had occurred on the unit and seven days since the last grade 2 pressure ulcer. There were action plans and quality improvement strategies in place to mitigate the risks of future re occurrences happening.
- We observed the 3pm 'Safety Huddle' meeting which occurred daily on the unit; a senior member of the nursing team discussed information displayed about the safety thermometer and ward assurance data with members of the team. The purpose was to ensure that staff were aware of any quality improvement strategies, changes and dissemination of information.

Cleanliness, infection control and hygiene

- Cleanliness within the ACCU was on the risk register due to established cleaning standards not being met on the unit which could pose a risk of patient harm. The risks were mitigated by weekly environmental audits, any identifiable findings from the audit that raised concerns were highlighted
- During the inspection we observed that the unit was clean and tidy, we saw the environmental audit being undertaken by the unit manager and cleaning supervisor; we observed that high areas around curtain rails were checked for dust. The results displayed for the environmental cleaning audit showed a compliance rate of 92%.
- Staff were 'bare below the elbow.' When appropriate to do so, staff wore gloves and aprons; there was adherence to disposal of personal protective equipment (PPE). The four bedded areas on the intensive care side had different coloured aprons per bedspace to reduce the risk of cross infection.
- We observed appropriate hand-washing techniques. Hand-wash sinks were supplied with hot water, soap and paper hand towels. There was hand-sanitising gel at the entrance to the unit and we observed staff and visitors using this when arriving and leaving the unit. The hand hygiene audit results for December 2014 were 85%, there was a re audit in January 2015 with a compliance rate of 100%.
- It was 73 days since the last episode of Methicillin-resistant Staphylococcus aureus (MRSA) and 197 days for MRSA bacteraemia (when bacteria enters the bloodstream). There had been two episodes of C. Difficile which had been investigated within the last month, an investigation was undertaken and findings were fed back to the team. Members of the senior medical and nursing team attended a monthly infection control meeting every two months.
- We observed that the sluice areas were very clean and tidy; all commodes had labels showing when they had been cleaned.
- We found that ventilator acquired pneumonia (VAP) and Central Venous Catheter (CVC) infection rates were audited.
- The unit had negative pressure ventilation facilities to care for patients who required isolation, procedures were well established. During the inspection we observed one patient being moved to a single room, nurses demonstrated a clear understanding of infection control management procedures.

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Environment and equipment

- The ACCU was a purpose built unit that was spacious, well laid out and accessible. There was an electronic swipe card entry system, a receptionist was available from 8am to 8pm to answer the telephone, and assist relatives and visitors and there was enough storage.
- Equipment safety checks were carried out on each shift by clinical support nurses (band 6); they completed daily safety checks and used signed labels to confirm that checks had been completed this was for 24 hours, then reviewed unless they had been used. Resuscitation and emergency/difficult intubation equipment was available and staff were aware of its location. The equipment was sealed with an intact tag in place denoting that the equipment had been checked and unused. The arterial blood gas (ABG) analyser room was large, well laid out and tidy. Nurses transported ABG samples in a safe way.
- Technical service support was provided seven days per week from 8am to 8pm. There was no unit or trust equipment plan, replacement of equipment occurred through the risk register.

Medicines

- From July 2014 to November 2014 the ACCU failed the Controlled Drug (CD) audits that were undertaken by the Pharmacist department. Issues identified included there were not always second signatures, total balances not being maintained accurately when being moved from page to page. All of these issues were discussed at the daily safety hub, to highlight the importance to staff of adhering to trust policy.
- There was also an on-going SI investigation with regard to patients who were admitted with their own CD. Procedures have been put in place to record patients own CD in a separate CD book and stored in plastic containers within the locked cupboard
- There was a separate storage room for intravenous fluids which was accessed by a swipe card system, the room was tidy and clean. The room was restocked regularly by a technician.
- There was a separate doctor's fridge which contained drugs needed for patient's requiring emergency intubation. We were told that doctors had responsibility for checking the contents of the fridge. It was unclear if there was a log for checking this.

- Medicines reconciliation means that when patients are admitted to hospital the medicines they are prescribed on admission correspond to those that the patient was taking before admission. There was evidence of clear records of previous medications in the notes from the pharmacist and on two of the prescription charts we reviewed.

Records

- We reviewed six Prescription charts and found that there was inconsistent recording for the indications for antibiotics and dates when treatment should be stopped. Both Venous thromboembolism (VTE) and stress ulcer prophylaxis regimes were consistently prescribed and administered.
- Arterial and central venous catheters lines had flush solutions consistently prescribed and signed. Patient allergies were recorded and displayed.
- A proforma recorded assessment and planning of nursing care but we found none of them had been completed.
- Nasogastric tube (NGT) position checks and documentation for pH were not consistent. Confirmation of appropriate positioning of the NGT in relation to a specific chest x-ray was not completed although available on the documentation provided. Recording of the length of the NGT was not consistently done.
- We looked at three different records where doctors completed a daily medical review proforma, all three records did not have the afternoon consultant ward round summary completed over a weekend from Friday to Sunday.
- We reviewed a sample of clinical notes which were a paper based system. Information about the patient's admission and referral details were recorded on a proforma. The notes were in keeping with the Academy of Joint Medical College Minimal Standards.

Safeguarding

- All Staff members demonstrated an awareness and understanding of their responsibilities in relation to safeguarding policies and procedures.
- Band 6 and 7 nurses were trained to level three for Safeguarding. We were told that all staff were trained to level two; there was limited availability for training at level three for band 5 nurse

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Mandatory training

- We were told that the training rates were held centrally in the Trust, it was difficult to calculate figures as the data was three months behind in 'real time'. We were told that a record of staff attending mandatory and equipment training was kept locally. We asked for but were not provided with evidence to verify this.
- There was evidence of strong support from the practice nurse development team in providing development days for staff to access.

Assessing and responding to patient risk

- The Patient At Risk score was a system which was used to monitor patients deemed to be at risk of deteriorating; this was a mechanism for calculating certain indicators whether or not a patient was deteriorating clinically, and if so, whether further or new intervention was required
- Patients were monitored using recognised observational tools and monitors. The frequency of observations was dependent on the acuity of the patient. There was a critical care outreach team that provided support for the management of deteriorating patients on the wards. This service was available seven days a week from 8 am to 8 pm.
- There was a written escalation policy that identified the criteria for the management of emergency admissions to ACCU. All patients requiring admission would be referred to the consultant on duty.
- The critical care outreach team visited the ACCU every morning to identify patients that had been stepped down to the wards from the unit, they utilised patient information on an electronic hand held system. The system was stand alone and did not link in with other patient data; information input was by members of the critical care outreach team. Handover was face to face with the hospital at night team.
- During the inspection we were told that two patients had been cared for in theatre recovery, overnight due to bed capacity in ACCU.

Nursing staffing

- The normal funded establishment for the unit was 39 WTE nurses per shift, included within this were three nurses in charge of allocated teams and three clinical support nurses.

- In 2014 the ACCU had a vacancy rate of 25% which required a high use of agency and bank shifts to provide adequate staffing numbers to provide nursing care to critically ill patients. The unit had been proactive in the recruitment of nurses from overseas with 100 new nurses starting in post within the last year. The establishment figures for the ACCU were 210 WTE, with a current vacancy rate of 8%.
- On one day of the inspection there were 10 (24%) agency staff on duty as part of a complement of 42 nurses for the shift. The core standards for critical care states that no more than 20% of establishment should be made up of agency or bank nurses per shift. The unit was experiencing increased acuity which necessitated increasing the normal daily complement of staff from 39 to 42 nurses for each shift. Normally the unit accommodated 22 level 3 patients, but had increased the number to between 26-28 patients.
- There was a marked decrease in the number of agency and bank shifts utilised per month since a peak of 800 agency shifts in August 2014 to just over 200 agency shifts in December 2014. The trend for bank shifts also showed a decrease from 250 bank shifts in September 2014 to 90 shifts in December 2014.
- The unit had a link administrator who coordinated agency and bank bookings. The systems to address the risks associated with using agency and bank staff were not robust, a standard statement had been developed and sent to the bank coordinators detailing expectations of the skills of agency nurses working on the ACCU. This included ensuring that the nurses had a valid Nursing and Midwifery PIN registration.
- The unit had a system to verify the identity of agency and bank nurses but this was not being used consistently; previously a folder system had been used to record nurses' details including PIN numbers. That system was going to be reintroduced as it had not been consistently utilised.
- Nurses were orientated to the ACCU by the clinical support nurses, however if the unit and acuity of the patients was high these nurses were expected to be included in the nursing numbers with a patient to care for. This posed a risk that agency nurses would not always be orientated to the unit.
- Handovers from a nursing perspective were brief and consisted of safety issues for the day/night plus any key issues. Staff were pre allocated by the shift leaders, there was a request book in use to request to care for

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the same patient from a continuity perspective which staff used. Also specific requests could be added to ensure specific learning needs could be met, staff could work with their mentor or practice development nurse. Staff we spoke with reported this system worked well and that their requests were met. Individualised patient handover was given to the allocated nurse at the bedside.

- The nursing staff was led by a band 7 ward manager. Nursing staff were divided into four teams, with team leaders, band 5 staff nurses and support staff. A number of new staff had recently started; there was not a practice development nurse in post currently. The RDHU had a comprehensive induction checklist that had recently been developed for new staff starting on the unit.
- On the RHDU at the change of each shift the nurse in charge handed the care of patients over to all staff starting their shifts. Staff told us that they got clear information on the plan for each patient at bedside handovers.

Medical staffing

- The consultant to patient ratio was 1:15 which was in accordance with national recommendations. Medical cover was delivered by 17 consultants, (15 WTE) two consultants worked part time their roles were split with research posts.
- Consultant cover for the ACCU was split into three teams designated A, B and C; each team was led by a consultant Monday to Friday, while two consultants covered ACCU at the weekend. There were 31 trainee doctors on the ACCU rota, from different specialisms.
- There were two ward rounds held daily, a structured proforma was used for the ward round a written update was available for staff to refer to. Feedback from junior doctors we spoke with was positive, they felt well supported there was good clinical supervision, training and they were made to feel welcome as part of the team.
- RHDU medical handover takes place at 08.30 am; a ward handover takes place at 5.30 pm. Consultants ward rounds took place at 9 am and again at 4 pm.
- The consultant nephrologists had a weekly rota; there was a registrar on-call 24 hours a day and a trainee junior doctor.

Major incident awareness and training

- There was a hospital-wide major incident plan, which included intensive care and anaesthetic response. Senior medical staff had been involved with the Major Incident planning group and, they were confident in their roles.

Are critical care services effective?

Good



The unit had a multidisciplinary collaborative approach to care and treatment which was evidenced based and followed national and best practice guidance. Patient outcomes were routinely measured to ensure quality. New staff received an extensive induction and benefitted from a proactive and comprehensive training plan, the challenge will be for the new number of staff starting on the unit, to aid learning and embed practice. Patients had their pain and nutritional and hydration care needs assessed and met effectively.

Evidence-based care and treatment

- The ACCU used a combination of national guidelines to determine the treatment they provided. These included guidance from the National Institute for Health and Care Excellence (NICE), Intensive Care Society (ICS) and the Faculty of Intensive Care Medicine (FICM).
- The unit demonstrated continuous patient data contributions to the Intensive Care National Audit and Research Centre (ICNARC). This meant that the care delivered and mortality outcomes were benchmarked against similar units nationally.
- In November 2014 a Critical Care Audit was held where medical staff looked at Ventilator-associated pneumonia rates and compliance with care bundles; ICU delirium screening; out of hours discharges from critical care; outcomes of elderly patients admitted to critical care

Pain relief

- Pain scores were completed consistently on all level 2 patients' charts, as well as on appropriate level 3 patients' charts.
- We spoke with three level 2 patients on the high dependency unit within ACCU. Two patients had Patient Controlled Analgesia (PCA) devices, which is a method

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of pain control that allows patients the power to control their pain. Both patients were happy with this type of pain relief they were able to anticipate and manage their pain threshold levels.

- We spoke with another patient who told us that the nurses asked regularly if they had any discomfort; the patient could have oral pain relief and thought the nurses responded promptly if they asked for pain relief.

Nutrition and hydration

- The ACCU used an Intensive Care Unit (ICU) Enteral feeding protocol to assess the nutritional needs of patients, based on height, weight and Body Mass Index. The nurses implemented the feeding protocol when patients were admitted to the unit, this decreased the risk and timeframe that patients were not being fed; all patients were fed optimally.
- Fluid intake and output was measured, recorded and analysed. The method of nutritional intake was recorded and evaluated each day. Energy drinks and food supplements were used for patients who needed them. ACCU staff followed a protocol for hydration and nutrition for ventilated patients and enteral tube nutrition was initiated.
- Dedicated dietician support was available Monday to Friday.

Patient outcomes

- Intensive Care National Audit and Research Centre (ICNARC) data showed that patient outcomes and mortality were within the expected ranges when compared to other similar services.
- We saw evidence of the current and recently completed audits that have been or are still currently underway on ACCU; included was the national audit National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Tracheostomy audit.
- The unit participated in organ-donation work. A review of Organ Donation Potential for the hospital was carried out from 1st January 2014 to 1st January 2015. Organ donation activity was measured through the National Potential Donor Audit managed by NHS Blood and Transplant (NHSBT). On all key indicators RLH performed above the UK national average, except for consent which was lower than the UK national average.

Competent staff

- The ACCU had a practice nurse development team that supported staff and facilitated a continual professional development programme for all staff. This included new staff having an ACCU 'New Staff Passport', a booklet that was given out during induction to the unit. The passport was a record of progress for individuals to update their training and process their achievements during their supernumerary period.
- When staff completed the New Staff Passport, they progressed to the National Competency Framework for Critical Care Nurses – Step 1. A competency based programme for staff to develop core skills in caring for critically ill patients under supervision from a mentor or practice development nurse. We saw two documents that were being used by staff, they told us about how they utilised the programme in their daily learning and received supervised support.
- An educational needs analysis was undertaken for the nursing team; the analysis reviewed the educational and training needs of ACCU staff. Data reviewed showed that staff with a post registration qualification in critical care was 25%.
- The Core Standards for Intensive Care Units (2013) recommend that a minimum of 50% of registered nurses should be in possession of a post registration course in critical care. Currently that level had not been reached on ACCU; the practice nurse development (PND) team were proactive in planning and supporting nurses in working towards their development.
- ACCU staff development opportunities were a structured programme for all levels of staff to access clinical and educational opportunities.
- There was a multidisciplinary approach to training and development included was- clinical supervision, international conferences. Working groups included pressure ulcer prevention, infection control, ICU Delirium, respiratory weaning and band 6 development groups for relatives and visiting.
- The RHCU staff we spoke with on the evening of the inspection both had a post- registration course in critical care.

Multidisciplinary working

- Staff on the unit from all disciplines told us that the multidisciplinary team worked effectively together as a cohesive team.
- There was a Critical Care Outreach Team (CCOT) that provided support for the management of deteriorating

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patients within the hospital. The service was available seven days per week from 8 am to 8 pm; and was made up of senior members of staff with an establishment of 5 whole time equivalent (WTE).

- The CCOT staff reported that they had a good relationship with the ACCU consultants and were able to approach them to discuss and review patients. Patients were reviewed using a patient at risk (PAR) score, promoting early detection and intervention if the patient's condition warranted a higher level of support from medical and nursing staff.
- RDHU staff told us that there was a good working relationship with ACCU staff and doctors, surgeons quite often joined ward rounds.

Seven-day services

- Consultant cover out of hours was provided by two consultant intensivists over the weekend.
- Physiotherapy services were available seven days a week from 8am to 6pm by a dedicated physiotherapist team; an on-call physiotherapist was available out of hours.
- The critical care outreach team was available seven days a week from 8am to 8pm.
- The unit was able to access radiological imaging out of hours; these were undertaken and reported on in a timely manner. Diagnostic equipment that was available included a portable head CT scanner; there was a specific time between 3-4pm to when access to the portable head CT scanner was available.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent forms were completed and present in the notes of four patients reviewed for percutaneous tracheostomy with evidence of discussion with their families recorded
- We observed the restraint policy being adhered too.
- The safeguarding lead described the procedure for applying for a Deprivation of Liberty Safeguards (DoLS) which was sent to the local authority.

Are critical care services caring?

Good



Patients were cared for by dedicated, kind and caring staff. We saw and heard considerate interactions between staff and their patients and privacy and dignity was maintained. Patients and relatives were involved in decisions about care and treatment and where able, gave informed consent. Some relatives felt that the visiting hours were restrictive, this issue had been raised with staff and plans to review visiting hours were underway.

Compassionate care

- We observed that staff practiced and understood the principles of delivering compassionate care to patients receiving intensive care. We saw staff support patients who were sedated, as well as some who were confused and anxious.
- We observed one nurse who was caring for a ventilated patient who was coughing and required suctioning (a procedure to clear secretions from the patients breathing tube) they explained what they were doing whilst continually reviewing the patients physiological and ventilator observations.
- We saw staff speaking with patients, introducing themselves and informing the patient of what they were doing and orientating them to time and place. We saw that patients' privacy and dignity was preserved, curtains were drawn around when personal care or examinations were being carried out.

Understanding and involvement of patients and those close to them

- We spoke with one patient who said they had been asked for their consent for any treatment and their opinions for any decisions to be made. The patient felt they were engaged in discussion about their care and understood the treatment plan and timescale.
- Relatives told us staff had given them the advantages and disadvantages of any proposed treatment options, including the risks and benefits. We spoke with a relative and friend of a patient who was admitted to the unit as

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an emergency, they felt that communication from staff prior to admission to the ACCU had been poor.

Immediately they noticed that the staff on the unit explained everything clearly and concisely.

- Another patient awaiting transfer to a ward, told us they were comfortable with the decision making process and both they and their family knew the plan of care and treatment.
- Patient confidentiality was maintained within the single rooms.
- On the RDHU we were told that patients were given notebooks to record their feelings about their care.

Emotional support

- One relative clearly demonstrated how staff on the ACCU had “Gone above and beyond” in the support that had been given. The patient had been an emergency admission whose progress was fluctuating and staff had arranged for accommodation to be made available nearby. If the relative stayed late on the unit they ensured that they were escorted to the accommodation. They felt they had constant support from staff and said they were “very calming”, and updated them about any changes in their relatives condition.
- ACCU had support from a psychologist who worked with patients and relatives. There was a follow up clinic for ACCU patients, held monthly lead by a consultant and supported by two band 6 nurses for rehabilitation post admission to ACCU.

Are critical care services responsive?

Good



Staff were proactively engaging with relatives to review visiting times and listen to their concerns. Capacity on the unit meant that it was not always possible to respond at all times to the need to admit or discharge patient's at the most appropriate time. Medical staff had carried out a retrospective study that identified steps to target the forward flow in the hospital to improve the step down of patients from critical care.

ACCU had not received many complaints; there was evidence of transparency in dealing with complaints and engaging staff with feedback and learning.

Service planning and delivery to meet the needs of local people

- We were told that work was being undertaken to review visiting times for relatives and friends to the unit. Two members of staff produced data from a staff audit. This was highlighted in the minutes from the senior staff meeting in October 2014.
- Following the recruitment of new nurses, the emphasis was about embedding the team and developing skills to ensure they could be responsive to their patients' needs.

Meeting people's individual needs

- The waiting area outside of the ACCU was split into three separate areas and allowed relatives privacy. There was information about the visions and values and the care campaign for the trust. There was also information about how to contact the Patient Advice Liaison Service (PALS) and language and interpreting services.
- A translation service was available however interpreters could take up to two days to arrange. Patients had access to a relative support counsellor and the unit also had a psychologist who offered support to patients and families.
- There was a 'Tell Matron' box with comment cards beside the waiting area to allow relatives to give feedback. Feedback from December 2014 was displayed on noticeboards in the form of comments from relatives and visitors. Topics highlighted included about care and understanding shown to patients, communication and feedback about relative's progress. Feedback was displayed from relatives and patients, but there were no comments from ACCU about any action taken.
- At the time of the inspection there were no patients on the unit with learning disabilities. Staff told us about strategies they had utilised when a patient had previously been admitted to the unit. The priority was to link with family members and carers and social workers who knew the patient best. Using known carers of the patient encouraging involvement as appropriate Staff contacted the learning disability nurse and held a multi-disciplinary team meeting to plan in order to meet the patient's needs.

Access and flow

- Bed occupancy was higher than the national average and ranged from 92% to 98% from January to December 2014.

Critical care

- Admission processes on to the ACCU were coordinated Monday to Friday by the designated bed manager for ACCU, which included elective admissions and discharges. The elective surgical workload mostly level 2 patients utilised an electronic booking system to prioritise the elective list.
- Delayed admissions of more than one hour ranged from 14.5% in January 2014 to 49.6% in December 2014.
- The number of delayed discharges was similar to the national average. An audit was carried out by medical staff on the unit in October 2014 which looked at the clinical impact of out of hours (OOH) discharges. Discharging patients overnight had historically been associated with an excess in mortality. The audit which was a retrospective snapshot analysis of patients was conducted at least 48 hours after discharge in October 2014; concluded that the focus needed to be on discharging patients at an appropriate time and one area for improvement was targeting the forward flow of patients.
- An audit carried out about the number of patients who were scheduled to be admitted to the unit following elective surgery found that operations where patients were determined to require critical care post-operatively were cancelled on the day of surgery. The main reason for this was due to hospital flow problems that prevented critical care step-downs.
- There were two risks on the Barts risk register referring to poor patient flow to and from ACCU, the other was Neuro step down from ACCU – the risk theme was access to treatment and capacity.

Learning from complaints and concerns

- The unit received a small number of complaints and we were told about two that had occurred in November and December 2014. They had been resolved and the learning from them shared with staff. Formal complaints were redirected to the hospital's Patient Advice and Liaison Service. Outcomes and actions from complaints were disseminated to staff; we observed this at the daily 3pm Safety Huddle meeting.

Are critical care services well-led?

Good



There was effective communication at a local level and team cohesiveness on the ACCU, the team worked effectively which was visible to staff and people who used the service. Staff at different levels, in different teams and from different disciplines worked together putting the patients' needs first. There was a forward looking statement of vision and values that the team had developed. Risks to the delivery of quality care were identified, analysed and mitigated systematically.

Vision and strategy for this service

- The team had developed a vision - for the unit to be internationally renowned for standards. Staff told us that staffing had been a major issue that had impacted on the quality and service they could provide to patients and relatives. However the team were more positive with new staff starting and they recognised the challenge was to move forward to provide a high quality service.

Governance, risk management and quality measurement

- There was a trust risk register in use which held entries relevant to the ACCU. We saw minutes from the Governance meeting held in October 2014 which showed that nine risks on the risk register relevant to the unit had been discussed. Actions taken had either closed the risk in one instance, or the rating of the risks had remained neutral, increased or been downgraded. Incidents had been reviewed and actions identified including arranging to offer a patient and family a meeting.
- An ACCU consultant was the governance lead for the service and attended mortality and morbidity meetings.
- The daily safety huddle ensured that staff were aware of any quality improvement strategies and changes.

Leadership of service

- Staff members told us that they did not see executives from the board on the unit. The mechanism to feedback issues was not always addressed.

Critical care

- There was evidence of strong local leadership from both the medical and nursing staff within the unit and staff said they were supported by their leaders.

Culture within the service

- There was a strong team identity that was cohesive; many positive comments were made about inclusiveness and being listened to. There was a transparency about if things went wrong, the investigative process was open and there was a willingness to learn.
- We saw that staff were very supportive of one another and took pride in the care they delivered to patients

Public and staff engagement

- Relative feedback was sought through feedback mechanisms such as 'Tell Matron' comment cards. Staff had listened to feedback and a working group was looking at rationalising visiting hours, aiming for a more inclusive approach.

Innovation, improvement and sustainability

- There were opportunities for staff development through rotational posts, in the practice development team, patient follow up clinic or the bed management role for ACCU. Rotational posts developed the practitioner skills set and gave a broader perspective of management. More senior staff at band 7 had the opportunity to look at development of overall clinical leadership and the team. There was an opportunity to experience the unit managers' role for a two month secondment. Leadership training could also be accessed through an MSc or MBA pathway. Band 6 staff had the opportunity to apply for rotational posts to assist in their development. There were opportunities to join the PND, bed management post or the outpatient's clinic to follow up ACCU patients post discharge from the unit.
- There was a weekly payment control meeting to justify bank and agency spending costs to ensure sustainability.

Maternity and gynaecology

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

Information about the service

The hospital provides maternity services to nearly 5000 women in the London Borough of Tower Hamlets. The service runs outpatient, and antenatal clinics, including a maternal foetal assessment unit and a foetal medicine unit, located in the same area. The hospital also runs the community midwife services. A triage service enables women to be directed to the most appropriate form of support. All women attend the hospital for their first antenatal appointment at clinics run by community midwives who thereafter provide care for low risk women in the local area. Specialist consultant-led antenatal clinics are run for women with additional conditions such as diabetes, mental health or heart, kidney or neurological problems.

The 35-bed labour unit, which includes the two triage rooms, is divided into two areas. The midwifery led area (6E) is for lower risk women and has an early labour lounge and rooms for induction of labour and birthing. There is one fixed birthing pool, and inflatable birthing pools are available for use in other delivery rooms. The high-risk labour ward (6F) adjoins the two obstetric theatres. In addition to delivery rooms, this area has a four-bed bay for high-dependency women. On the eighth floor, a pre- and postnatal ward has 30 beds and cots used for transitional care (normally 11 rooms), four prenatal rooms and nine amenity rooms. There are two four-bedded bays.

The hospital runs an off-site midwife-led birthing centre, the Barkentine Birth Centre, for low risk mothers. This is located on the Isle of Dogs.

An emergency gynaecology unit (EGU) is open on weekdays and Saturday mornings for women with pregnancy and non-pregnancy-related acute gynaecological problems, referred by their GP or from A&E. There is a 12-bed inpatient ward (8C) is for gynaecology patients.

We inspected all maternity and gynaecology areas within the hospital and spoke with 13 women and seven relatives. We spoke to 42 members of staff, including maternity support workers, midwives, nurses, doctors of all grades, administrators, senior managers and domestic staff. In addition, we held meetings with midwives, trainee doctors, consultants and administrative staff to hear their views. We also reviewed information provided by the trust, such as audit and safety outcome data.

Maternity and gynaecology

Summary of findings

The accommodation was clean and high quality and we saw some excellent team working and some innovative initiatives. However there were not enough medical and midwifery staff and there was evidence that this compromised the care offered to some women. Women in labour were prioritised but this meant that other areas were often short-staffed with an impact on waiting times for other women.

We also had some concerns about security of mothers and babies because of the high number of visitors at all hours. We had no significant concerns about safety or security in gynaecology.

There was a systematic approach to clinical governance which included process for reviewing and learning from serious incidents, complaints and a programme to update guidelines to promote consistent practice across the trust.

Midwifery staff and trainee doctors spoke highly of their training. A values and behaviour programme had been launched in maternity services across the trust to improve the way staff interacted with women and with each other and to improve the standard of care. There were positive comments about this programme from staff and from many women who had used the service, although women made some adverse comments about waiting times in antenatal clinics and for discharge. Bereaved women were sensitively supported.

The hospital took part in national audits and carried out some local audits to assess and evaluate the effectiveness of care provision. The results of these were presented to staff although audit data was not always benchmarked against other hospitals other than those within the trust.

Outcomes for women and their babies in maternity services were similar to other hospitals.

Leadership for maternity and gynaecology services was provided by the women's and children's health clinical academic group (CAG). This did not appear to provide an effective route from ward to board and neither doctors nor midwives felt that their concerns about

safety, or the sustainability of working under pressure were acknowledged by management. Data to support management of the service was of variable quality and could not be generated through the IT system.

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Are maternity and gynaecology services safe?

Inadequate



There were not enough doctors and midwives to deliver safe care and this impacted on other areas of safe care for ensuring accurate record keeping, managing medicines, keeping up-to-date on mandatory training.

Security of mothers and babies within inpatient areas was a concern because there was a high volume of visitors at all hours and the electronic security system was not used.

There were timely processes for investigating and managing serious incidents. Staff discussed safety issues regularly at 'safety huddles'.

Incident reporting

- There had not been a recent Never Event in maternity at the hospital (Never Events are serious, largely preventable incidents that should not occur if appropriate preventive measures had been implemented). However, staff openly mentioned an event that had occurred at another unit within the trust and the learning they taken from that in 'Never event, Never again' sessions, reinforced by safety briefings and audits.
- During 2014 there had been 39 serious incidents in maternity at this site (Nationally, about 10% of incidents reported in hospitals occur in maternity departments). The process for responding to serious incidents had been standardised across the trust to improve the timeliness of the investigation and to follow up on actions agreed after the investigation. The procedure which promoted adherence to the duty of candour, was robust and multidisciplinary, and involved families appropriately. Supervisory and trust investigations worked in tandem to reduce duplication. A tracker alerted staff when an incident was near its review deadline. There were no serious incident reports overdue at the time of our inspection.
- There had been 401 maternity incidents reported on the electronic system in the past year. All incidents were reviewed by the clinical governance lead and nursing/midwifery manager, one of whom took primary responsibility for reviewing the incident and feeding

back to the reporter. Incidents were discussed at a weekly multi-disciplinary risk forum to identify cases for potential escalation as serious incidents or other incidents requiring consultant involvement. A supervisor of midwives attended the maternity meeting and took part in the investigation of complaints and incidents when appropriate. Top incidents in December had related to staff shortages and workload.

- There had been 69 incidents in gynaecology across all sites, of which five (7%) had been classified as serious incidents. We were not given site-specific data.

Cleanliness, infection control and hygiene

- During October and November 2014 seven mothers had been readmitted with sepsis after caesarean section. The infection control team was investigating appropriately and had made some recommendations about cleaning of theatre tables and changing solutions used for preparation for epidurals and for wound sites. Theatre ventilation was also being reviewed. These changes in practice were highlighted in the 'shift safety briefings' published on the labour and postnatal wards. The investigation was not complete at the time of our inspection but we were told that no link between the cases had yet been identified. The investigation included a complete review of theatre practice and actions, and sought to identify whether level of activity was a contributor.
- The labour ward was spacious, clean and uncluttered. We noted that recent cleaning audits had scored 100%. Dated green stickers were used to show items that were clinically clean and ready for use.
- Hand sanitising gel was placed outside individual rooms, predominantly for staff use, but there was no encouragement for mothers and visitors to use this. Staff hand hygiene audits were not carried out regularly but those we saw showed 100% scores.
- In September 2014 one case of MRSA bacteraemia had been investigated, but not raised as a serious incident because mother and baby were both well. There had been no recent *Clostridium difficile* infections.

Safety Thermometer

- A white-board in inpatient areas showed a 'safety cross' completed for each day of the month, which gave an overview of care, similar to the national Safety Thermometer (a tool for measuring and monitoring patient harm and harm-free care). However, this did not

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reflect the actual staff on duty when the inspection and unannounced visit took place when on each day and night shift there were three midwives short. The design of the tool only reflected one member of staff short, or two short, not higher numbers.

Medicines

- There was no daily ward pharmacy visit but the pharmacy was accessible by bleep or dispensary throughout the day. Reordering was weekly, or as required. There was 24-hour access to pharmacy.
- Medicines were securely stored in locked cupboards in rooms with key-coded access. The doors were shut and locked on each occasion we checked and good practice was observed with staff not leaving the door open when in the room. We noted good compliance with checking of controlled drugs.
- Mothers' allergies were documented and red wristbands were worn. We saw a notice on one birthing room alerting staff to the woman's latex allergy.
- We found a number of blood culture bottles that had expired. Staff were informed and these were removed from the clinical areas. On our unannounced inspection at the end of January we found bottles that would expire the next day, and again drew staff's attention to this. If used after expiration there was a risk of inaccurate testing.
- A review of medication between 1 August and 20 November 2014 showed very few incidents in maternity and gynaecology. There were no instances of harm and appropriate follow-up action with staff was taken through ward meetings as necessary.

Environment and equipment

- The triage area on the labour ward had two well-equipped rooms. Women accessing this service might be sent home, admitted to the early labour lounge or directed to the labour ward.
- All birthing rooms were large and equipped with piped gases (oxygen and Entonox) and had en-suite facilities. Equipment such as birthing balls was available to promote women being active in labour and supporting normality. We noted that some couches for partners in some rooms were torn, a possible infection risk, and that sharps bins were free-standing on tables and not closed, so there was potential for spillage.

- The lack of clear signage in the labour ward could lead visitors to the labour ward to wander inadvertently into other areas, and staff told us there had been times where visitors had gained access to restricted areas.
- The labour ward was adequately equipped. There were enough cardiotocography machines, used to monitor the foetal heart, even at times of heightened activity. Electronic blood pressure machines, a foetal blood gas analyser and an emergency adult resuscitation trolley were available, and there was one resuscitator to every two delivery rooms, which staff said was sufficient.
- Antenatal clinic accommodation was spacious and the clinic and Maternal and Fetal Assessment Unit were conveniently co-located with the scanning department.
- Some of the older ultrasound machines in the antenatal and emergency gynaecology unit were said to be in need of replacement because of the clarity of the images. We were told some women were given repeat scans on another machine for a second opinion, which caused additional delays to women's appointments. This was on the risk register for imaging and a capital bid had been submitted for funding.
- Staff said there had been occasional equipment shortages in obstetric theatres and that purchasing plans for supplies and equipment needed to be more closely aligned to the anticipated needs of the obstetric teams (Theatres were not run by the Women's and Children's Group). One theatre was closed for investigation related to the sepsis episodes during our inspection, so an adjacent paediatric theatre had been temporarily designated as the second obstetric theatre.
- There was no facility for electronic storage of anomaly scans on this site which was contrary to the national guidance in the Foetal Anomaly Screening Programme. Controlled drugs cupboards were being used for storage at present, but it was recognised that this was not appropriate as paper scans deteriorated over time. This was recognised and on the risk register and a proposal had been made.
- Staff said, and we observed, that IT access was sometimes slow.
- Specific trolleys were available on the high-risk labour ward for use in obstetric emergencies such as postpartum haemorrhage, extensive neonatal resuscitation and adult resuscitation. Checking procedures for these had been unclear and inconsistent. For example, the adult resuscitation trolley had a daily checking list which had not been

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consistently completed. This was highlighted in an audit in November. Subsequently, there had been no improvement in compliance so changes were therefore being made in practice to safely reduce the need for staff to check these daily. Following liaison with pharmacy, secure locks were to be introduced, which will reduce the need for checking to monthly.

Safeguarding

- There was a lead midwife for safeguarding (from the midwife safeguarding team) and a named midwife for safeguarding, the Head of Midwifery, who together provided advice and ensured there were clear multidisciplinary procedures for safeguarding and child protection concerns.
- All permanent staff providing direct care to pregnant women should have face to face level 3 safeguarding training. 90% of staff had attended level 3 training. Staff without direct contact completed level 2 training. There was training for first-year trainee doctors on perinatal mental health and safeguarding.
- Some staff had attended safeguarding supervision based on the Signs of Safety model, a tool to help practitioners with risk assessment and safety planning in child protection procedures. However, staffing pressures had meant that the safeguarding team (known in this hospital as the gateway team) and lead professionals had been prioritised for this supervision over other midwives.

Security

- Mothers and visitors entered the labour ward using an intercom system and the door was released by staff in the unit. There was no close monitoring of who entered the ward. We observed visitors opening and holding doors open for others, allowing a free flow of visitors in and out of the unit even after visiting hours. This was a potential safety issue, and a potential infection risk when large numbers of family members came to the labour ward. However, allowing some visitors to come late met the needs and expectations of the local Asian community.
- On entering the labour ward there were no staff to greet and show women the way. The former reception desk at

the entrance was closed – we saw a number of visitors sitting in this area at different times during our inspection. It was not clear whether the area was observed on CCTV.

- There was no ward clerk at night, which meant there was further reduced control over visitors. Midwives prioritised clinical care over monitoring the activity of partners and visitors and also said they were reluctant to challenge visitors out of concern for their personal safety. There had been minor thefts of food and equipment, but no serious incidents involving visitors .
- On the post natal ward there were some visitors late at night. This was because partners of women in amenity rooms could stay at all times. Other visitors had visiting time only access unless in special circumstances.
- Neonatal security had been identified as a risk on the risk register. We saw a draft infant abduction policy that assumed the use of baby security tags to set off alarms and locked down entry to specific areas. However, staff told us these tags had not been used for about six months because of multiple false alarms. Babies were labelled with the tri-band system: mother and baby had the same number, and there were two tags on the baby.
- Staff on the post natal ward said that babies were usually transferred to the ward with bands on, but that this was not always the case with mothers. An audit of mother and baby labelling in August 2014 had indicated that 23% of babies did not have identity tags. This was a concern because many mothers in the area had similar names. In response to audit the importance of labelling and ensuring babies had correct identity tags had been reinforced with staff. We did not see any babies without tags on our inspection.

Records

- Women carried their own pregnancy-related care notes in hand-held-records (the green notes) given to them at their first booking. They took the notes with them for appointments with the maternity unit, or for examinations with their community midwives. Women were booked with a midwifery team rather than a named individual midwife.
- Record keeping for the antenatal period, labour and postnatal period fell below expected standards. We saw an audit against Royal College of Nursing & Midwifery standards that identified concerns. As a result of these

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findings, notes were being checked by a designated midwife after the mother and baby had been discharged home from hospital. Staff said that having this failsafe could have a negative impact on record keeping because they knew the midwife chased up incomplete records. We saw a box of seven sets of incomplete notes left by the IT midwife: examples of the type of missing data included APGAR scores, names of staff present at the birth, intrapartum risk assessment and the assessment of the newborn. We noted wards were fined for not meeting record keeping standards. We were told that the pressure staff were working under could make it difficult to complete all records contemporaneously, so a staff member had been appointed to improve record-keeping standards.

- We reviewed 16 sets of notes. None had every essential element completed, and there was not a pattern of incomplete data. The care pathway was unclear in some cases, notes were not in chronological order and contained loose papers, Venous thromboembolism stickers were not consistently included, documents including cardiotocographies were not signed and dated to show staff designation. But there was evidence that these errors were being picked up retrospectively with intent to improve practice.
- The safeguarding team notes (for women in vulnerable circumstances) were clear and concise.
- Gynaecology notes we looked at were complete, but there were some loose pages.

Mandatory training

- Midwifery staff, including students, had four mandatory study days each year. Completion of mandatory training was below the trust 90% target for infection control (69% at the highest level of training, 76% at the lower level), 75% for medicines and 71% for information governance. Completion of training was monitored by their line manager and the practice development midwife. The training included customer care. The training database should highlight when training was due but we were told the lack of administrative support had led to difficulties in maintaining the database.
- There was mandatory multi-professional team training for skills and drills to rehearse obstetric emergencies including cardiotocography assessment. In June 88% of staff had completed this. Every midwife and doctor had copy of the Practical Obstetric Multi-Professional Training (PROMPT) manual which

was evidence of commitment to high level training. Live training had been cancelled towards the end of 2014 because of labour ward pressures, but simulation training sessions took place.

- Medical staff commented favourably on their education and training.

Assessing and responding to patient risk

- The escalation policy was used regularly. The data was recorded and reported upwards within the CAG. The CAG had responded in terms of recruiting more staff when the mother to midwife ratio had slipped when agency staff were no longer used, and a Birthrate plus review (an established framework for maternity workforce planning) had been carried out and its recommendations were under consideration. Although the review had been considered within the CAG, it was not clear that it had been reported the Trust Board.
- There were systems to identify women at risk and midwives we spoke with demonstrated a good knowledge of the action to take when they identified a woman in vulnerable circumstances. We saw clear safeguarding notes and care plans for those assessed as at risk. If women did not attend antenatal appointments, they were telephoned and if they failed to attend two appointments, a home visit took place or was carried out. There were also processes to address the needs of women who attended the unit in labour who had not had antenatal appointments and a midwife talked us through this process.
- There were two well-equipped obstetric theatres. Planned caesareans were carried out three days a week in one theatre. In an emergency requiring a third theatre, one of the adjoining paediatric theatres could be used.
- There were arrangements to ensure checks were made before, during and after surgical procedures. This included completion of the World Health Organisation (WHO) surgical safety checklist in operating theatres, which was recorded on the computerised patient record. Staff reported that this was the checklist was not embedded and not always completed. The checklist was continuously audited on a small number of women to check compliance and we saw copies of audits.
- We observed effective working relationships between the midwives and medical staff on floor 6. Women in the low-risk area (who in theory were less likely to need

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foetal monitoring) had ready access to medical review, which led to women staying on within this area if complications developed that did not require constant medical input. The doctors visited women on that part of the ward as needed. The distinction between these units was blurred in that some consultant-led women were in labour in the low-risk area because of the pressure on capacity in the unit, and women in this area were by no means all low risk. This was against the philosophy of low-risk care and further compounded the lack of clarity over which care pathway a mother was on and who was their lead professional, but in practice ensured that the higher risk women who were in the 'lower risk' unit had safe care. When the new midwife-led unit opened later in the year there would be sufficient space for the higher risk women on the existing delivery unit.

- One important risk raised with us was the challenge of late booking women who did not disclose their HIV status. This was a potential risk to women and staff and while a review of a specific serious incident that we witnessed proposed actions to avoid a recurrence of a specific incident, the actions did not address the root cause, which related to clear pathways and full documentation.
- There were clear protocols to deal with obstetric emergencies such as postpartum haemorrhage. The risk of inadequate management of pathological cardiotocography had been reduced through additional training for staff who did not demonstrate competence which all staff had completed. We saw evidence of training in records and staff told us they had undertaken training during 2014. The training was in line with NICE guidelines..
- All inpatient women were monitored using the modified early obstetric warning score to record observations. When required, midwifery staff completed observations on babies and recorded these on the neonatal early warning score charts. We reviewed some eight of these observations in notes and found they were appropriately completed. The service had introduced a system to check notes and report on non compliance and we saw evidence of this being used.
- Staff were able to describe at what point concerns were escalated to the lead midwife or medical staff.
- Staffing levels were a risk and staff shortage was the norm, so midwives were regularly moved from less critical areas to support the labour ward. Out of hours

the coordinator (lead midwife) was responsible for assessing staffing levels, and on identifying risk contacted the on-call manager. Options were to contact bank staff or call into the unit the on-call integrated team midwives, home birth midwives, birth centre midwives and/or the on-call manager or supervisor of midwives. The escalation processes, and diverts when required, maintained safety.

- We witnessed staff caring for more than one woman in established labour. The hospital figures showed that overall each month 95% of women had one-to-one care in established labour.
- Staff had access to emergency trolleys in the event of an obstetric emergency.

Midwifery and nursing staffing

- The trust did not meet the London Safety Standards recommended minimum birth to midwife ratio of 1 midwife to every 30 births. The midwife-to-birth ratio had risen to 1:34 earlier in the previous year but recruitment would reduce this to 1:32, the trust target. The ratio on our inspection was 1:33 because not all new staff had started work. We saw evidence that the staffing establishment had been increased, but because of staff leave and sickness the increase had not yet had a noticeable effect on the number of staff on duty. On the days of our inspection, no clinical area had the required number of staff on duty. Records showed that there were times every week during a one-month period when no bank staff were able to fill slots on the labour ward.
- Birthrate plus (an established framework for maternity workforce planning) had shown in July 2014 that a ratio of 1:28 would be appropriate to the acuity levels of mothers giving birth at this hospital. 56% of births at Royal London Hospital were in the higher risk categories but this figure rose to 79% in labour for reasons such as obesity, diabetes, and feto-maternal conditions. We were told that a business case was being considered to further improve the midwife-to-birth ratio; 23 additional midwives would be needed to meet the recommended ratio. This was not yet on the formal risk register but did form part of a January report to the CAG board.
- Community midwives operated in four teams: Bow, Tower, Riverside, and Gateway, the latter for women with additional social needs. Community midwives were

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on-call for the labour ward four times a month, for four-hour shifts, but they told us they often stayed longer. Midwives from the birth centre had to come in to support the labour ward six times in January 2015.

- Staff reported they did not always get breaks and they were late off duty at times and did not get reimbursed for this time. They used to record extra hours but this had been discouraged by management.
- Midwives spoke highly of the obstetric consultant support.
- The band 7 coordinator midwives were not supernumerary, and while there should be two band 7 midwives on each 12-hour shift, there was often only one, particularly at night. This was confirmed on the unannounced visit when there was only one band 7 who had to cover the low-risk area, triage and deal with staff shortages, as well as looking after four women. On that day there should have been 15 midwives and were 12. There had been 11 midwives on day shift. We witnessed eight women in triage and two in the triage rooms all cared for by one midwife. Six women undergoing induction of labour were cared for by another midwife and two requiring one-to-one care were looked after by one other midwife. There was concern that one woman was developing sepsis but there was no scope for midwives to offer close surveillance, but they had notified the medical team. Staff said “team working keeps it safe, but we are not able to do the niceties”.
- Midwives worked flexibly in the antenatal clinic and associated units, and some staff were relocated to labour ward when it was busy, with consequent impacts on waiting times. This had happened three times in January.
- Agency midwives had not been used in the maternity service since 2010. This was because of the risks to safety from the use of agency staff who were less familiar with systems and processes in the unit. A midwifery bank had been established and integrated teams had been put in place.
- The welcome and support given to new staff was reported as being ‘excellent and not like anything I’ve experienced before’. An individualised induction pack was developed for each new member of staff, with names of staff to contact on their first day. All staff had been emailed before the new staff arrived.
- We saw close team working between the obstetric and midwifery team. The midwifery handover included the doctor on duty from the theatre team.

- One of the midwives in the antenatal screening team was Pegasus-trained enabling appropriate counselling services for mothers when haemoglobin disorders in pregnancy were suspected or detected.
- Nurses rather than midwives worked in the high-dependency unit and in theatre. There was only one operating department practitioner full time. There were two theatre nurses during the day and one theatre nurse at night. We saw theatre rotas that had in excess of 50% bank and agency staff and staff reported agency nurses and operating department practitioners had been employed to cover shifts at Christmas.
- Nursery nurses supported transitional care on the postnatal ward. This enabled mothers to stay with their babies when they required additional care because of prematurity. Antibiotics for babies were given by nurses from the neonatal unit, which enabled regular contact between the two units.
- The dedicated gynaecology ward was staffed by appropriately trained nurses and there were no staffing shortfalls. The emergency gynaecology unit was also fully staffed.

Medical and theatre staffing

- The trust as a whole had fewer consultants than the England average, 30% compared with 38%. There were 10.5 consultant obstetricians and gynaecologists on the rota; 8.5 of these had joint obstetrics and gynaecology roles. Two doctors were obstetricians only. Staff said it was sometimes challenging to have only one doctor on-call for obstetrics and gynaecology, but junior doctors said on-call consultants were always available for advice and came into the hospital when appropriate. Consultants told us they were often in when on-call.
- There were 71 hours of consultant presence a week in maternity services. The recommended consultant presence for a unit of this size was 98 hours (Safer Childbirth London Safety Standards and Royal College of Obstetricians and Gynaecologists). If hospital births continued to rise there would need to be a further increase in consultant cover. Staff had made the trust aware of the risks for mothers through a formal paper comparing the hospital with others in London, showing potential for substandard care, rising incidents and complaints through not having more senior cover for

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emergency caesareans sections and management of difficult cases. There was no agreed plan for improvement of consultant cover at the time of our inspection.

- Two consultants took the lead on managing the obstetric and gynaecology service and worked well as a team.
- The structure of consultant cover was three shifts each day. This limited the continuity and consistency of care for women some of whom would potentially see three different consultants while in labour. The consultants were considering changing this pattern.
- Elective caesarean sections, represented about 8% of births, slightly below the national average, and took place three days a week. We were told that elective caesareans were rarely cancelled. The caesarean section rate was 24.5%.
- We witnessed an effective multidisciplinary medical handover covering maternity and gynaecology including A&E cases. Staff had printed notes for all the gynaecology in-patients and conducted handover from the labour ward board for maternity.
- We did not see a paediatrician on the labour ward during our inspection but were told that they would be called if needed, and would always attend.

Major incident awareness and training

- The trust had a plan to support business continuity, which staff were aware of. This set out clearly what to do at different levels of service disruption. This was used when there were not enough staff.
- We saw that the delivery unit had been closed on six occasions within the last calendar year. In June 2014 some mothers had been diverted during parts of the day on five out of seven days. When possible mothers were diverted to other Barts hospitals, but in June 2014 some mothers, mainly those awaiting induction of labour had been sent to hospitals outside London. The capacity issue to which this risk related was rated high (20) on the risk register.

Are maternity and gynaecology services effective?

Good



Staff working in each area of maternity and gynaecology knew how to access professional guidance to inform their practice. The trust had set up a programme to update guidelines to promote consistent practice across the trust.

Midwives had been supervised and supported to maintain their competencies and professional development and had appraisals. Trainee doctors were well supported.

The hospital took part in national audits and carried out some local audits to assess and evaluate the effectiveness of care provision. The results of these were presented to staff, although audit data was often not benchmarked against other hospitals.

Outcomes for women and their babies in maternity services were within expected limits. Women received antenatal and postnatal care in the community with antenatal appointments at the hospital when appropriate. There was effective multidisciplinary working in maternity and gynaecology services.

Evidence-based care and treatment

- The trust had a programme to review clinical guidelines with reference to the National Institute for Health and Care Excellence (NICE), the Royal College of Obstetricians and Gynaecologists (RCOG) and other relevant bodies. Policies and guidelines were available on the intranet and were easy to navigate. We checked 14 guidelines. Four were beyond their review dates: HIV management (September 2014), use of water in labour (September 2014), sepsis (September 2014) and care in normal labour (March 2014). Legacy guidelines had all been modified in January 2015. Clinical staff told us they accessed current NICE or RCOG guidelines when up-to-date local guidelines were not available and demonstrated how they did this.
- There was a research programme in maternity and gynaecology.
- The trust contributed data to the national Neonatal Intensive and Special Care programme and to

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MBRRACE-UK. The service had responded to the need to reduce stillbirth, which was also the subject of local research, by appointing a bereavement/MBRRACE midwife who would shortly take up post.

- In National Neonatal Audit Programme 2013, the hospital results were below expected standards on three measures: the number of babies who had their temperature taken within an hour of birth (score 89% compared to expectation of 98–100%); the number of babies under 32 weeks receiving retinopathy of prematurity screening (89% compared to target of 100%); and documented consultation with parents within 24 hours of admission to neonatal care (83% compared to target of 100%).
- There was a monthly audit meeting in maternity and in gynaecology services. Clinical duties were rescheduled to enable staff to attend and midwifery/nursing and medical staff told us that information from audits was also emailed to them. Continual audits in maternity services included postpartum haemorrhage. An early audit of the one-stop clinic had revealed some pointers for improvement and a re-audit was planned. Learning from audits was spread through safety briefings which we saw in all clinical areas and were shared at handovers and in weekly meetings.
- In gynaecology services audits of guidelines included management in early pregnancy of ectopic pregnancy and miscarriage. The findings were presented to an audit meeting which had led to changes in the choices given to women for follow-up checks.
- There were joint monthly perinatal morbidity and mortality meetings and regular morbidity meetings in gynaecology. We saw examples of clear presentations from staff on particular cases or groups of cases, but it was not clear how learning from these meetings was more widely disseminated to influence practice.
- Care bundles for common conditions had been introduced in maternity triage to improve consistency of care for women presenting with symptoms such as vaginal bleeding, ruptured membranes, and reduced foetal movements. This had significantly reduced antenatal admissions and as a result care bundles were being rolled out across the trust.
- The Northgate failsafe system for blood spot tests for six inherited diseases in babies had been introduced last year and staff said this was working well, both for babies born out of the area and for those born in Tower Hamlets but living out of the area.

- In response to the low numbers of bookings before 12 weeks and 6 days, a one-stop booking clinic had been successfully introduced. These were run by community midwives in the hospital. This clinic enabled women to be seen earlier and, for those needing referral to screening, speeded up the process. Since its introduction in March 2014, most women were being screened on time. Although not yet meeting the target for taking blood within the 8–10 week window for sickle-cell screening, staff said that this was being monitored. As most women in the area were aware of their sickle-cell status, the clinic had not so far seen an adverse effect on patient safety. The one-stop clinic was being extended to other hospitals within the trust.
- We saw an excellent picture book to explain foetal abnormality screening to non-English speakers. When there was an abnormal result, the mother would be invited to a clinic on the next day.
- The service for termination of pregnancy offered appropriate multi-professional input, scanning, choice of method and good administrative support.

Pain relief

- Women's options for pain relief included epidural analgesia, opiates and nitrous oxide (gas and air). Intra-muscular and oral analgesia were available in all areas and patient-controlled analgesia was witnessed in use for a mother with intra-uterine death. Midwives were able to issue simple analgesia such as paracetamol.
- The epidural rate was 29%. Epidurals were available to all women who requested this in the high-risk area of the labour ward. Obstetric anaesthetists and an operating department practitioner were available.
- There were water birth facilities, one fixed birthing pool and nine inflatable pools (with disposable liners) and these facilitated relaxation and pain relief. The use of birthing pools had risen by 25%.

Nutrition and hydration

- The hospital had retained level 3 accreditation in the Baby Friendly Hospital initiative (a worldwide initiative to encourage breast feeding). The hospital had very high breast feeding initiation figures with 91.5% of mothers either exclusively or partially breastfeeding in 2014.
- Women reported that hospital food was reasonable and offered a choice of dishes.

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Patient outcomes

- The IT system at the hospital was not effective in generating statistics on standard maternity outcomes, which was a trust-wide issue being investigated. Some information had to be hand counted, which was labour-intensive and less accurate. By contrast, Newham Hospital could generate maternity monitoring data electronically. We were told that The Royal London Hospital's IT system might replace the Newham one, which would be a retrograde step unless assurances could be given that reliable and accurate maternity statistics could be generated electronically.
- The numbers of births were rising and projected to continue to rise in line with the 2% population increase in this part of London and management were aware that this would require an increase in staffing.
- In December 2014, the trust was identified as an outlier as part of the CQC Maternity Outlier Programme. Based on hospital episode statistics data for the period April to June 2014, 25% of births were delivered by emergency caesarean sections. Across the trust an audit was carried out and it was found the increase was justified on grounds of the health of women and babies, however there were some learning points and an action plan was submitted. At the time of our inspection the emergency and elective caesarean sections were averaging 23% since July 2014, similar to other hospitals rates.
- Fifty-three percent of babies were delivered without intervention. The service did not set internal targets for delivery method, nor benchmark against national targets.”
- The reported rate of one-to-one care averaged 95%. This seemed optimistic given the staffing levels observed during our visit. One-to-one care was calculated retrospectively from a notes audit, and staff reported and we observed that midwives were often caring for more than one woman in established labour. However, the women we spoke with had all had one-to-one care.
- There had been no maternal deaths directly associated with pregnancy or labour.
- The high dependency unit had reduced the number of women going to the intensive therapy unit and enabled them to stay with their babies. We observed good team working in the unit.
- We were told that enhanced recovery had been introduced for hysterectomy, including classes for women to explain the process.

Competent staff

- Staff reported having a range of good training recently in topics such as cardiotocography interpretation, audits and case reviews.
- We saw appraisal records showing that staff had had appraisals where relevant, and staff confirmed this.
- Staff were responsible for their own training updates using a training passport. There was a structured support programme for band 5 and 6 midwives.
- We saw a list showing that midwives were allocated to a supervisor. The ratio of supervisors of midwives (SOMs) to midwives was 1:20–22, less favourable than the recommended ratio of 1:15, and each SOM had very different sizes of caseload. There were 12 SOMs including the head of midwifery and director of midwifery. Two more were awaiting training and further recruitment was taking place. We were told caseloads would be rearranged after the recruitment. The Local Supervising Authority annual report to the Nursing and Midwifery Council 2014 noted that it was sometimes difficult for supervisors to meet the expectations of the role because of the pressures of clinical work. There was praise in the Local Supervising Authority report for the work of the SOMs in developing good practice.
- Band 7 staff said the Great Expectations programme had provide valuable training, including the opportunity to develop management skills. It had also helped team working “which is what keeps it safe”.
- Sonographers carried out all types of pregnancy scans in order to maintain their skills. Nurses and midwives were receiving training to undertake ultrasound scans and trainee doctors were also able to undertake ultrasound training.
- The head of midwifery reported being well supported by the director of midwifery. The general manager who was her line manager was based at another site, and participated less in supporting her with operational issues.
- Trainee doctors told us they were well supported and were very positive about their training and the wide-ranging experience. There were education sessions every morning, a journal club and opportunities for audit and chairing meetings.

Multidisciplinary working

- Staff told us there was good multidisciplinary working and we observed this.

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- External multidisciplinary working involved other hospitals as necessary for example if there were foetal heart problems a referral would be made Great Ormond Street Hospital, and some twin conditions would be referred to St George's Hospital.

Seven-day services

- Midwifery staffing in all clinical areas was set at the same level/standard every day and night. There was morning-only consultant cover at weekends, and reduced lower grade medical cover at weekends and out of hours.
- Antenatal and scanning clinics ran from Monday to Friday, unless catch-up clinics were needed after bank holidays and then these were scheduled with full participation from the ultrasound team.
- There was 24/7 access to a pharmacist on site.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Women told us they fully understood the choices they made and had consented to, such as the options for screening or the reasons for elective caesarean section. We saw completed forms as evidence of this.
- The joint work with social services departments on assessing the needs of women with learning disabilities included discussions about capacity. Midwives had training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- When consenting to termination of pregnancy, the disposal of foetal tissue was discussed with women, the form in use did not allow them to sign their consent to the method for the products of conception, which would be good practice.

Are maternity and gynaecology services caring?

Good



We observed all staff interacting with women with kindness and understanding, even when they were under pressure. Staff demonstrated an awareness of the importance of maintaining women's dignity and privacy.

Bereavement services for women with pregnancy loss were sensitive to cultural needs and appropriate, with debriefing

and counselling available. A bereavement midwife would often be the named link for the family involved, or a supervisor of midwives would assume this role. Memory boxes were available.

Recent feedback from women collected by the hospital and by other agencies demonstrated improvements in mother's confidence in maternity services staff. The number of complaints about poor attitude had fallen and we saw positive comments about the friendliness and kindness of staff in the free text completed by women on the questionnaire run by the hospital. This was confirmed by women we spoke with.

The hospital scored slightly lower than other trust sites in the Barts questionnaire in the proportion of women offered a choice of pain relief and midwife support throughout labour, but all scores were over 84%. There were some adverse comments about waiting times.

Patient understanding and involvement

- Women we spoke with said they had been given a range of information and that they were clear about their birth plans and explanations of treatment. Partners said that if they asked questions they were given good answers, but that information was not always volunteered if they did not ask.
- Some mothers said they were given a choice of where to give birth, but we did not see clear evidence of this recorded in notes. Most said that doctors and nurses had given clear explanations at antenatal appointments and answered their questions reassuringly. One woman mentioned that the lack of continuity of care meant she found herself repeating her medical history at each midwife appointment and being offered inconsistent advice.
- Women were very positive about one-stop clinic when they first attended the hospital.
- Mothers using community midwifery were allocated to a named team by 16 weeks. The service target was for women to be looked after by a maximum of three midwives within that team to increase the opportunity for continuity of care. The trust reported meeting this target in 90% of cases.

Compassionate care

- We observed good and appropriate care on the labour ward, including telephone interaction. Most women said midwives were supportive and friendly. We saw

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midwives remaining polite even with assertive relatives. However, one woman complained to us that she had spent three days in induction and had not been assessed by a doctor in that time; midwives had said they were too busy to attend.

- There were illuminated signs outside each room to indicate room 'in use'. However, these were not always used and it was possible to walk into a room where a mother was receiving care, thereby compromising privacy and dignity.
- The results of the CQC National Maternity Survey 2013 found that the trust scored close to the national average on the question about the kindness and understanding of staff after the birth. It had shown the trust was worse than other trusts for being able to move around in labour, skin-to-skin contact, being left alone in labour, response to call bells, being treated with respect and having confidence in staff. had shown the Trust as worse than other trusts in being able to move around in labour, skin to skin contact, being left alone in labour, response to call bells, being treated with respect and having confidence in staff. The trust was addressing this through the Great Expectations project and was measuring progress through questionnaires. Staff considered mother's experience was improving. Findings of Healthwatch and the Local Supervising Authority supported this, as did mothers themselves. Consideration was being given to extending this programme to cover gynaecology.
- Some mothers were critical of night staff on the post natal ward. Two women mentioned staff checking eBay rather than attending to their buzzers, name badges partly concealed and some personal aspects of care discussed publicly.
- In the Friends and Family survey some women on the gynaecology ward felt they had not had enough support in talking about their worries and fears.

Emotional support

- Women using the maternity services could access support for specific health issues such as diabetes or mental health needs.
- A multi-faith chaplaincy offered a bereavement service in the event of a baby's death, and a newly appointed bereavement midwife would be involved in supporting families through this period.
- The hospital did not currently offer women an opportunity to meet midwives after birth to reflect on

their feelings about the experience and any concerns about this. We were told a Birth Reflections was planned, once the bereavement midwife commenced employment later in January 2015.

Are maternity and gynaecology services responsive?

Good



The birthrate in Tower Hamlets was rising at over 2% a year, and the service had already exceeded the physical capacity of the new unit which was opened in 2012.

Women were encouraged to make a choice about how their pregnancy and birth was managed. Provision was made for women who did not speak English, and there were pathways for women with a range of other health or social needs.

There was an effective emergency gynaecology service. Terminations of pregnancy and miscarriages were handled sensitively and women had a choice of procedure.

The flow of women through antenatal clinics, triage, the delivery unit and the postnatal ward was affected by staff shortages and resulted in unnecessary delays for women, although women themselves seemed to tolerate the days.

Service planning and delivery to meet the needs of local people

- The top maternity risk on the risk register (rated 20) at the hospital was capacity in the delivery suite. This had been on the risk register since September/October 2014. The birthrate was rising faster in Tower Hamlets than nationally, and the opening of a co-located midwife-led birth centre on the eighth floor, to increase capacity for a further 1500 low-risk births had been delayed. Women awaiting discharge were often two to a room, which carried potential infection risks, and efforts were being made to speed up discharge from the post natal ward with a 24/7 midwifery rota to examine newborns. There were several mitigating actions: the escalation chain to senior managers, the extreme workload policy was in operation (which meant all available staff were being used), there was close liaison with the other operating theatres to take overflow emergency deliveries if necessary, and the trust was investigating options to

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improve flow. They were also diverting some women requiring induction of labour to other trust hospitals while being aware that this was not a good experience for women.

- The proportion of women booked before 12 weeks had risen steadily over the year and was now 87% compared to a trust target of 90%, which is the national target.. This had been achieved following changes in booking practices across the service and one-stop clinics. Early booking correlated with safer outcomes for mother and baby, and helped identify women needing additional medical support.
- We found there was an understanding of the needs of the local population. Tours of the unit were available in English and also in Bengali, which was spoken by a high proportion of mothers. Bengali-speaking advocates were employed by the trust to support mothers with interpretation. A telephone interpretation service was also available, and staff said family members were not used.
- Women were asked about their preferred place and type of birth at their first antenatal clinic appointment. This was reviewed throughout the pregnancy and direct referral to appropriate medical and social teams was available to midwives. There was little home birth activity within the service. This was reported as being in part due to the lack of space and privacy within the home and partly due to the high cultural mix of the local population where home birth is not requested. The Barkentine Birth centre offered a non-hospital birth experience to widen the range of choice for women and encourage normal birth.
- Midwives described clear pathways for women with conditions such as diabetes, which was prevalent in the local population. Specialist consultant clinics were available for a range of problems including third-degree tears, for women with previous miscarriages, or for women with reduced foetal movement. We observed good care planning for women with complex needs, including pre-planning meetings attended by all members of the multi-professional team who would be providing care. Plans were then visible and available to staff in appropriate areas.
- In response to the rising number of pre-term and low birth-weight babies in the local population, the hospital had introduced a growth assessment protocol as one of a number of initiatives.

- Breastfeeding and physiotherapy classes were held on the postnatal ward to maximise women's opportunity to attend.
- Transitional care was also available on the post natal ward. Transitional care is recommended practice and is provided on the postnatal ward so that babies who need treatment such as antibiotic medication can stay with their mothers.
- The Emergency Gynaecology Unit provided an effective one-stop diagnostic service, for 1400 women a year referred by their GP or through A&E with pregnancy or non- pregnancy related problems. Women were offered a range of medical and surgical treatment options to manage miscarriage and ectopic pregnancy so that they could be offered a clinically appropriate choice of care. All nurses working there were trained in counselling, and women's feedback was very positive. There was clear written information for women.
- Women were given choices over the treatment for miscarriage: expectant management, surgical management or evacuation under general anaesthetic. For ectopic pregnancies, women also had choices of medical or surgical treatment, where appropriate
- There was a specialist midwife for foetal medicine, and counselling was offered. When there was miscarriage, stillbirth or termination because of foetal abnormality, women were given an explanation of the choices available to them for the disposal of the baby, or foetal remains. However, the process did not enable women to sign to confirm their choice of burial or cremation, in line with best practice. Two designated rooms for women and partners during and after the loss of their baby were in the labour ward.

Access and flow

- Women in the local area were able to refer themselves by telephone or completing an online form, or could be referred by their GP. The booking appointment was at the hospital but most women had care from community midwives thereafter. The service provided consultant-led care for women needing increased medical surveillance in pregnancy and childbirth.
- We walked the 'maternity patient journey' from the hospital entrance in Whitechapel Road. This involved a long walk through public areas, which raised concerns around safety and privacy and dignity. The signage was confusing. We were told at the main reception desk that triage was in the labour ward in 6E, yet the first sign to

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follow was Women's Unit. On arrival on floor 6, it was not immediately clear where to go: subsequent signs said Delivery Suite, Labour Ward and Delivery Unit. The entry to the delivery unit could be easily confused with the entrance to the obstetric theatre suite. At night there were no staff on the main reception to give directions.

- The lifts were confusing to use because the required floor had to be selected using a touch screen. The wait for the lift was over three minutes on each occasion used.
- The maternity triage unit was very busy on each occasion we visited, and waiting times were long, especially after the Maternal and Foetal Assessment Unit had closed.
- Although the Maternal and Foetal Assessment Unit was open 8am to 8pm, we were told that in the evening women might have a long wait for a medical opinion because the registrar on duty also covered gynaecology. On three occasions in January a midwife was transferred from the Maternal and Foetal Assessment Unit to the labour ward.
- Antenatal clinics overran because a high number of women needed advocates for translation and this was not planned for and appointment times adjusted. This led to complaints about waiting time and needed to be addressed either by increasing the number of midwives or lengthening appointment times. Women were positive about the ease of changing appointments, and we saw that the service ran catch-up clinics on Saturdays to make up for some antenatal cancellations after holiday periods to ensure women had timely appointments
- There was pressure of beds on the post natal ward, because of slow discharge processes and the number of at-risk mothers who were kept in hospital longer for monitoring. Although midwives carried out newborn examinations 24/7, discharge processes caused frustration to families. The causes of delays were attributed to the pharmacy, the absence of a phlebotomist, the need for doctors to sign off mothers, and delays in paperwork completion. One woman we spoke with had been informed that she could leave the previous day, but was still waiting by early afternoon on the next day.

- The gynaecology ward had had very high bed occupancy since September 2014 because it was also used for non-gynaecology female patients. We were told bed pressures from outliers on the ward occasionally led to cancellation of planned procedures.
- Most patients (92%) were referred for treatment for gynaecology within the 18-week target. We saw 16 patients had been waiting over 18 weeks. There were no patients on gynaecology cancer pathways because these patients were currently treated at St Bartholomew's Hospital; the service was due to transfer to The Royal London Hospital in March 2015.
- Gynaecology surgery cancellations were low, for example seven cancellations in October of which two were because of patient non-attendance. Gynaecology surgery took place in the main theatres. A woman in outpatients mentioned that it was hard to get appointments at the right time, for example when treatment was needed at a fixed point in a cycle. Another woman, who was referred by another clinic, said scans went missing. It was not clear where the failure lay, but the patient obtained and sent the scans herself. She said the Patient Advice and Liaison Service was unhelpful (and we noted that the website does not give details of gynaecology services at Royal London Hospital).

Access to information

- Most women we spoke with who were receiving maternity or gynaecology services said midwives and doctors had given them clear verbal explanations as well as giving them written information. Written information was in English, but each leaflet signposted help with interpreting in other languages or how to obtain a large print version. There was also information on the website
- Across the trust sites there had been a slight fall in the number of face-to-face translation episodes from the previous year. It was not clear whether this reflected a decrease in need or cuts in provision. We were not informed of any monitoring to ensure that these services were used appropriately.
- Women were given an information pack when they were booked for maternity services. After birth, they were given a comprehensive discharge pack, which included advice on breastfeeding, postnatal exercises, how to identify a sick baby and how to contact the midwifery team for postnatal care

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- Written information was given to women when they were discharged from gynaecology services, with the telephone number of the ward in case they had any queries.
- There were a large number of leaflets on display in waiting areas, including on: breastfeeding, induction of labour, vitamin K, perineal tears, jaundice and antenatal classes that were also run in Bengali and Somali at various venues.

Learning from complaints and concerns

- Patients and their families were encouraged to provide feedback on their experiences. Information was readily available in clinical areas to explain to people how they could raise a concern or make a complaint. Staff encouraged women to raise concerns at the time so they could be dealt with quickly.
- There had been 67 complaints received since April 2014. The main issues were communication, delays in care and being sent home in early labour. There was evidence of action to address these. Response times to formal complaints had also improved and were dealt with within 25 days. The service reviewed complaints quarterly to identify themes and actions. The themes were shared with staff. When complaints highlighted practice issues, these were addressed as part of behaviour management through the Great Expectations programme, which linked behaviour to the six Cs of nursing's 'culture of compassionate care': care, compassion, competence, communication, courage and commitment. Band 7 staff said this made dealing with performance issues easier.
- There were no overdue complaints since June 2014.
- Gynaecology complaints, though lower than maternity complaints, were said to be rising across the trust. We received no hospital-specific information on this, but were told that communication was the main theme. Resolution meetings where senior staff met women had been introduced successfully in gynaecology.

Are maternity and gynaecology services well-led?

Requires improvement



Leadership for maternity and gynaecology services was provided by the women's and children's health clinical

academic group (CAG). This did not appear to provide an effective route from ward to board, and staff did not feel their concerns were listened to. For example, despite staff concerns, incident reports, reports by external organisations, and national benchmarking information indicating the need for higher staffing levels in relation to the number of births had only this year been added to the risk register.

There was impressive commitment and teamwork from clinical staff. However, there was not enough reliable data on which to plan and monitor the service and drive the service forward.

A values and behaviour programme called Great Expectations, to improve the way staff interacted with women and with each other and to improve the standard of care, had led to improvements in women's satisfaction. A number of staff spoke in support of this training.

Vision and strategy for this service

- The hospital aimed to improve patient experience and there was a strategy and a three year plan to implement it. This was well understood at senior management level but not by all midwives who felt the promises that maternity capacity and staffing would be increased had been made too often with no tangible progress. It was also not clear that the trust board supported the development of the maternity service
- A values and behaviour programme had been launched in maternity services and staff were invited to take the 'Great Expectations' pledge to improve the way they interacted with women and with each other and to improve the standard of care. This programme combined development of staff, feedback from users and launching trust values of positive behaviour.

Governance, risk management and quality measurement

- The merger in 2012 had resulted in changes to strategic planning and clinical governance arrangements. In addition to the CAG board meetings, and clinical governance meetings, there was a monthly Improvement Board for gynaecology and maternity. The meetings were attended by clinical and nursing/midwifery heads of the services from each of the locations to discuss audits, review cost improvement projects and make proposals for future projects. There were also cross-site meetings of leads for services such as the Emergency Gynaecology Units. Staff recognised

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the benefits from links with other hospitals, such as sharing learning and innovation, and enabling staff to work at other locations to develop their skills. However it was also clear that there were site-specific issues which were sometimes blurred by the Barts-wide presentation of data.

- There were some good arrangements for assessing and monitoring the quality of service provided. Risks associated with Never Events had been effectively managed and mitigated. However, from reviewing the CAG and corporate risk registers, it appeared that these did not reflect all the high-level risks staff told us about, for example the risk to women from low consultant and midwife numbers in relation to patient acuity, and also site security. The level of consultant cover had been discussed at the Maternity Annual Risk assessment in June 2014, but was not on the risk register until January 2015.
- The hospital had difficulties in collecting electronically the full spectrum of data expected in a maternity unit of this size and complexity. For example, data was not collected on delayed caesarean section. The absence of reliable data made it difficult to develop and monitor key indicators of performance. We found a number of examples where management papers were using slightly different data on the same issue. Although this risk was well recognised by senior staff, we did not see a plan to improve IT to generate data to support planning and monitoring.
- The maternity dashboard was in development and produced by the service was inaccurate, with figures not equalling the total number of births. Data on birth method was missing for over 350 women and information relating to breastfeeding was omitted for over 300 mothers. The dashboard also recorded 'unknown delivery method' for 149 births, which equates to 3.5% of all babies born. Feeding method was also recorded as 'unknown' for 256 women.
- Senior management did not seem to have considered the potential security risk of open visiting on the labour ward or be aware that electronic baby tagging was not in use.
- We saw effective processes for reviewing complaints and Serious Incidents, and systems for ensuring staff learned from incidents and complaints, such as weekly

newsletters and 'Hot Topics' (complaints and incidents), open meetings and summaries of current issues displayed on noticeboards and highlighted at handover meetings.

- The reduction in the number of managers after the merger had increased the workload and had ultimately proved unsustainable. New managers had recently been appointed so there was a head of midwifery on each site. Staff welcomed this and said they had seen improvements specific to their hospital as a result.

Leadership of service

- A training programme for lead midwives had encouraged them to adopt a more active management role, and staff reported that this had increased their confidence in leadership. Midwifery staff conveyed positive feedback about the leadership of the midwifery team and consultants spoke of good midwifery management that had moved the service forward. However some midwives felt those above band 7 did not understand the working pressures on the wards.
- A number of staff, nurses and medical staff perceived the leadership at the top of the CAG to be remote and unsupportive. They felt women's issues were inadequately represented at board level, and the needs of the service were neither understood nor articulated at this level. An example was the level of consultant cover, which had risked becoming a significant safety issue until it had been picked up by the medical director, and was now being considered. They felt the CAG management structure was not working as it should.
- Staff said they rarely saw senior trust staff unless there was a celebration such as the confirmation of the level 3 UNICEF breastfeeding award.

Culture

- A number of medical and midwifery staff had been in post for several years and enjoyed working at the hospital. They spoke well of the way all staff worked together as teams, both doctors and nurses. They were positive about management at service level. They valued the teamwork and shared values on the ground to keep patients safe
- New staff were impressed with how welcoming and friendly the service was, but we were told of difficulties of retaining new staff, in part because of the pressure of work on the labour ward.

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- Medical trainees were well motivated and praised the quality of teaching. There were daily education sessions, peer-led teaching on Fridays and senior trainees were able to chair meetings. Trainees valued exposure to a range of complex cases and said consultants were easy to contact for advice and approachable at all times.

Public and staff engagement

- Midwifery and administrative staff understood the values in the 'Great Expectations' programme. There was evidence that action was taken to respond to negative feedback and to monitor progress in improving patient experience.
- Communication with staff was through weekly newsletters and 'hot topics'. Staff confirmed that there was an expectation that poor attitudes would be challenged and were encouraged to see that there had been a measurable improvement in women's satisfaction over the last year.

- There was an active hospital Maternity Liaison Services Committee, which sent a monthly log of issues from mothers who wanted a response from the service. Members of the Maternity Liaison Services Committee had acted as observers on band 7

Improvement, innovation and sustainability

- The women's information project had led to the development of leaflets on 19 topics that were informative and helpful to mothers; eight more leaflets were in preparation.
- The one-stop booking clinic to bring together all tests and scans early in pregnancy and avoid women making multiple hospital visits was appreciated by women and enabled earlier referral if there were problems.
- The care bundle project for women in early labour had considerably reduced antenatal admissions – from 1,652 to 182 in a year.

Services for children and young people

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

Information about the service

The hospital provides a range of paediatric services, including general surgery, medicine and paediatric intensive care to children and young people. Services are based on the sixth, seventh and eighth floors of the hospital and managed by the trust's Women's and Children's Health Clinical Academic Group.

The service provision is a children's outpatients department, various medical wards, a day care ward, a 12 bed paediatric assessment and short stay unit (PASSU), a six bedded paediatric critical care unit (PCCU) and a neonatal unit. The hospital carried-out inpatient and day case surgery in paediatric operating theatres. The paediatric outpatients department had consulting rooms which were permanently allocated to individual paediatric consultants. The hospital is accredited as a level 2 paediatric oncology shared care unit.

During our inspection of services for children and young people at the Royal London Hospital, we spoke with parents / carers, children and members of the trust's staff. These staff included medical, nursing, management and ancillary staff. We visited the children's outpatients department, PCCU, PASSU, wards 7C, 7D, 7E and 7F and the neonatal unit. We observed care and reviewed records and documentation. We reviewed other documentation from the trust and from stakeholders, including performance information provided by the trust.

The trust refers to each of its divisions as CAGs, which stands for Clinical Academic Groups. For the purposes of this core service we will be referring to the Women's and Children's Health CAG as the women and children's division.

Services for children and young people

Summary of findings

There were significant nursing shortages in paediatric surgery, and no acuity or dependency assessment was carried-out to determine staffing numbers. In the neonatal unit there was a risk to child safety because of the low numbers of nurses qualified in the specialty. Staffing levels on the paediatric critical care unit did not meet Royal College of Nursing staffing guidelines.

Audits were not routinely completed, local and national guidelines were out of date and senior staff told us that performance data was unreliable. Patient outcome information was limited because of a limited audit programme. We found effective multidisciplinary working across children's services at the hospital. A range of weekly, multidisciplinary meetings took place that allowed staff from across the various services to discuss, plan and reflect on patients whose care needs did not fit a standard treatment pathway.

Throughout our inspections on all wards, we saw staff treat patients and their parents with dignity and respect. All of the parents and relatives we spoke with were positive about staff, who they referred to as caring and friendly. They said the care they and their child received was kind, compassionate and supportive.

There was limited service provision for adolescents and inadequate support for children and young people with learning disabilities.

There was no voice, vision or strategy for children's services at an executive level. Local clinical and nursing leads showed a passion and vision for the future of the service, but they were not engaged in shaping the future of the service. Performance data to monitor the quality of the service that was being provided was unreliable. Several local and senior leaders told us that they had given up trying to get their voice heard by the executive, and that they just did what they were told.

There was a 'them and us' separation conveyed between staff and the executive team. We were told by many staff that there was a punitive culture. There was a culture of not reporting incidents in paediatric surgery because staff did not feel that it was a useful process, as

they had not seen changes made when they had reported previous incidents. Despite these failures of executive leadership, staff had a strong bond at a local level, and felt supported by their immediate colleagues.

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Are services for children and young people safe?

Inadequate



There were delays in investigating incidents with a significant number of incidents overdue for investigation.

Staff in paediatric surgery raised concerns due to considerable shortages of equipment. We were told that surgical lists would be started without all the equipment ready at the start of the list, and that sometimes equipment needed to be turned around in the same list. There was also a significant risk to patient safety in paediatric surgery due to patient records not being routinely available for anaesthetists.

During the week we were on inspection, two babies with respiratory deterioration had to wait for four hours for an x-ray. There had been five bleeps sent to the diagnostics team before there was a response. These delays put the children at risk of clinical harm.

There were significant nursing shortages in paediatric surgery, no acuity or dependency assessment was carried-out to determine staffing numbers. In the neonatal unit there was a risk to child safety due to low numbers of nurses qualified in specialty. Staffing levels on the PCCU did not meet RCN staffing guidelines.

There were below average numbers of consultants, middle grade and junior doctors employed by the trust compared to national average. The neonatal unit were managing the risks through recruitment and the development of a workforce plan, but there were concerns highlighted with gaps in the consultant establishment.

Incidents

- Children's services reported nine serious incidents between October 2013 and September 2014. These included five child deaths and two transfusion and a communicable disease / infectious disease issues.
- There were delays in investigating incidents, at the time of our inspection there were 100 incidents overdue for investigation.
- The system used for allocating incidents for investigation was not regularly maintained and cleansed. Therefore, often incidents were allocated for investigation to staff who no longer worked for the

organisation. Also, incidents were allocated to staff members who rarely investigated incidents and so their infrequent use of the system, despite automated reminders and weekly reports of all incidents that weren't closed being circulated, there were significant delays.

- Senior local leaders could reallocate incidents if they noticed they were incorrectly allocated, but this was an ad-hoc approach and we were given examples of more than one incident having been reallocated in early 2015 that dated back to 2012.
- Staff were aware how to report incidents and the manager stated that any incident involving children was reported on the electronic system, even if it did not occur in the children's services the manager was alerted by email.
- Staff in paediatric surgery were not routinely reporting incidents as a result of not seeing any changes from when incidents had been previously reported highlighting the same issues.
- The most frequently reported incidents related to medication errors and transport issues. In December 2014, 17 of the 95 incidents reported were drug errors, six related to controlled drugs.
- Many of the staff were not aware of whether paediatric mortality and morbidity meetings took place. However, the trust provided us with evidence that monthly meetings were held, and from November and December 2014 we saw the case studies that were discussed for children's services and learning points were identified from these case studies.

Patient harm data

- Patient harm data was displayed on wards in relation to staffing numbers, infection control, medication, etc. but the way the information was completed was inconsistent across wards and the way the data was presented was not clear. For example, the key showed that a red cross was to be used if the ward was one member of staff short and a blue cross if the ward was more than one member of staff short, but a blue cross didn't denote how many staff the ward were short of from their daily expected establishment.
- Staff used different ways of displaying staffing levels for the AM and PM on boards. Some put a half black, half

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red cross which didn't make clear which line related to which part of the day, and on another board we saw two small crosses in one box which were used to represent AM and PM.

- We also found anomalies with the way incident data was displayed
- No patient harm data was completed for paediatric surgery as the reporting format used was for adults and not child specific. Staff completed the template filling in N/A for not applicable in the entry boxes.

Cleanliness, infection control and hygiene

- Failures had been identified in cleanliness audits on children's inpatient wards in October 2014, however, these scores improved in November and these wards were found to be compliant, when cleanliness was audited in December 2014.
- At an entrance to ward 7E which was only meant for staff use, but we saw patients being given access to the entrance, a hand gel dispenser had been removed and not replaced for more than 24 hours.
- There was very little signage throughout inpatient areas to advise visitors of the importance of hand hygiene and that they follow infection control practices. Sinks for hand washing were not easily accessible in all inpatient areas.
- There was personal protective equipment outside all inpatient rooms, and hand gel containers.
- All staff groups observed appropriate infection control practices and were bare below the elbow.
- All areas we visited were visibly clean. Cleaning schedules on all wards included who was responsible for the task and were audited regularly. We observed that the utility room was clean and odour free. All clinics were clean and uncluttered.
- The majority of the equipment we saw was clean and labelled with the date it was last cleaned.
- Sharps bins were correctly assembled and appropriately used.

Environment and equipment

- Staff in paediatric surgery told us that there were considerable shortages of equipment. We were told that surgical lists would be started without all the equipment ready at the start of the list, and that sometimes equipment needed to be turned around in the same list.
- We witnessed no impact on patient safety due to this issue during the inspection, and we identified a fast

track system for sterilising and turning around equipment to mitigate the risks, but this issue still presented a significant risk to patient safety and staff shared that they were concerned.

- Also, we were told that 50% of appendectomies were done open, against surgical preference, due to equipment shortages. Staff said that they hadn't raised an incident in these circumstances as it had become accepted.
- The majority of resuscitation trolleys seen on wards, were checked daily and a record of these checks was maintained. However, on the neonatal unit there was no record of a check or an audit in 2014 until November, and even since then, the checks had been sporadic.
- Staff raised concerns about the phlebotomy room in clinics and said that it was not fit for purpose as the room was dark and it was difficult to see in the room. We were also told that the bench with samples on and the computer in the room were hard to access as they were too high, and staff said they experienced neck, back and shoulder pain from working regularly in this room.
- Breast feeding rooms in all wards and clinics were clean but the bench in each the room was placed in a position very close to the chair, which made it difficult for mothers to position the baby for breastfeeding while protecting their head from the bench.
- Signage was difficult to follow and parents commented that it was difficult to find children's clinics. We were frequently asked by parents how to find certain clinics as we were carrying out our inspection.

Medicines

- We identified risks to child safety from an example that was shared with us by a member of staff. We were told that there had been an incident where there had been 10 transitional care babies on the neonatal ward and that seven of these babies were on antibiotics. There was no treatment room available for nurse to prepare medicines for infusion, therefore this was done at the bedside posing a risk of cross infection.
- While the nurse had a drug chart, one of the babies did not have an identity wristband which put the baby at considerable risk of being prescribed the wrong medicine.
- We looked at the recording of controlled drugs in paediatrics. All balances were correct and entries complete. Daily checks were carried out and regular audits. We saw the audits carried out by pharmacy and

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heard how discrepancies and incidents were notified to the accountable officer of the trust who was based at the Royal London. The hospital had recently expanded their audit tool and this had resulted in increased reporting.

- However, we found a number of recurring incidents and themes identified by audits suggesting that learning from audits was not being implemented in a timely manner. Controlled drug audits of paediatric wards and paediatric theatres in December 2014 showed that all these areas controlled drugs were not being safely managed.
- The children's services had a designated pharmacist who regularly visited the wards and medication training was provided at ward level by the pharmacist.
- Staff said they were well supported by the pharmacy team. The recent introduction of a new medicines chart had been challenging for nursing staff due to different codes for not giving medicines being used on the new chart. However, despite no formal training being provided, nurses told us that the pharmacy team supported the changeover at a local level. We reviewed drug charts which showed that medicines were prescribed by registered medical practitioners. Charts were clear, signed as appropriate and included information on allergies.
- We saw from audits and also heard for paediatric nurses that paediatrics had their own reporting systems and designated pharmacists involved in ward pharmacy and also oncology where needed. Nurses sourced information from the children's BNF we saw on the ward, from pharmacists and the trust intranet and a local neonatal formulary.
- We saw for ready access on the ward copies of intravenous monographs for paediatrics which were all current. A nurse we spoke with told us about the training they had received in their first six weeks. They told us that they had to demonstrate that they understood the trust's policies and procedures and were assessed as competent before giving out medicines. We observed medications were stored appropriately and fridge temperatures were within appropriate levels.

Records

- There was a significant risk to patient safety in paediatric surgery as we were told that on a daily basis, an anaesthetist would find that they had no notes for a patient and had to take their guidance from patient letters.
- We found a DNA CPR (do not attempt cardio pulmonary resuscitation) form that had been introduced without following trust policy and was not the correct trust form. We raised this with staff on the ward as soon as it was identified.
- There was a paper system used to log children who went in to the discharge lounge including the time they came in to and left the ward. The discharge lounge was also used for assessing children and a paper system was used to book children in for assessment. This was done outside of the electronic patient record system.
- On the whole medical and nursing patient notes were completed appropriately and were signed and dated, but we did find examples of poor record keeping. In one set of nursing notes it was unclear why the patient had been admitted and the patient was due for discharge that day with no plan in place. In another set of notes, signatures were missing where they were required. One child's confidential records were found with another child's notes.
- A specific chart was used for the insertion / removal of a device such as a nasogastric tube stating who inserted the tube and when, to make sure that the device was changed in line with policy, and that there was an audit trail.
- Documentation to support the implementation and monitoring of a paediatric early warning score system was completed appropriately.
- Care plans we reviewed on PASSU and on the PCCU were person centred, had been completed appropriately and there were daily evaluation records of whether health and emotional needs had been met.
- Records were kept securely.

Safeguarding

- Some nursing staff we spoke with stated many safeguarding incidents reported informally and not through the trust's safeguarding processes.

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- On admission to children's services staff used a template to gather relevant information as to whether child is on protection plan or has a social worker. The template prompts flagging of records, but is dependent on parents sharing the information.
- There was no audit data available to assure the consistency of the information templates use.
- Staff we spoke with knew what level of safeguarding training they had received and reported recent updates on child sexual exploitation.
- We were told that safeguarding training was provided face to face by the safeguarding team as part of the wider trust induction for all new staff. When speaking with new staff they confirmed this.
- Training data for Level 1 and 2 for children's safeguarding is captured in the mandatory training data and the trust were not meeting their own targets for the delivery of level 2 training. Assurance of level 3 training and the availability of data to support the delivery of this training was not reliable. We found that the named doctor and named nurse were delivering level 3 sessions, but the recording of compliance and the content of these sessions was not being routinely done.
- The safeguarding children team has a named nurse and an advisor at the hospital and staff told us that members of the safeguarding team were available to them to provide support and advice.
- There was a 24 hour 'on call' rota of named nurse children which was well publicised and staff in all children's areas could name the safeguarding practitioners within the team and how to contact them.
- Named doctors provided updates and support to paediatricians through 'learning sessions' although there was nothing available for other staff groups, and no plan to evidence how this shortfall was being managed.
- All referrals to children's social care were managed by the safeguarding team. There were several local authorities servicing the population and the safeguarding team ensured that records were signposted to the correct authority. Staff also made telephone contact with the local authority or the police, to make a referral.
- The hospital had a paediatric liaison nurse who attended children's wards and the neonatal unit on a regular basis. A CAMHS worker attends the site daily which ensured early referral into mental health services where required. There were also weekly psychosocial

meetings with representatives from the safeguarding team attending, as well as representatives from paediatrics, neonates, mental health and local authority representatives.

- Cases and concerns were shared and onward referrals progressed as required. A log of these meetings showed appropriate signposting and outcomes being recorded. Despite these multidisciplinary meetings and the support in place in terms of dedicated resource and training, there was little evidence of a learning or staff awareness of changes in practice that resulted from incidents. Senior safeguarding leads supported the view that "learning lessons" was not embedded into practice.
- There were processes for ensuring that children who had not attended for an outpatient clinic were followed up. The receptionist for outpatients ensured that each child who had not attended was referred back to the consultant. The consultant would then consider whether the child should be discharged from the clinic list and referred back to their GP with a covering letter stating that they had not attended, or be offered another appointment time.

Security

- There was a security system for entry to the wards. We observed staff politely challenging unknown visitors to determine the reason for their visit.
- There was a child abduction policy (due to be reviewed by the trust board at the time of our inspection) and a missing child policy. While the service did not have formal rehearsals to test the policies, the senior management team told us that the missing child policy had been implemented in the previous 12 months when children with challenging behaviours had left the ward. We were told that following one incident, the policy was reviewed to ensure that it contained information relevant to patients who were being treated for mental health conditions, including the use of physical restraint to safeguard patients from harm.

Mandatory training

- Training for non-clinical staff on level 1 Infection control training was compliant with the trust's own target of 90% of the staff group having received the training. Only 70% of clinical staff had received this training which was significantly below the target.
- Training for staff on the management of medicines was also significantly below the trust's 90% target at 57% for the relevant staff group.

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- A local service manager told us that they felt that one of the contributing factors for staff not completing mandatory training was a lack of staffing, which resulted in it being difficult to release staff to attend.
- There was a significant disparity between the mandatory training figures provided centrally by the trust and what senior nursing staff in the women and children's division reported. Local records on the wards highlighted that a higher number of staff had completed all their mandatory training than trust-wide data displayed.

Assessing and responding to patient risk

- During our inspection, two babies with respiratory deterioration had to wait for four hours for an x-ray. There had been five bleeps sent to the diagnostics team before there was a response. These delays put the children at risk of clinical harm.
 - The regional paediatric transfer team brought children from Newham University Hospital and Whipps Cross Hospital if they needed intensive care, but did not transfer high dependency care babies or children.
 - Nursing staff on the PCCU told us that there were plans to transfer all high dependency children from Newham and Whipps Cross hospitals to the Royal London Hospital, and the trust were running a pilot with the London Helicopter Emergency Medical Service (HEMS) in which a consultant was going out with the London HEMS to review the children at Newham and Whipps Cross. If necessary, the consultant was bringing the children back to the Royal London in an ambulance, as the regional retrieval service will not transfer high dependency children. Since starting this pilot, this had occurred three or four times in the last six months.
 - Pregnancy testing was ad hoc in surgery which put patients at risk.
 - The trust used a bedside Paediatric Early Warning Score (PEWS) system to ensure the safety and wellbeing of children. This system enabled staff to monitor a number of indicators that identified if a child's clinical condition was deteriorating and when a higher level of care was required.
 - Apart from the failure identified to be able to access radiology, staff were aware of the appropriate action to be taken if patients scored higher than expected using PEWS; patients who needed close monitoring and children were cared for appropriately.
- One band 5 nurse demonstrated how they made sure that clinical need was a priority over bed management and that they felt empowered to challenge proposed bed moves, as clinically inappropriate, and that their decision was respected.

Nursing staffing

- There were significant nursing shortages in paediatric surgery, with nursing shortages evident during our inspection. No acuity or dependency assessment was carried-out to determine staffing numbers and the same staffing was deployed regardless of need.
- In the neonatal unit there was a risk to child safety, which is a recognised risk on the trust's relevant risk registers, that the skill mix for specialist nurses is not sufficient. Only 40% of the unit's nursing staff were qualified in speciality.
- Staffing levels on the PCCU did not meet RCN staffing guidelines.
- Staff told us that they had difficulty recruiting to the PCCU as the scope of the unit and the type of cases the unit takes. The ten bedded unit was only funded for six beds and during our inspection there were only one or two infants on the unit at any one time and these infants did not require intensive care. As well as the challenge in recruiting staff, there was a risk that existing nursing staff were not able to maintain or develop their skills in supporting critically ill children.
- Senior staff in children's clinics told us they had establishment shortages and that it was increasingly difficult to recruit new nurses. There had been an increase in the number of clinics, in the autumn of 2014, but there had not been an increase in staffing for these clinics. We were told that a business case had been presented to senior leaders evidencing the need for two additional part-time staff, but this was not approved.
- Staff told us they had lost staff from abroad, and would find it hard to recruit staff from abroad as the trust had a policy that staff could not take six weeks leave at any one time. We were told that many staff from abroad had wanted to use their holiday entitlement for an extended visit to their country of origin.
- As well as in surgery, ward leaders across children's services told us that they did not use an acuity tool to calculate their staffing establishment.
- However, despite this, the local management of children's inpatient wards, demonstrated an

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understanding of the establishment and skill mix needed for the wards and showed that they had taken steps to assure themselves that they were appropriately staffed.

- Paediatric inpatient wards had responded to make sure that they were appropriately staffed for the winter period, which included, appointing an agency nurse on a long-term contract to cover the period.
- Nursing staff on these wards told us that when they were at establishment, they were able to meet patient need. None of the staff we spoke with had any concerns that patient safety was compromised by staffing numbers.
- Nursing staffing was planned six weeks in advance using an e-rostering system. The system was also used to book bank and agency staff through. This system takes into account skill mix and identifies the nurse in charge on shifts.
- Bank and agency staff were used to cover sickness and vacancies. In the last 12 months, in the PCCU the average usage was 8.6% and in paediatric specialities including oncology, haematology and cystic fibrosis the figure was 7.7%. Bank usage for the same period in paediatrics, including urgent care, was 10.8%.
- Several staff in leadership roles told us that the use of agency nurses for children's inpatient wards was significantly lower than the rest of the hospital.
- Newly appointed staff told us that their recruitment had been timely and that they'd had their disclosure and barring service check completed, and their offer letter within 10 days of their interview.
- We observed an appropriately managed and structured nursing handover for children's inpatient wards.

Medical staffing

- There were 31 (WTE) paediatric consultants based at the hospital. This was slightly below average numbers of consultants, middle grade and junior doctors compared to national average, but above national average for the registrar group.
- The neonatal unit were managing the risks through recruitment and the development of a workforce plan, but there were concerns highlighted with gaps in the consultant establishment. The unit was four permanent consultant's down on its establishment, with one of those posts recruited but not in post yet. Out of hours cover was appropriately managed.

- The PCCU was supported by five specialist intensive care consultants who provided cover to the unit 24 hours a day, through in-house provision and an on-call rota.
- Junior medical staff reported delays in having contracts issued and swipe cards being activated for the areas they needed to access.
- We observed a medical handover on one day where no consultant was present and only junior doctors participated. We were told that this was not the usual practice and that the consultant had been delayed by public transport.

Are services for children and young people effective?

Requires improvement 

Audits were not routinely completed, local and national guidelines were out of date and senior staff told us that performance data was unreliable.

Patient outcome information was limited due to a limited audit programme.

Throughout children's services including paediatric surgery, children's pain was effectively managed and the provision of effective pain management was supported appropriately by the hospital's pain team.

We found effective multidisciplinary working across children's services at the hospital. A range of weekly, multidisciplinary meetings took place allowing staff from across the various services to discuss, plan and reflect on patients care.

Staff obtained consent from patients and or their parents / carers appropriately in relation to care and treatment.

Evidence-based care and treatment

- When asked, all senior leaders in the CAG said that the data in their performance dashboards was unreliable. They told us that they always had to deploy a considerable amount of time and resource to validate the information provided. They told us that there had been historical unresolved issues with the trust's

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information governance and that while steps had been taken to address the issues, including the introduction of a new paediatric informatics lead, the data provided at the time of our inspection could not be relied upon.

- Across the hospital's children and neonatal service provision, local guidelines had not been kept up to date and many of the guidelines were not complete, with no author for the guidelines named. National Institute of Clinical Excellence guidelines on tuberculosis on the neonatal unit were dated 2006, and these guidelines were last updated nationally in 2011
- The team who had oversight of clinical audit across the women and children's division could not be assured of what audits were and were not being carried-out in the hospital for children's services. The process relied on local teams registering the local audits they wanted to conduct, and local teams did not routinely communicate this information to the clinical effectiveness audit (CEA) team.
- The CEA team were not resourced to hold local leaders to account for registering local audits, to make sure they contributed to national audits or in order to deliver change as a result of audit outcomes.
- The trust provided us with a list of clinical audits for the hospital which included audits from 2011 to 2014. There were no clinical audits listed for 2014/15. There were approximately 70 clinical audits applicable to the hospital's children's services registered from June 2011, and only four of them had been marked as completed with others all showing a status of 'in progress', 'ongoing', 'pending further information', 'action plan requested' and 'status unknown'.
- We looked at the list of known local audits that had been registered in 2014. There were approximately 40 of these audits registered and none of them were marked as being completed, and over half of these had passed the date they were due to be reported on.
- While the management and delivery of the national and local audit programme across children's services was ineffectual, some consultant nurse specialists demonstrated regular audit activity providing them with patient outcome data to evaluate. They also developed their service in line with royal college of nursing, department of health and royal college of paediatrics and child health guidance. This was particularly evident for the specialties of cystic fibrosis and diabetes.

Pain relief

- There were no distraction techniques used in phlebotomy to help reduce patients' pain and distract them from painful procedures. Play specialists and play assistants were available to assist the medical and nursing teams, as required.
- Emla cream, which is used to numb the area where bloods are to be taken from, was not routinely used before bloods were taken. Administration was dependent on the parent asking for it or if the child was unhappy when the member of staff tried to take the blood. This could lead to long waits for children, we observed a child waiting 30 minutes for their bloods to be taken only for this not to be possible as they were upset when the member of staff tried to take the bloods. The child then went to the waiting room and waited 10 minutes for the nurse to put the cream on and 30 minutes for the cream to work before being recalled.
- However, there was evidence to show that throughout children's services including paediatric surgery, children's pain was effectively managed and the provision of effective pain management was supported appropriately by the hospital's pain team.
- Records to support the delivery of effective pain management were completed appropriately.
- The hospital's pain team and community nurse specialist had carried-out regular audits and reviews to assess the quality of the service, including an epidural review and audits of post-operative pain management for idiopathic scoliosis.

Nutrition and hydration

- There was a multidisciplinary approach to provide support for children with their long-term nutritional needs.
- Food and fluid charts were introduced as necessary, monitored appropriately and used effectively.
- Drinks, snacks and an appropriate choice of food were available for children and young people. Multiple faith foods were available on request.
- We observed a meal time and found that choice was supported and that children and young people got their preferred meal when they wanted it.

Patient outcomes

- We were not provided with any evidence of audit data for children other than neonates.

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- The hospital participated in the National Neonatal Audit Programme undertaken by the Royal College of Paediatrics and Child Health (RCPCH). The latest report was published in October 2014 for the period from January 1 to 30 September 2014.
- The hospital's performance against the four national standards with a target of 100% compliance was that:
 - 97% of babies of less than 29 weeks gestation had their temperature taken within the first hour of birth. The percentage difference between 97% and 100% was one baby out of 36 that didn't have their temperature taken with one hour of birth.
 - 99% of mothers who delivered their babies between 24+0 and 34+6 weeks gestation were given a dose of antenatal steroids. The percentage difference was one birth in 102 where the mother was not given antenatal steroids.
 - 99% of small / delivered early babies underwent the first retinopathy of prematurity screening. One eligible baby out of 70 was not being screened.
 - The hospital had documented a consultation with parents / carers with a senior member of the neonatal team within 24 hours of admission in 92% of cases, which was 298 out of 325 cases.
- In the women and children's division, just under 84% of consultants were up to date with their appraisal. Trust data showed that 31 out of 161 appraisals were overdue.
- Nursing staff we spoke with who'd had their annual appraisal told us that they had identified their development needs, and had identified the relevant course on the trust's intranet to meet this need. These staff were clear on how to apply for funding for these courses, but told us that funding had been refused on several occasions without reasons being given.
- During a ward round we observed a doctor identifying the skills that a junior doctor needed to be assessed on that day. In coordination with the senior nurse, they took ownership of the junior doctors learning and arranged for them to undertake and be assessed on these competencies.
- There was a six month development and mentoring programme for all newly qualified staff, and staff we spoke with valued this process, felt well supported and had competencies assessed and signed-off.
- All phlebotomy staff were also trained in paediatric phlebotomy and attended regular training updates including on child safeguarding.
- Staff were assigned to specific clinics each day, dependent on their skills, to ensure clinics are staffed with appropriate staff.
- All nursing staff in children's clinics were registered children's nurses.

Competent staff

- Only 40% of nurses on the neonatal unit held a post registration qualification in neonatal care, against a national recommendation of 70%. There is only one practice nurse educator across all three of the trust's hospitals for neonates, which meant that there was limited educational support available to nurses on the neonatal unit.
- To ensure the nursing establishment met the national standards for the number of nurses trained in intensive care, the hospital funds two new places on the PCCU annually. All band 6 nurses have completed this course and the unit are now starting to offer the course to band 5 nurses working on the unit.
- There is a challenge in keeping up the skills of nurses on the PCCU as there are very few children who are ventilated. Nurses were not rotated to busier units to maintain their skills.
- The PCCU has a dedicated practice educator who told us that they organised teaching at local level and also on paediatric wards.

Multidisciplinary working

- We found effective multidisciplinary working across children's services at the hospital. A range of weekly, multidisciplinary meetings took place allowing staff from across the various services to discuss, plan and reflect on patients whose care does not form a standard treatment pathway. Examples of the weekly meetings included surgery, neuro-disability, complex care and nephrology.
- Parents shared with us examples of input their children received from physiotherapy, occupational therapy, dietetics and speech and language therapy.
- Multidisciplinary team involvement in care was documented in children's notes.
- Play therapists were available on the wards, including the PCCU and provided support to the wellbeing of the child.

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- Clinics have a play specialist post, however, the post holder was on maternity leave and like for like cover had not been provided, We were told a play worker provided support in their absence.
- Children's services used an electronic discharge system for children (apart from in the children's discharge lounge), which all staff could log in to and which supported the timely provision of information to local authorities and community services such as health visitors.

Access to information

- We were told that children were seen in the paediatric outpatient department with a temporary set of notes on very few occasions, but we could not identify how regularly children were seen with temporary notes as no evaluation had been undertaken. There were no recently reported incidents triggered by staff not having notes available.
- Clinics were targeted with making sure that 80% of GP letters were sent to GPs within 10 days, but we were told by senior clinic staff that they were not meeting this target. GP letters were copied to patients when appropriate to do so.
- The hospital was not able to provide us with the data to demonstrate how many letters were being sent within ten days and what actions were being taken to address not meeting the target.

Consent

- Staff obtained consent from patients and or their parents / carers appropriately in relation to care and treatment. Staff were able to explain how consent was sought and how they involved both the child and the person with parental responsibility in obtaining consent where appropriate.
- We noted that verbal and / or written consent was obtained for both medical and / or surgical interventions, with signatures obtained to confirm consent.
- Consent forms for surgical procedures included an explanation of any risks to the child from receiving treatment, a statement from an interpreter if appropriate, who information had been given by to inform consent and a record of any additional procedures that may be required.

Are services for children and young people caring?

Good



Throughout our inspections on all wards, we saw staff treat patients and their parents with dignity and respect. All of the parents and relatives we spoke with were positive about staff that they referred to as caring and friendly. They said the care they and their child received was kind, compassionate and supportive.

Consultant nurse specialists demonstrated an appropriate understanding of the needs of children and young people and in developing services, made sure that that they and their families were involved in decisions about their care.

One play specialist was dedicated to working with older children. We saw how this play specialist empowered this groups' voice and involved them in their care.

We found evidence of multidisciplinary psychosocial support being facilitated throughout children's services.

Compassionate care

- Throughout our inspections on all wards, we saw staff treat patients and their parents with dignity and respect.
- We saw that doctors and nurses introduced themselves appropriately and that curtains were drawn to maintain patient privacy. We observed staff knocking on doors before entering, and that staff were polite and respectful to both parents and children.
- All of the parents and relatives we spoke with were positive about staff they referred to as caring and friendly. They said the care they and their child received was kind, compassionate and supportive.
- The trust has developed a children and young people specific friends and family test and they have piloted this at the hospital. The pilot results were due to go to the trust board around the time of our inspection.
- We observed positive interactions between parents / children and clinic reception staff. Reception staff spoke quietly when taking patient details to protect confidentiality. Parents could take children to play areas and reception staff came and told them when they could attend their appointment.

Services for children and young people

Understanding and involvement of patients and those close to them

- There was no recognition of the diverse population the hospital serves with no official leaflets or signage in different languages.
- Some reviews were carried-out by surgeons in the discharge lounge area which was a former inpatient ward. Set appointment times for review were given, but parents and children were not always visited at these times and could wait up to four hours for review, with no explanation given.
- We observed a child and their family being supported by an interpreter to complete diagnostic tests in one children's clinic.
- We saw children and families being reassured by the nursing staff and heard explanations of their care being given.
- Notice boards in all clinics stating name of clinic, waiting times and nurse in charge.
- The phlebotomy service had visual and verbal alerts for calling patients, the electronic board informed parents and young people of their appointment and which room to go to, and also informed patients on the current waiting time.
- Consultant nurse specialists demonstrated an appropriate understanding of the needs of children and young people and in developing services, made sure that that they and their families were involved in decisions about their care.
- The hospital had a part-time play specialist who worked with adolescents and was regularly gathering positive patient feedback about their weekly adolescent sessions through questionnaires and through engaging with children, but this learning had not been evaluated at the time of inspection.

Emotional support

- A range of clinical nurse specialists were employed to support children and their
- There were support mechanisms and care plans to meet the individual needs of children receiving oncology therapies such as chemotherapy and radiotherapy.
- The cystic fibrosis clinical nurse specialist led a nurse led multidisciplinary team, and developed and

implemented a clinical pathway for young people becoming young adults to support young people of 13 to 14 years of age though to late stage transition at 18 years old.

- The pathway provided various opportunities for young people to access emotional support and for intervention as appropriate.
- We saw evidence of multidisciplinary psychosocial support being facilitated throughout children's services.

Are services for children and young people responsive?

Requires improvement 

There was limited service provision for adolescents and inadequate support for children and young people with learning disabilities.

At the time of our inspection the PCCU was ten bedded but was only funded to utilise six of the beds, with only two of the six beds being used for most of our inspection. These beds were not being used by children with critical care needs.

An inpatient ward was being used as a discharge lounge, but its use as such, was not recognised by all staff.

The trust had an above average readmission rate for elective gastro surgery and non-elective plastic surgery for 1-17 year olds, and above average emergency readmission rates for diabetes and epilepsy.

We found that the local team had appropriately managed the demand for inpatient beds during the winter pressure months, by increasing the bed base and increasing staffing.

If children did not attend their outpatient appointment the receptionist alerted the consultant and took the notes in at the end of the clinic for the consultant to review and to determine next steps.

Service planning and delivery to meet the needs of local people

- When we last inspected the trust in October 2013, the provision of adolescent care was identified as an area the trust must improve.

Services for children and young people

- At the time of this inspection an internal review of adolescent provision was being concluded, however, the project lead had only been in post for two and a half months, with the trust having been aware of the need to improve its provision of adolescent care for a year prior.
- We were told that the delay in implementation was due to capacity, and it being unclear what provision was needed.
- It was recognised by all staff that we spoke with below the executive tier, that there was a need to increase activity on the PCCU, but we were told by senior local leaders that there was no executive buy-in or vision for where the patients would come from. At the time of our inspection the PCCU was ten bedded but was only funded to utilise six of the beds, with only two of the six beds being used for most of our inspection. These beds were not being used by children with critical care needs.
- We were told that the PCCU had started an outreach service giving telephone advice to Newham and Whipps Cross Hospitals. All calls were logged including what advice was given. The team told us that they would like to begin visiting children at these hospitals to review them and potentially retrieve them, but this work was not currently funded and there was no evidence that there was senior approval of this initiative.
- The trust plans to move emergency surgery to the Royal London from Newham University Hospital, with elective cases staying at Newham. This would amount to about 100 cases per year. However, throughout our inspection we received mixed messages and uncertainty about what the plan was, when it was going to happen and even whether it was still going ahead.
- Due to the increase demand for allergy services a business case had been submitted to increase this service. The general manager started recruiting staff on the understanding that this plan had been approved, and recruited additional nurses and a dietician. However, the service was not commissioned and the business plan was not supported, and a planned second consultant could not be appointed. It was unclear what would happen to the staff already appointed to a service that was no longer supported for development.
- The trust had an above average readmission rate for elective gastro surgery and non-elective plastic surgery for 1-17 year olds, and above average emergency readmission rates for diabetes and epilepsy.
- An inpatient ward was being used as a discharge lounge on weekdays with two members of nursing staff dedicated to oversee the lounge. Senior leaders in the CAG didn't recognise that the space was being used consistently as a discharge lounge as part of any plan to manage flow. The provision was not being monitored.
- The discharge lounge was also being used for surgical reviews and for babies with prolonged jaundice and these cases accounted for 80% of all its admissions. For the other 20% of children going through the lounge, we saw examples of children being moved to the lounge for very short periods of time (with one example of just ten minutes) before being discharged from the hospital.
- These patients were being discharged off the electronic patient record system and were logged in to the discharge lounge on a paper system. This meant that there was an incomplete and inaccurate record of all the children classified as inpatients in the hospital at any one time.
- The service had dedicated pharmacy support, however there were frequently reported delayed discharges due to delays in take home medications being provided.
- We found that the local team had appropriately managed the demand for inpatient beds during the winter pressure months, by increasing the bed base and increasing staffing. This included employing agency staff for a fixed term. All the staff we spoke with on inpatient wards felt that this period had been well managed by ward managers with the support of the general manager.
- There was a newly appointed paediatric bed manager, who had been in post two weeks and they were currently on induction. The role will be available from 8:30am and 4:30pm and out of hours cover would be provided by ward managers / site practitioners.
- If children did not attend their outpatient appointment the receptionist alerted the consultant and took the notes in at the end of the clinic for the consultant to review. The consultant then took action as appropriate depending on such factors as the individual child and the reason for appointment and would contact the GP if the child did not attend on two occasions.
- Length of stay on the paediatric wards was in line with the national average.

Access and flow

- The hospital treats 65% of the trust's paediatric activity and has seven wards.

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Meeting people's individual needs

- The discharge lounge operating from a space designed as an inpatient ward admitted children for surgical reviews and with prolonged jaundice and these accounted for 80% of all its admissions. The lounge had no budget and therefore it was unable to provide food for children using the lounge, unless they had come from a ward and then their previous ward were asked to bring their lunch down. This however, would only be relevant for 20% of its admissions. We were told this issue had been escalated but no action had been taken.
- A senior member of PCCU staff told us that they were not resourced to offer adequate bereavement support to parents and siblings, as there was one nurse for this role across the trust, They told us that sometimes this nurse was also asked to provide support to children who were bereaved when a parent died in the hospital's intensive care unit.
- Surgery day care staff told us there was no interpretation service available for deaf patients.
- A children's inpatient ward manager told us that support for children with learning disabilities was lacking and that they were reliant on children's parents. They said that when a child was admitted with a learning disability, they had no recognised support to meet their needs. The lack of support for these children was also raised with us by other nursing staff.
- Younger people told us that there was no access to wifi on inpatient wards and limited access to televisions.
- Staff had access to in-house interpreters; however, they said they were increasingly having to book external interpreters for eastern European languages as these languages were not supported internally. We were told that this could lead to delays in care provision if medics and allied health professionals hadn't picked-up on the need for an interpreter early enough, in order to book them to support the facilitation of discussions to progress the delivery of care and treatment.
- We saw that there were a lack of distraction aids such as pictures for children in phlebotomy, staff said they had raised this issue and made suggestions of how this could be resolved, but they said no action had been taken.
- This was in contrast from the majority of the environment in the hospital where children's services were provided. Throughout inpatient wards all areas

- were tailored to be child friendly and the space was purpose built, including a rooftop outdoor play area and a large indoor play area which was themed based on feedback from children who use the service.
- The phlebotomy service runs Monday to Friday 9am until 5pm. There are no set appointments and parents take a ticket on arrival, and could wait up to 30 minutes to be seen. We were told there was a play worker in each clinic to provide for children, but we did not see this person during our inspection. A Play Specialist assigned to children's clinics had gone on maternity leave, and there had not been a like for like replacement of that role while they were absent.
 - We found several projects throughout children's services and good practice in supporting children through play. This included the provision of play support for children undergoing an MRI and in dental clinics. There was a part-time post dedicated to adolescents and part of their role was to arrange adolescent evenings, and medical students provided general play throughout the week. Staff involved in this work spoke positively about the support they offered to children, however, they also told us that they were under resourced and were finding it challenging to meet all children's needs.
 - There were eight play specialists and four play workers for approximately 130 children at any one time. Recognised guidance suggests that all children should have access to a play specialist. One member of staff said "we try our best to cover, but it's tough going".
 - A business case was being developed at the time of our inspection to make a proposal to provide play specialist support that met published standards.
 - There were low level counters at the clinics reception to allow eye contact with children and people who use a wheelchair.

Learning from complaints and concerns

- The trust employs a decentralised complaints handling model.
- All complaints were assigned to local service leads and they are tasked with contacting and liaising with the complainant, investigating complaints and providing satisfactory resolution for the complainant.
- There had been an historic backlog in complaints handling at the trust and they had been working with the Parliamentary and Health Service Ombudsman in order to improve the patient experience.

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- The trust asked all its divisions to submit a plan for how it intended to address its backlog of complaints. We asked for the plan for the women and children's division, but this was not provided by the trust.
- Each division was also asked to submit a quarterly thematic review of complaints to provide for learning and improving approach to complaints handling. We asked for these reviews for the women and children's division. We received two reviews for the periods April to June 2014 and July to September 2014, but these reviews were headed with the words 'Women's Health' and they were focused on maternity and gynaecological services at the trust and not children's services. So even though it was requested, no evidence was provided to us by the trust, to demonstrate learning from complaints about children's services.

Are services for children and young people well-led?

Inadequate



There was no voice, vision or strategy for children's services at an executive level.

Local clinical and nursing leads showed a passion and vision for the future of the service, but they were not engaged in shaping the future of the service.

Performance data to monitor the quality of the service being provided was unreliable.

Service delivery was not prompted by outcomes and there was little evidence of practice being determined by local and national guidelines.

Several local and senior leaders told us that they had given up on trying to get their voice heard by the executive, and that they just did what they were told. There was a 'them and us' separation conveyed between staff and the executive. We were told by many staff that there was a punitive culture.

There was a culture of not reporting incidents in paediatric surgery as staff did not feel that it was a useful process, as they had not seen changes made when they had reported previous incidents.

Despite these failures of executive leadership, staff had a strong bond at a local level, and felt supported by their immediate colleagues.

Vision and strategy for this service

- The voice for children's services was lost under the umbrella of the women and children's division. While there was a clear strategy for maternity services at the hospital, there was no vision or strategy for children's services.
- Local clinical and nursing leads showed a passion and vision for the future of the service, but we were told that they were not engaged in shaping the future of the service.
- There was an evident frustration for all tiers of staff below the executive, that they weren't able to effect change and deliver a service to meet local need.
- Senior clinical and nursing staff shared that their voice had become weaker, since a non-executive director who took a lead on children's services had left the board, and no replacement voice had been appointed
- Non-elective children's surgery was due to be transferred from Newham University Hospital to other locations including the Royal London, but doctors and other staff were unaware of the plans or timescales for this proposed change.
- An external peer review of the hospital's PCCU was carried out in 2013 by the Paediatric Intensive Care Society. At that time, the review said that the board should give serious consideration to strengthening capacity and that the unit was "on the cusp of viability in the long term". We were told that the board had not acted on any of the recommendations in the review, apart from to increase consultant numbers.
- There had been a slow response in adequately developing the hospital's children's services to meet the needs of adolescents. Also, despite evidence of pockets of good practice to support the transition of young people to adult services, there was no evident trust strategy to develop appropriate transition pathways.

Governance, risk management and quality measurement

- Risks associated with the provision of services were logged on the divisional risk register. While there was

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evidence that risks were discussed and updates applied to the register, we noted that some risks had existed for a year or more with little or no progress being made to mitigate the risks.

- A range of dashboards were used by the various clinical services to help monitor the overall quality of services being provided to neonates, children and young people. However, several clinical and nursing leads told us that the dashboard data they were provided with was unreliable and they could not be assured the data was accurate.
- Service delivery was not prompted by outcomes and there was little evidence of practice being determined by local and national guidelines. Submission to national audits and the carrying-out of local audits was sporadic with the team employed to monitor this work, under-resourced and ineffectual.
- The system for logging, reviewing and investigating incidents did not hold those responsible for identifying and embedding the learning accountable. The list of those responsible for incident investigations was not appropriately maintained.
- There was no evidence of consistent learning from complaints about children and young people's services.
- Cost improvement targets were on track to be delivered across the service.

Leadership of service

- There was a lack of visible leadership for the service at the hospital.
- At the time of the inspection, children and young people's services did not have a named non-executive board member representing the service at board level.
- Staff told us that they felt well-supported by their ward sisters.
- Ward sisters however, told us that as they were not supernumerary, it made it very difficult for them to perform their leadership role as they were always included in staffing numbers and expected to deliver care.
- Junior doctors spoke positively about the support they received from consultants who they told us were always approachable and available to provide assistance, often staying late on the wards to support them. However, junior doctors raised concerns that the extra hours consultants provided were not sustainable.

- Nursing and clinical leads at ward level, led teams who told us they enjoyed working with each other and that they supported each other, Staff who worked on wards, matrons and local clinical leads told us they could effect local change as they worked well as a team.
- Local leaders effectively managed the inpatient wards over the winter months to make sure they could meet the needs of patients.

Culture within the service

- Several local and senior leaders told us that they had given up on trying to get their voice heard by the executive, and that they managed the day to day running of the service, as that was all they could control. More than one clinical / nursing lead told us that they just did what they were told.
- Staff were friendly, supportive of each other and team working among the clinical specialities was reported as being strong and effective. Many staff expressed how much they enjoyed working with their colleagues and as a consequence enjoyed working at the hospital.
- However, throughout out inspection there was a 'them and us' separation conveyed between staff and the executive. We were told by many staff that there was a punitive culture in relation to their interactions with senior managers, and several staff used the phrase 'blame culture' and the word 'bullying'.
- We were given an example of an unofficial mentoring scheme that had developed at a local level, where some local leaders would take staff under their wing to support them. A constant theme in discussions with staff was that orders would regularly be given by senior leaders with no reasoning provided. We were told examples of this and witnessed an example when on inspection.
- There was a culture of not reporting incidents in paediatric surgery as staff did not feel that it was a useful process, as they had not seen changes made when they had reported previous incidents.
- There was a positive culture of challenge on children's inpatient wards and staff respected and listened to each other's opinion and clinical input.

End of life care

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

Information about the service

The hospital palliative care team (HPCT) consists of 3.6 whole time equivalent (WTE) clinical nurse specialist posts and a 0.5 WTE clinical psychologist. This includes one 0.6 WTE team leader who was currently on maternity leave and whose clinical work was being covered by a ward nurse seconded from oncology as a band 7. Leadership duties were not being covered. There were 1.3 WTE consultant posts and two medical registrars.

All of the above posts were shared with three other hospitals within the trust - St Bartholomew's, London Chest and Mile End Hospital. It was estimated that The HPCT's work at the hospital was 50% of the total work load. The team also had a social worker who spent 90% of their time at these other locations.

The hospital reported 573 patient deaths between April 2013 and March 2014. The HPCT had a caseload of 329 patients between April 2013 and March 2014.

We visited a number of wards where care was being given to patients at the end of their lives. These included general medical, care of the elderly, orthopaedic, acute assessment, cardiac/respiratory and gastroenterology wards. There were no specific oncology wards. We spoke with patients and relatives when this was possible. We reviewed medical records and talked with staff from a variety of disciplines. They included porters, chaplains, mortuary and bereavement staff, ward clerks, healthcare assistants, consultants, doctors, nurses and service managers.

Summary of findings

The service lacked clear leadership and strategy - it had no influence within the clinical academic group (CAG) structure. The service was not able to understand how complaints or incidents might relate to end of life care, the hospital was not measuring the quality of services delivered to patients receiving such care.

Limited action had been taken in response to the 2013 review of the Liverpool Care Pathway (LCP) and at the time of the inspection the pathway had not been replaced. 50% of 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms we reviewed had not been fully completed.

Staffing shortages had an impact on the service's ability to provide good care and we found examples where patients receiving end of life care were not being properly supported.

End of life care

Are end of life care services safe?

Requires Improvement 

There was no systematic way for themes that were relevant to patients receiving safe end of life care to be identified or analysed. There was appropriate access to syringe drivers, which had been standardised in response to a national patient safety alert, and drugs to patients in the last few weeks of life had been prescribed appropriately. However, there was no policy or guideline on the consistent use of opioids, leaving scope for drug errors.

DNA CPR forms in patient were not always fully or correctly completed. HPCT assessed and responded to patients risk, however referrals made to the team were often late.

Incidents

- Staff were knowledgeable about the incident reporting process. They confirmed that, to their knowledge, there had not been any Never Events or Serious Incidents relating to end of life care.
- We learnt during our inspection that there had been an issue last year with faulty syringe drivers, which was resolved by purchasing new equipment in response, as far as we could see, to the National Patient Safety Alert regarding syringe drivers. A small, undated, audit had been carried out regarding the safe use of syringe drivers. However, there was no other way of understanding whether reported incidents related to patients receiving end of life care and whether there were themes that may arise through the reporting process.
- Staff told us the potential risks to patients receiving good end of life care were not enough staff and staff not recognising that patients required end of life care. It was not possible to extract if any incidents had related to these 'live issues' that staff were concerned about.
- There was no systematic way to identify and learn from incidents relating to end of life care.

Mandatory training

- There was a mandatory training handbook for staff. Staff told us they had to sign to say they had read it. In order to get a 'green box' for each course, thus completing their handbook, staff completed courses on a variety of

topics, which were followed by a quiz to demonstrate their learned knowledge. A central training department chased up individual staff who were behind on meeting their mandatory training requirement.

- We asked if the service collected training figures or were aware of HPCT staff training performance. We were told there was an annual performance report for the palliative care team which contained this detail and would be supplied. We later found an annual report was not produced.

Safeguarding

- HPCT clinical nurse specialists demonstrated an understanding of the safeguarding reporting process and of recognising vulnerable adults at risk of harm. HPCT met with and liaised with the trust safeguarding team on specific safeguarding issues and reported having a good working relationship with them.
- We were given examples where ward staff had been encouraged to refer cases to the trust safeguarding team by HPCT clinical nurse specialists. We were also given examples of working with community palliative care to safeguard vulnerable adults. This included working to ensure the safety of a patient with a learning disability in the last few weeks of life, where there were safeguarding issues with dying at home.

Medicines

- The hospital achieved its National Care of the Dying Audit for Hospitals (NCDAH) organisational key performance indicator for clinical protocols for the prescription of medications for the five key symptoms at the end of life (score 5/5).
- There was appropriate access to syringe drivers, used to administer regular continuous analgesia. These were available through the medical equipment library. Access to syringe drivers could be difficult at night, when staff told us they needed to ask other wards. One sister estimated access took one hour in daytime and a maximum two hours at night. The syringe drivers used had been standardised in response to a national patient safety alert.
- We were given numerous reports from ward staff that they did not have a problem with the supply of syringe drivers and that they had been trained to use them.

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- We encountered patients in the last few weeks of life with multiple needs where drugs had been prescribed appropriately. We found examples, such as on the acute assessment unit, where ward staff accessed end of life medication swiftly.
- Ward staff approached doctors if they thought a patient was dying and also get a rapid response from the HPCT. Junior doctors reported that they found pharmacists, HPCT consultants and clinical nurse specialists accessible and helpful with prescribing end of life medication.
- There was no policy or guideline on the consistent use of opioids. This meant there was considerable scope for drug errors and misprescribing when doctors moved between wards and failed to appreciate that the drugs had different potencies when administered by different methods. There was no consistency in the use of opioids, with some wards using morphine and others diamorphine.
- The trust lead nurse and lead consultant for palliative care told us that guidelines for the prescribing of opioids were not easily accessible on the trust intranet. Diamorphine was the drug of choice, but wards used morphine as well as oxycodone and there were no restrictions on the prescribing of strong opioids either orally or by syringe driver. There was no palliative care input into governance of controlled drugs and no policy for or monitoring of strong opioid prescribing for palliative care patients. They were not aware of any opioid prescribing incidents. There was not a pharmacist with special interest in palliative care.

Records

- HPCT staff wrote details about contact with patients in the ward medical notes. They also made an electronic record that they had seen a patient.
- Referral forms to the HPCT were completed by HPCT members following contact with ward staff or specialists.
- There was an informal set process for assessments rather than a proforma. HPCT assessments were written in the medical case notes. Assessments seen included headings of pain, bowel, social, PRN meds, and we noted one set of notes with advance care planning that simply stated: 'ideally would like to go back home to Caribbean'.
- A 'communication form' was completed, which travelled with patients when they moved to different settings

such as hospice and the community. This contained details of diagnosis, preferred place of care, family involvement, medical information and other organisations involved.

- We found that HPCT contact with patients had been clearly documented in the case notes. We also found good examples of decision-making clearly documented. Discussions with relatives had been clearly documented as were details of progress with fast track and continuing care referrals.
- On one ward (14E, medical ward) there was an end of life care folder which was kept by the ward clerk. It included bereavement checklists, end of life care plans, initial assessment and PowerPoint teaching slides on nutrition and hydration.
- We reviewed 15 DNA CPR forms in patient found seven of them had not been fully or correctly completed. For instance, forms that had not been counter-signed by the nurse in charge and forms signed by only one doctor. We also found forms that had been completed where it was not possible to tell what decisions had been agreed because of the misleading way in which the forms had been completed. There were examples where families were not consulted and the reason for the decision simply stated 'futility'. We found one DNA CPR form where the decision contradicted what had been written in the notes.

Assessing and responding to patient risk

- There were daily morning handover meetings within the HPCT where they discussed all new patients. A patient list, which detailed which patients were being seen by the team, was then updated. Work was prioritised and patient visits were planned at these morning meetings.
- HPCT members felt patients were often referred too late to the HPCT by wards and were often very close to death. However this issue had not been escalated internally. Instead the HPCT staff told us they tried to identify referrals as they visited the wards to try to prevent this.
- There was no analysis of types of patients the team cared for or had input into their care work done by the team. Patients' dependency was not measured.
- We found that risks related to patients receiving end of life care were managed as general risks to patients. For

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instance, we found examples of managing individual risks such as pressure care, dementia, fluid intake and discharge home on a variety of wards. These were being managed in conjunction with HPCT input.

Nursing staffing

- There were 2.6 time equivalent WTE clinical nurse specialists within the HPCT; one experienced CNS, a newly appointed CNS and an oncology ward nurse on secondment 0.6 WTE.
- The three WTE posts were shared between hospital and three other hospitals within Barts Health NHS Trust: Saint Bartholomew's, London Chest and Mile End. There were 800 new referrals across four sites last year.
- Most referrals were from the hospital because there were fewer specialists to cover end of life care such as in oncology.
- We heard from a number of sources that there was a lot of pressure on meeting the end of life care needs of the hospital from the amount of nursing resource available to the HPCT and wards.
- More recently the clinical nurse specialists had been asked to also work between two other sites within the trust - Newham University Hospital and Whipps Cross, to cover sickness and staff shortages, which had placed further pressure on the nursing staffing of the team. Also one of the experienced clinical nurse specialists was soon to retire and there was no plan in place to cover for this.
- Ward nursing staffing pressures had also impacted on meeting patients' end of life care needs. A lot of newly qualified nurses had started recently, while more experienced nurses had left. This had been in part attributed to a down banding of nursing grades in the hospital. For instance, some wards reported to us that where they used to have six band 6 nurses, they now had two, which also impacted on newly qualified nurses' ability to learn from more experienced staff.
- The HPCT told us that both HPCT and ward nursing staffing shortage issues compromised meeting patients' end of life care needs and that there were 'palliative care pockets' of work which impacted on staffing pressures where work was busiest.

Medical staffing

- There were 1.3 WTE consultant posts and two medical registrars, all of the posts worked across the trust.

- It was estimated that the HPCT's work at hospital was 50% of the work load overall. We asked for and were not provided with job plans. Specific programmed activities were never clearly described by consultants and it was difficult to understand how this time was spent.

Major incident awareness and training

- There were 50 spaces in the mortuary, with an extra 20 spaces in case of extra demand. These were located off site and had never needed to be used.

Are end of life care services effective?

Inadequate



Limited action had been taken in response to the 2013 review of the Liverpool Care Pathway and at the time of the inspection the pathway had not been replaced. There was a lack of evidence to support the hospital's adherence to national evidence-based guidance. There was no evidence of formalised ways of measuring patient outcomes. The HPCT supported ward staff to manage patients' pain at the end of their life, however national audit results showed the hospital was worse than the England average. There were a number of positive multidisciplinary working relationships between HPCT team members and ward teams.

Evidence based care and treatment

- New end of life care planning documentation and guidance to replace the Liverpool Care Pathway had been written but had not yet been implemented across the whole hospital. There was a lack of clarity about the status of the documentation - it was both being trialled and rolled out across the trust. We were told by the associate medical director who reported to the medical director on end of life care that it was being trialled on some wards where draft versions had been made available through the intranet. However, HPCT registrars told us the HPCT were encouraging people to use it, but it was not yet in its final form. The form did not specify input from doctors. The forms were usually filed with nursing documentation and did not form part of the patient's medical record.
- Policies on the intranet for end of re were out-of-date.
- Ward staff had not been familiarised with this documentation or been given any training in its use. At the time of our inspection, we found different versions

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of this care planning process available because there had been some redrafts before this current trial. Some people referred to it as a 'care plan', others as 'interim guidance'.

- On wards where the 'care plan' was not in use, nothing had replaced the Liverpool Care Pathway to support patients receiving end of life care, and there seemed to be confusion about how to meet the care planning needs of dying patients.
- For instance, a senior house officer from the endocrinology wards had heard about care planning documentation for the dying patient from some colleagues, but had not used it or been briefed in its use. A general medicine matron told us they did not use care planning for dying patient and tended to use their own paperwork adapted to the needs of the dying patient. On a hyper acute stroke unit the ward manager said they had not heard of end of life care plans. A sister on an acute admissions unit told us the HPCT clinical nurse specialist was asking about the care planning documentation two weeks ago. We were told they tended not to use it because they were unsure of the paperwork and tended to move dying patients to care of the elderly wards.. A surgery ward told us they were not aware of end of life care plans. On another ward a band 7 nurse told us they did not have specific care plans for end of life patients. On a cardiac/respiratory ward a band 7 nurse told us they had used the interim guidance for end of life care but did not use the care plans because they did not know about them. On a medical ward, a band 6 nurse was using the new end of life nursing care plan. The nurse in charge told us they could download it from the intranet and told us they had had teaching on the Liverpool Care Pathway but not on the new documentation.
- In critical care they were working to develop their own end of life care plan to replace the Liverpool Care Pathway's removal. HPCT registrars said they did not know about this, although it had been mentioned in the end of life care committee minutes.
- There had been no analysis of local needs assessment of current service provision against major national documents such as NICE guidance 2011, the Neuberger report, the Leadership Alliance for the care of dying people, the National Transform Programme or the

National Care of the Dying Audit. The trust draft end of life strategy document did not contain detail of how the recommendations will be met through specific initiatives and service developments.

- The new draft end of life strategy had been drafted and was planned to be presented to the board for approval in February 2015 did not reference any published practice guidance. We asked the trust's lead consultant and lead nurse for palliative care what were the sources for the draft strategy. They were unable to name any influences.
- The hospital contributed to the National Care of the Dying Audit for Hospitals (NCDHA). It had received the results from this audit and an action plan had not been developed in relation to this.

Nutrition and hydration

- A HPCT clinical nurse specialist told us that they would advise relatives and staff on nutrition and hydration issues.
- On a medical ward, we found a patient in the last few weeks of life with multiple chronic conditions, not eating or drinking. They had been assessed by the medical team and HPCT and nutritional and hydration needs had been discussed with the family and care plan agreed.
- On a general medicine ward we found that the family of a patient in the last few weeks of life was distressed regarding their loved one's fluid and nutritional status. There was a clear, detailed record by a junior doctor who had involved the family and planned to discuss with senior doctors and HPCT.
- On the hyper acute stroke unit we found clear and detailed hydration and nutrition documentation.
- The DNA CPR form was unclear whether it meant stop all treatment or what the level of intervention there was meant to be regarding fluids, because of its misleading layout and poor completion. Some ward staff we spoke with said they did not always understand what its intention was
- The hospital's NCDHA score for reviewing patients' nutritional requirements was 38%. This was worse than the England average of 41%.
- The hospital's NCDHA score for reviewing patients' hydration requirements was 40%. This was worse than the England average of 50%.

Pain relief

End of life care

- The HPCT saw its role as prompting symptom management, which included pain management. Advice was given to ward staff in relation to managing patients at the end of life. The ward staff also contacted the HPCT for pain symptoms management advice. Ward staff told us the HPCT supported them with pain management.
- HPCT assessments, located in patients' case notes, showed that pain management was addressed by the team. We also found contributions from the pain team for management of end of life care for patients.

Patient outcomes

- Patient outcomes were not being measured by the HPCT.
- In the NCDAAH, the hospital scored 64% for reviewing interventions during a patient's dying phase. This was better than the England average of 56%. The hospital was also better than the England average of 82% for reviewing the number of assessments undertaken in a patient's last 24 hours of life (98%).

Competent staff

- Ward staff were not trained in end of life care.
- HPCT clinical nurse specialists could access external courses if they wished, but there were budget constraints. There was a place at the Oxford Palliative Care course each year. There were also psychology modules, facilitation and train-the-trainer skills courses. There was inter-agency teaching and learning from audits.
- HPCT members told us they used to have a link nurse programme but this stopped about three years ago for no reason. Staff on a surgical ward told us they had a link nurse going to a bereavement day on 6 February, which was organised by the bereavement coordinator.
- HPCT registrars take part in teaching four times a year; this included symptom control and the role of the HPCT. We were told consultants don't teach other staff. Three doctors in training all told us they had some palliative/end of life care training when they started at the trust. They also told us they learnt on the job and had good support from the HPCT.
- Supervision for the two HPCT registrars was provided by the two HPCT consultants.
- The HPCT worked with the local hospice and formally met three times a year to share learning and presentations on specific topics.

- The hospital did not achieve its NCDAAH organisational indicator for access to specialist support for care in the last hours or days of life (score 1/5).
- The hospital did not achieve its NCDAAH organisational indicator for continuing education, training and audit (score 0/20). There was no action plan in place to address.

Multidisciplinary working

- There was multidisciplinary working. Records for patients receiving end of life care showed input from ear, nose and throat specialists, diabetes clinical nurse specialists, dieticians, speech and language therapists, the pain management team and the nutrition clinical nurse specialist. On a general medicine ward there was clear, comprehensive documentation on one patient receiving end of life care from psychiatry and physiotherapy, and a referral to oncology, colorectal clinical nurse specialist and clinical psychology. On another ward we found a patient with multiple needs. They had received support from six other staff groups within three days.
- HPCT staff told us that ward nurses sometimes came to their multidisciplinary meeting if they had a patient to discuss, as did chaplains. HPCT also did joint working and visits with hospital teams such as the pain management team and the older person's psychiatry team.
- There was also liaison between the HPCT and community palliative care teams and hospices. There was not a meeting for joint hospital and community palliative care leads but, we were told, lots of phone contact at registrar and clinical nurse specialist level.

Seven-day services

- There were no seven-day services available from the HPCT and no plans at present because of the lack of staff resources. Outside of weekday hours and at weekends there was a consultant on-call system. Ward teams we asked knew how to access the palliative care consultant on-call service, who they found approachable and helpful.

Access to information

- The HPCT kept all their records of contact with patients in ward files, along with any assessments they had completed, for ease of access for the ward teams. On

End of life care

some wards such as the hyper acute stroke unit, medical notes were held on computer. It took several attempts to access these because of the slow running of software.

- The HPCT lead nurse told us there was a 'communication form' that was generic across North-East London. This gave details of the specialist input with palliative care that was shared across services and sent to district nurses, GPs and community support services on patients' discharge.
- The hospital achieved its NCDAA organisational indicator for access to information relating to death and dying (score 5/5).

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- A HPCT clinical nurse specialist gave examples of assessing patients' capacity for specific issues and tasks. They told us that there had been an improvement of ward staff's awareness of capacity issues. We found examples of where wards had worked with individual issues of capacity and deprivation of liberty.
- On a medical ward we observed a patient receiving end of life care whose tendency was to walk around the ward, placing themselves and others at risk. A risk assessment had been completed for them to receive close observation from a mental health nurse. An older persons psychiatry consultant had completed a Deprivation of Liberty Safeguard assessment, in the patient's best interest and with family involvement. They had been assessed and were awaiting discharge to a specialist unit. We found an assessment by a trainee clinical psychologist and deprivation of liberty stated in medical notes, but there was no Deprivation of Liberty Safeguards form in the notes, although a best interest meeting had been held.
- On a general medicine ward we found a patient receiving end of life care where there were issues with capacity and planning a complex discharge. There was a careful assessment of decision and specific capacity documented, including multidisciplinary team discussion. However, there was no DNA CPR form.
- We observed some patients receiving end of life care had been identified as being not for resuscitation, DNA CPR. They had the appropriate form in their records so that staff were aware of what action to take in the event of a cardiac or respiratory arrest.

- We had concerns regarding the adequacy of the trust's new DNA CPR form, which did not reflect best practice or evidence based guidelines. There was no acknowledgement of the legal duty to consult with the patient where they had capacity before imposing a DNA CPR order. There was no acknowledgement of an assessment or statement of capacity. The form also included a 'limitation of treatment' section where decisions on treatments that were potentially life prolonging such as fluids and intravenous antibiotics, which needed to be made individually, had been combined/conflated with DNA CPR and could lead to confusion about what had actually been decided or agreed. We fed these concerns back to the Chief Executive and Medical Director during our inspection.
- Some nurses found the section on the form that referred to treatment escalation confusing (for example, tick-box decisions about intensive therapy unit care or further fluids and intravenous antibiotics). An example was given of a patient who had a DNA CPR order and who the ward staff thought was dying. When she became hypoglycaemic they did not understand the instructions given on the DNA CPR form in the treatment escalation section and gave her intravenous dextrose.

in the first place.

Are end of life care services caring?

Requires Improvement 

HPCT staff spoke with care and compassion at their handover meeting and considered the dignity of end of life care needs of a patient. They were sensitive to people's needs in a holistic way. Relatives we spoke with told us that staff were caring. However on two wards senior staff were unaware they had any palliative care patients on their wards despite patients on both of the wards being known to the HPCT. We observed a nurse shouting loudly at a patient who could not speak or understand English. We observed nurses calling patients by their bed numbers rather than by name in front of patients.

Compassionate care

- We spoke with the family of a patient in the last weeks of life. They told us that overall they felt that staff were caring.

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- Bereavement officers and mortuary staff demonstrated sensitivity and caring.
 - Chaplaincy services were coordinated by a full-time Imam. Staff and family relatives said the services supported them and instilled a culture of caring and compassion amongst staff.
 - Some staff told us they did not always see compassionate care on the wards. They felt staff were not always aware of patients' spiritual needs, which had meant a low rate of referrals to chaplaincy.
 - Senior ward staff were not always aware that they were caring for patients who were receiving end of life care.
 - We observed a nurse shouting loudly at a patient who could not speak or understand English, we observed nurses on one ward calling patients receiving end of life care by their bed numbers rather than by name in front of patients.
 - HPCT staff spoke with care and compassion at their handover meeting and considered the dignity of a patient with end of life care needs. They were sensitive to people's needs in a holistic way.
 - The hospital did not achieve its NCDHA organisational key performance indicator for clinical provision/ protocols promoting patient privacy, dignity and respect, up to and including the death of the patient (score 5/9).
- Emotional support was offered by the bereavement office by giving access to services such as Silverline.
 - The bereavement office staff saw offering emotional support to relatives as part of their role. They viewed helping to answer any unanswered questions they may have as helping bereaved relatives through the grieving process. We were given an example where they were meeting with a bereaved relative the following day to offer emotional support and to help answer any unanswered questions they may have.
 - The bereavement office staff demonstrated an understanding for the need for cultural sensitivity around elements of bereavement. The bereavement coordinator within the trust told us there was access to counselling and befriending through local voluntary organisations that were knowledgeable and able to meet local people's cultural needs around bereavement.
 - Each year a bereavement conference was held as an opportunity for staff to seek the support they required. The last conference was attended by 150 trust staff from a range of staff groups and advocates attended.
 - We attended a HPCT handover meeting. The emotional impact on family and staff caring for a dying patient was considered. The psychologist suggested a practice development meeting for staff on the ward to address the emotional impact of caring for one particular patient.

Patient understanding and involvement of patients and those close to them

- HPCT nurses involved relatives and, where possible, patients in the planning and delivery of care. Conversations involving families and friends, updating them with patient progress and around decisions such as preferred place of care, were routinely taking place.
- The bereavement coordinator met with relatives after a death and talked through aspects of next steps and provided information to relatives on this.
- The hospital scored 86% in the NCDHA for the indicator for health professionals' discussions with both a patient and their relatives or friends about their awareness that the patient was dying. This was better than the England average.
- The hospital achieved its NCDHA organisational indicator for the formal feedback process regarding bereaved relatives' or friends' views of care delivery (score 1/4).

Emotional support

Are end of life care services responsive?

Requires Improvement



The service was not planned to meet the needs of people as the needs were not known. Discharges were not 'fast-track' because of staff shortages and high volume of documentation. It was not known if patients preferred place of care was achieved. There was open access for relatives visiting patients who were dying. There were adequate facilities to meet multi faith needs of people and the bereavement services were well organised and responsive to people's needs. Staff worked across multiple locations that impacted on meeting patients need and being responsive. There was no learning from complaints.

Service planning to meet the needs of local people

End of life care

- There was a bereavement coordinator, who was also a clinical nurse specialist, whose role was to work alongside mortuary services, chaplaincy, the coroner's office and the registrars to see that arrangements were in place after death. They were also responsible for providing information to relatives and booklets around services available at the hospital, and for coordinating arrangements to view the deceased's body.
- The majority of patient accommodation was in newly built wards which had access to side rooms for patients who were dying. The HPCT told us part of their role was to advocate on patients and families behalf to promote access to side rooms. On one medical ward, the nurse in charge told us they did not usually care for end of life patients unless a side room was needed. There was open access for relatives visiting patients who were dying. There were no relative beds for side rooms, although some wards had access to a relatives room off of the ward, which had a bed.
- We found information from Macmillan was available in some ward rooms, with information about different cancers and services available. We found a 'care after death' booklet available on wards for relatives. A ward sister told us that staff will go through this with relatives and that the bereavement office may come up to ward to meet the family.
- There was a male and female Muslim prayer room with adequate washing facilities available. We found these to be well maintained, pleasant and peaceful spaces with information available for visitors.
- There was a multi-faith chapel (quiet room). All facilities were good and clean. A Jewish community room was maintained by a local Jewish charity who had been given the space by the trust. It provided a comfortable and quiet space with kitchen facilities for people to use.
- There was enough space in the mortuary, the facilities were clean and had been well maintained.
- Deceased patients were transferred from the wards to the mortuary in concealed trolleys for dignity and privacy, through service lifts and tunnels and so out of sight of the public.
- There were two mortuary viewing areas. Both were well maintained and dignified. The public entrance to the mortuary viewing area was from the road. A Monday to Friday and out-of-hours service were provided. Out of

hours involved ward staff assisting the families with the viewing process, along with mortuary staff who came in and porters who assisted placing the deceased in the viewing area out of hours.

- The bereavement office was organised in terms of attaining death certificates and releasing bodies for burials within 24 hour. The bereavement policy stated that the site manager would arrange for the signing of all necessary documentation for legal and religious reasons. The bereavement office also contained a good amount of information for relatives.
- Chaplaincy offered a responsive service. Out-of-hours services were also available through an on-call system. Chaplains visited wards across the hospital to link up with people. However, chaplains we spoke with did not feel as though their service was well utilised by wards and medical staff and their profile was not as high as they felt it could be, because ward staff did not generally refer people to them. This left chaplains feeling they could be providing a better service to people. For instance, sitting with distressed patients, and being called by ward staff to support people. They did not feel they were considered in holistic appraisals of patient need or that a high enough value had been placed on people's religious or spiritual needs. It might also reflect morale or a low staffing issue.

Meeting people's individual needs

- The HPCT were responsible for meeting the individual end of life care needs of patients by prioritising and managing a workload across the trust. Once one of the HPCT clinical nurse specialists had seen a patient, they would try to see this same patient for the continuity of the relationship. There had been an increase in workload across the trust. This had implications for meeting the patients' individual needs and for the continuity of care.
- A family who were visiting a patient in the last weeks of life told us they felt that staff responded well to individual need and they were overall satisfied with the care their loved one had received. They told us they found some nurses very helpful, but there was a reliance on agency nurses who were not so responsive. The patient's wishes and preferred place of care was met.
- Families had been included in the planning and delivery of care for dying patients. Ward teams were aware of the need to address family issues. Junior doctors told us they regularly spoke with families. We found appropriate

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discussions with families documented in patient notes. HPCT members also regularly liaised with families and ward staff told us they felt well supported by the HPCT nurses when dealing with complex family issues.

- We also found examples where patients had been referred to the hospital Imam at the family's request. We also found examples where notes referred to discussions regarding spiritual support having taken place, but with the outcome 'not applicable'.
- Ward staff told us there was easy access to interpreters, who were available face to face or over the phone. Face-to-face interpreters were available the same day or next day. We found one example where a ward sister told us a family for one patient receiving end of life care tended to make long visits and would translate. In one set of notes we found that a translator for a Mandarin speaker had attended a ward round.
- An example of considering a patient's needs was when their preferred place of care was to go to a nursing home near to their family but outside of the trust catchment area. Staff were facilitating this move and engaging the family and encouraging them to view homes in their area. This was done in a considerate and caring way that considered the family's emotional needs.
- The hospital's score in the NCDH for assessment of the spiritual needs of a patient and their nominated relatives or friends was 40%. This was better than the England average of 37%.

Access and flow

- An audit from one month's data in February 2014 suggested that 95% of patients referred to the HPCT were seen within 24 hours despite the service being Monday to Friday 9 to 5 and no provision over weekends or over bank holidays.
- The referral process to the HPCT was flexible and anyone could refer; physiotherapists, specialist teams, wards and relatives, as well as community palliative care. Any team member could accept referrals, including verbally. HPCT staff told us it was very easy to refer to a local hospice, which could be the same day on the basis of a phone call. Wards also reported to us that the HPCT responded promptly to referrals, usually within 24 hours.
- Fast-track discharges were slow. The HPCT described fast-track discharges as a 'nightmare' because of the

volume of paperwork involved and the lack of available staff to complete the documentation. Furthermore not all staff had access to the online forms that needed completion.

- A nurse in charge of a medical ward told us that ward nurses referred patients to district nurses and the community palliative care teams. We were told that fast-track discharge could be efficient to go home but problematic if the patient was going to a nursing home.
- Transport was an issue for some patients at the end of their life. We were told this was because they were not seen as a priority, which could hold up fast-track discharge. We were given the example of a young patient with advanced cancer not getting home until 1.00am after a long wait. A ward sister told us a private ambulance service was available through site managers to arrange rapid transfers.
- Delays with pharmacy organising medications to take home was reported. It could sometimes take all day, even for the simplest of prescriptions.
- Staff told us preferred place of care was discussed with patients. However it was not measured if achieving patients' preferred place of care and preferred place of death was achieved.

Learning from complaints and concerns

- We were told that the trust lead consultant for palliative care was part of a trust-wide meeting where complaints were reviewed. There was no way to extract hospital complaints that related to end of life care from hospital data in order to improve learning. The HPCT lead nurse told us there were plans to address this through the end of life care board.

Are end of life care services well-led?

Inadequate



An end of life strategy was drafted in November 2014 and, at the time of our inspection, had not been approved by the board. The draft strategy outlined action on a number of remedial concerns as the trust had not replaced the Liverpool Care Pathway. Clear leadership and governance for the service was not evidence within the CAG structure. There was a lack of direction and a lack of leadership.

Vision and strategy for this service

End of life care

- The draft End of Life Care Strategy was due to go to the board for approval on 4 February 2015. The executive summary stated the strategy needed redefining following the cessation of the Liverpool Care Pathway which had been withdrawn in 2013. At the time of our inspection the Liverpool Care Pathway was the guidance available on the intranet. Implementing the compassionate care plan for the dying, including end of life in mandatory training and identifying a non-executive director to provide a board link were included as key to the strategy. None of these were currently in place.
- The medical director and associate medical director with responsibility for end of life care told us of their vision for the service. The vision was to develop a strategy group and try to build up collaboration with local commissioners and local hospices using the Gold Standards Framework and developing care planning, metrics and 'Coordinate My Care'. Coordinate My Care is a clinical service sharing information between healthcare providers, coordinating care, and recording wishes of how you would like to be cared for. Coordinate My Care was initiated London-wide in 2008. There was money to develop the software, and training and support staff to set it up. It was not clear why it had taken the trust so long to consider using it. This potentially compromised optimum pathway communication for patients.
- We were told that the 'nursing care plan for the dying patient' would be launched one month after the strategy had gone to the board, but there were no clear plans of how this was to be achieved within the strategy we were shown.
- The medical director had handed over the chair of the end of life strategy group to the associate medical director, who had an interest in palliative care. They were working with four different commissioning groups across the trust to develop a single strategy but have found common agreement of priorities a challenge.
- A CQUIN worth £300k was planned for benchmarking and developing a dashboard to include a notes audit, recording numbers of death, a DNACPR audit and measuring length of stay. The medical director and associate medical director identified this CQUIN to us, but the trust nursing and medical leads did not appear to be aware of it when asked whether there were any relevant CQUINs.
- The bereavement coordinator chaired the trust bereavement committee, which met monthly and included chaplaincy and mortuary staff. There was not a meeting for joint hospital and community palliative care leads, but we were told there was lots of phone contact at individual clinician level. A business meeting took place every month for the team covering The Royal London Hospital and three other hospitals that shared the palliative care team. The specialist palliative care business meeting occurred every two months. This was a meeting of all the team leaders in the SPC service in the trust with managers and the clinical director and lead nurse for haemato-oncology and palliative care. The end of life care group met monthly and was chaired by the associate medical director with responsibility of end of life care.

Leadership

- The medical director handed over the chair of the end of life strategy group to the associate medical director who was able to spend more time on this. We were told the group had lost some momentum because of staff sickness but was now on track. However the associate medical director was leaving and there was no clear plan for a replacement at this stage.
- There was no non-executive member of the Trust Board in this group. Leadership of the service was unclear.
- The lead nurse for haemato-oncology and palliative care in the trust attended meetings but was not present otherwise because of the broad workload of other duties within the cancer and surgery CAG. There was 0.6 WTE of a band 8A nurse who provided HPCT leadership across three hospital sites, but who was currently on maternity leave and the post was not being covered.
- It was not clear in the CAG structure where end of life care was a priority. The service spread across more than one CAG. Palliative care and end of life care were not identified clearly on the organisational chart.

Governance, risk management and quality measurement

- There were a limited number of audits carried out and there was no strategy or resources to support them. A small, undated audit had been carried out regarding the safe use of syringe drivers.
- A study of response times to referrals had not been carried out since our last inspection in 2013.

End of life care

- The trust lead nurse for palliative care held a large management portfolio that encompassed oncology and other duties. One of the HPCT referred to them as the 'oncology lead' and her level of input in to the HPCT was described to us as low. There was a strained relationship between the trust's nursing and medical leads for palliative care.
- Chaplain services were well led in that it was well thought out and organised. The lead chaplain had regular three-monthly meetings with the chief nurse to discuss chaplaincy issues and staff's issues across the trust.
- The medical director and associate medical director with responsibility for end of life care said the priorities were the face-to-face availability of specialist nurses and education in end of life care. Services were very thinly spread and HPCT staff felt unable to give what was needed because of this. They felt quality was compromised and there was untapped end of life care need within the hospital.

Public and staff engagement

Culture within the service

- The medical director and associate medical director told us that it was 'noticeable the strain the trust is under'. They told us there was a huge need for education and staff support and there were less opportunities and interest in training and implementation of new initiatives for end of life care.
- Staff across the hospital told us that morale was very low within palliative care. HPCT staff felt that as a team they remained open and cohesive despite all of the challenges they faced. Palliative care in the trust and hospital had become fragmented. If one acute hospital within the structure had difficulty delivering on its end of life care commitments, or its quality of care more generally was challenged, it could now impact on the others. Actions from strategy meetings were not clear.
- The HPCT did not carry out any public or staff engagement initiatives. We were told this was because there was not enough staff and treating patients were the team's priority.
- The bereavement coordinator and clinical nurse specialists gave out information packs to families when they came in to pick up death certificates. It also contained a bereavement questionnaire. The bereavement coordinator was pulling together 2014's outcomes at the time of our inspection. These were being broken down by hospital. Relatives graded the care they experienced from excellent to very poor. There were 42 respondents trust-wide, with 28 from The Royal London Hospital. Only five responses by families gave a grade poor or very poor for hospital. In all cases the bereavement coordinator provided feedback to wards. The process relied on families feeling able to respond so close after bereavement and bereavement offices giving out the information packs after bereavement.

Outpatients and diagnostic imaging

Safe	Requires improvement	
Effective	Not sufficient evidence to rate	
Caring	Good	
Responsive	Requires improvement	
Well-led	Requires improvement	
Overall	Requires improvement	

Information about the service

Barts Health NHS Trust provided The The There were over 600,919 first and follow-up outpatient appointments booked at the hospital in 2013/14.

A number of different specialities are covered by the outpatient department, including the breast clinic, fracture clinic, dermatology, ear, nose and throat, ophthalmology, general medicine, cardiology, oncology, diabetic medicine, endocrinology, gastroenterology, general surgery and other clinics. The outpatients and diagnostic imaging department (OPD) is open on Monday to Friday from 9am to 5pm.

Phlebotomy services are provided within the outpatient department. The diagnostic imaging department supported outpatient clinics as well as inpatients, emergency services and GP referrals. The diagnostic imaging department undertook x-rays, CT scans, interventional imaging, fluoroscopy, ultrasound, nuclear medicine and MRI.

We visited all areas associated with the service and spoke with 45 patients and 25 members of staff including senior managers and service leaders. We observed care and treatment and looked at care records. Before our inspection, we reviewed performance data about the trust and data specific to the hospital.

Summary of findings

The service was not always responsive to the needs of their patients. The hospital was persistently failing to meet the national waiting time targets for non admitted patients and had stopped reporting. Appointments were cancelled more often than the national average and clinics frequently ran late. Patients were not always informed about the reasons for delays.

Performance and monitoring data which would have assisted the department to develop and improve its services was not collected and available to staff. Action had not been taken to address identified issues raised by staff.

Staff were caring and compassionate and patients were involved and understood their care and treatment.

Medical records storage was not fit for purpose; and there were issues with tracking and prepping of medical records at the hospital.

There were several speciality clinics such as cardiology and breast surgery as well as one-stop clinics for maternity and gynaecology specialities at the hospital run by clinical nurse specialists. This meant patients could be seen quickly, assessed and treated at the same time without the need to go home and come back for treatment or a follow-up appointment after initial consultation.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Requires improvement



Incident reporting systems were in place to enable staff to report incidents; we were told that outcomes of investigation from incidents reported were not always shared with staff so that lessons could be learnt and services improved.

Emergency equipment was in place for use between two different clinic areas; however, there was no risk assessment in place for its use between these two clinic areas, and the senior nurse in the clinic was unaware of an arrangement for the use of the resuscitation equipment between the two areas. About 85% of staff had received mandatory training designed to ensure they could carry out their role safely. There were adequate suitable arrangements to safeguard children and patients in vulnerable situations.

Some staff told us they did not have regular team meetings and the occasional meetings planned were often cancelled at the last minute because of shortage of staff. They complained that there was no opportunity for them to express their views, share experiences, discuss challenges in their day-to-day work or learn from each another.

Treatment records we checked were informative and showed a clear pathway of what care and treatment patients received at the hospital.

Incidents

- The hospital had an electronic incident reporting system in place. Staff said that they could access the hospital's incident reporting system, and understood their responsibilities with regard to incident reporting. However, some staff told us they did not report incidents because they did not have time, and agency staff were not able to report incidents because they didn't have access to the hospital's computer system.
- There were differences in staff receiving feedback after reporting incidents. Some staff said they received prompt feedback and guidance relating to reported incidents. However others told us they had completed incident forms and received no feedback.

- All staff we spoke with in the diagnostic imaging department understood their responsibilities to raise concerns, to record safety incidents, concerns and near-misses. Staff felt confident that they could discuss incidents with their direct line manager and that their concerns were listened to and acted on. However we noted that there was an incident recorded on the incident reporting system by the pathology department and there was no record to show that lessons were learnt from the incident.
- Staff told us they were confident in raising any concerns with their line managers verbally. Senior managers met regularly to discuss compliments, complaints and incidents. Themes from incidents were discussed at the senior managers meetings, minutes of the meetings confirmed this was the case.

Cleanliness, infection control and hygiene

- All staff we spoke with had completed infection control training. We observed that reception staff and clinical staff complied with the bare below the elbow policy.
- We observed staff use personal protective clothing appropriately, including gloves and aprons. However, hand gel sanitizer's were not readily available within the clinic waiting areas and at the corridors leading to the clinics.
- We noted that an infection control audits had been completed in 2014 by the outpatient department, and action plans were put in place which dealt with issues that arose out of the audit.
- The clinic areas and imaging department were visibly clean and tidy. We saw staff cleaning the areas between use by patients using appropriate wipes, thus reducing the risk of cross-infection or cross-contamination between patients. Within the pathology department staff took active measures to ensure that infection control issues were appropriately dealt with.
- Toilet facilities were located throughout the outpatient's and diagnostic imaging department and these were clearly signposted. We looked at a sample of these and saw they were regularly cleaned with records showing when they were last cleaned.

Environment and equipment

Outpatients and diagnostic imaging

- The environment within the department was safe and fit for purpose. We looked at resuscitation equipment and found it was appropriately cleaned, checked, signed and ready for use. Other equipment was visibly clean, regularly checked and ready for use.
- There was adequate equipment available in all areas. Staff confirmed they had enough equipment to work with and had been trained to use it.
- The main outpatient department was a purpose-built department located within the tower block of the hospital with its own dedicated lifts, receptionist and waiting area.

Medicines

- Medicines were stored in locked medicine cupboards. Nursing staff ordered all medicines through the hospital pharmacy. Two nurses checked controlled drugs medicines taken from the locked medicines cupboards for administration. There was a lockable medicines fridge, with daily temperature checks recorded. The nurse in charge carried the keys to the controlled drug cupboard at all times.
- We found that controlled drugs and fridge temperatures were not regularly checked by staff working in some clinics. Medicines were not always stored correctly. We saw the fridge unlocked in one clinic, even though the instruction on the fridge door said "lock the door".
- We inspected the drug cupboard, and checked controlled drugs and the register; controlled drugs were not checked daily. We saw controlled drugs in the cupboard and there was no corresponding entry of the drugs in the controlled drugs book; we spoke with the charge nurse who had no idea why the drugs were in the cupboard and who requested them.

Records

- Staff told us they usually had medical records available when patients were in clinic for their appointment. We observed that there were issues with accessing medical records due to shortage of storage area, also staffing shortage meant organising and tracking records caused delays for some clinics. A medical records audit to assess and confirm whether records were always available for clinics had not been completed and was not planned.
- The majority of patients we spoke with had not experienced any problems with their medical records not being available for clinics. Staff confirmed that in the

event of medical records not being available, temporary records were created with information available electronically, so patients would always be seen even if their medical records were not available, because the electronic patient records and patients letters were always available on the computer system. Electronic records were available only to authorised people, and computers and computer systems used by the hospital were password protected.

- We observed that a few clinics did not use patient identification sticky labels. Doctors had to repeat the handwritten information on each page of the medical record. This meant there was a risk that patient identification details were inconsistent and it was an avoidable administrative burden on medical staff.
- Medical records department were located in the basement of a disused building, accessed by going outside the main tower building where the clinics were located. At night, this meant that staff had to leave the building to retrieve records, increasing the risk to their safety.
- The medical records storage facility was not fit for purpose, with some records stored in different rooms and some records were in cages waiting to be tracked and shelved. We counted 35 cages full of medical records waiting to be tracked and shelved, some of them had been there for more than three months without been sorted out due to staff shortages and lack of space. This had been highlighted to managers, but staff were unaware whether any action was being taken to address the problem. We raised our concerns during the inspection and when we returned unannounced three cages remained.
- We saw 15 cages of old dental medical records waiting to be archived off site. However because of shortage of staff, this had not been done. Despite the shortages on this site, some staff working in the department were sent to other trust locations to cover for staff shortages.

Safeguarding

- Most staff had completed training for safeguarding adults and children. Staff we spoke with were confident in reporting safeguarding concerns, and were aware of how to escalate concerns to a designated safeguarding team.

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- Staff we spoke with were aware of their responsibilities and understood their role in protecting children and vulnerable adults. They demonstrated knowledge and understanding of safeguarding and of the trust's process for reporting concerns.

Mandatory training

- All staff were required to complete mandatory training in health and safety, fire safety, infection prevention and control, basic life support and moving and handling on a yearly basis. Staff were alerted by their managers' when their mandatory training was due to be done.
- The information provided by the hospital showed that over 95% of Royal London Hospital staff had attended mandatory training. We were unable to see separate mandatory training figures for the outpatient and diagnostic imaging department staff. However senior managers told us that mandatory training of their staff was up to date, and they monitored the training data for their department to ensure compliance with the trust target of 100%.

Assessing and responding to patient risk

- The hospital had equipment and processes in place for responding to patient risk such as resuscitation equipment and fire extinguishers to respond in the event of emergency. The equipment was easily available and checked daily. This was not safe as patients would not be able to rec
- In the diagnostic imaging department, staff we spoke with knew who their Radiation Protection Advisor (RPA) and Radiation Protection Supervisor (RPS) were for their clinical area. Staff explained how they would report any concerns about safety to their line manager. We saw Local Rules drawn up by the RPA and copies of IR(ME)R 2000 regulations.
- Staff we spoke with demonstrated knowledge and understanding of patient risk, particularly for elderly or frail patients with more than one medical condition. We saw staff helping frail and elderly patients and supporting them throughout their outpatient experience.

Nursing staffing

- The outpatient clinics were staffed by registered nurses and health care assistants. Each clinic was run by registered nurses and was supported by health care assistants.

- Nursing staff told us most of the time they did not have enough staff and could become very over-stretched and stressed. When staff were absent, an escalation process was triggered which enabled other staff to be re-allocated. However this was not always effective and sometimes staff could not be found to cover the shortages.
- Nursing staff told us that although they were busy, they felt they provided good and safe patient care. They felt that staffing was generally insufficient and the department relied on bank and agency staff to fill vacancy.

Medical staffing

- Medical staffing was provided by the relevant speciality running the clinics. Medical staff were of mixed grades from consultants to junior doctors. There was always a consultant to oversee the clinics, and junior doctors told us that they felt supported by their consultants.
- Doctors we spoke with felt they had a good relationship with outpatient nursing and clerical staff. They said they felt well supported and could discuss issues with them.

Major incident awareness and training

- There was information relating to major incident preparedness. The trust plan for managing major incidents included utilising all areas of the hospital that was not affected including parts of the outpatient treatment area of the clinic.
- Staff we spoke with were aware of the procedure for managing major incidents such as winter pressures and fire safety incidents. Senior staff had completed major incident training and were able to describe the department's role in the event of a major incident.
- There were business continuity plans in place to ensure that the deliveries of services were maintained in the event of major incident.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Patients received treatment that was evidence-based and followed national guidance. Staff worked well together in a multidisciplinary environment to meet patients' needs.

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Medical staff were supported by specialist nurses. Patients told us that their doctors communicated well with them about their medical condition. They told us this was always done in a way that they understood.

Treatment records were informative and showed a clear pathway of what care and treatment patients were receiving at the hospital.

Staff working in the clinic told us they were encouraged in their professional development by their managers and supported to complete training. However, it had not been possible to complete training because of staff shortages and that made it very difficult to undertake study leave. Staff appraisals were undertaken annually but there was no other form of formal supervision for staff on a regular basis.

Evidence-based care and treatment

- The trust adhered to National Institute for Health and Care Excellence (NICE) guidelines for the treatment of patients. We were told that Clinical Academic Group had an effective process to monitor the implementation of NICE guidelines at the hospital. There were clear standard operating procedures (SOP) for imaging department as required under IRMER 2000 regulations. These addressed patient identification and responsibilities of individual members of staff, and also set training requirements for staff working at the imaging department..
- Staff described how they ensured the care they provided was best practice, and in line with NICE guidelines. Adherence with NICE guidelines was monitored in the relevant directorate clinical governance committees. Nursing staff told us how new practice guidelines were cascaded through the specialist areas they were working in.
- The service had undertaken audit activity of patient documentation. We saw audit results for 2014 which showed recommendations from this audit had been implemented. Staff were informed through meetings and bulletin to all staff to ensure documentation was completed in accordance with the trust policy and nursing and midwifery council (NMC) record keeping guidance.
- Safety alerts were received by managers and cascaded to all staff, displayed in the staff office and discussed at team meetings. We were told by the diagnostic imaging lead that the radiation protection monitoring at the hospital was satisfactory and in line with Ionising

Radiation (Medical Exposure) Regulations (IR(ME)R) requirements. We saw evidence through audits which showed that radiation exposure monitoring was up to date.

Pain relief

- Staff could access appropriate pain relief for patients. Staff told us patients had access to pain relief when it's needed. Patients reported their pain was well managed, monitored and recorded to ensure they received the appropriate amount of pain relief, as needed when in clinic.
- Staff in pain clinic told us prescribed pain relief was monitored for efficacy and changed to meet patients' needs where necessary. This is discussed with patients as part of their on going management of pain.
- Staff told us that they could give paracetamol to patients if they were in pain, but all other analgesics had to be prescribed before being administered to patients.

Patient outcomes

- We observed that none of the clinics had any safety or performance improvement data displayed about the clinic or the department.
- Information we received before the inspection indicated that the trust had a high new to follow-up patient ratio of appointments. New to follow-up patient ratios was a national benchmark, an indication of whether patients were being effectively managed, and if outpatient appointments were being used efficiently. to reduce repeated attendance.
- The service undertook clinical audits such as hand hygiene, waiting times, infection control and records of the audit in 2013/14, showed a high percentage of compliance with good practice.
- We reviewed policy documents, for example those concerned the management of sepsis, and found that the evidence base on which they were based was clearly stated. All local guidance that we reviewed carried a review date that was in the future.
- Diagnostic imaging services participated in national audits at trust level, including: Diagnostic imaging data set analysis (DID). The DID statistics showed that overall trust performance was in line with the national average in most areas.
- The hospital recorded data for 30% of the cancer patients for the Cancer Patient Experience Survey, this

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puts the hospital as one of the worst performing in London. The lead manager told us they had set up a steering group to coordinate actions taken in response to this survey.

- A cytotoxic medication prescribing system had been rolled out by the hospital in order to increase patients' involvement in the management of their care and improve workflow by providing staff with immediate access to patient records, ordering of medications and dispensing of medication by the pharmacy department. We were told by the lead nurse that the hospital had developed a new ways of working to improve patient information for every type of cancer, and redesigned information for two week wait appointments, diagnostic services and tests. Staff were given checklists to ensure consistency.
- Staff said the audit of clinic waiting times showed that the patients were consistently waiting for longer periods for their appointments, and clinics often run late and patients were noted to be waited for longer periods before they were seen and these had been flagged up to the management however no action had been taken.
- Senior staff had responsibility for implementing audit findings and monitoring action plans. However talking to some staff, they were not aware of all these audits been undertaken by the department and had not seen the audit findings and the completed report. The results of audits and the required actions were not shared with the staff and no change had happened as a result of these audits.

Competent staff

- All staff we spoke with confirmed they received annual appraisals from their line manager. However, we did not receive staff appraisal records to confirm whether all staff had their appraisals. While some staff said they had formal supervision meetings with their managers, most staff we spoke with did not.
- Staff received mandatory training such as infection control, safeguarding and health and safety. They were also provided with training relevant to their speciality such as general surgery, orthopaedics, cardiology, staff told us they were trained in the care of patients living with dementia or a learning disability. We saw evidence of this through the mandatory training data submitted by the trust.

- Staff on the reception desk told us that they had not received any training in relation to communication skills or conflict resolution, but often had to deal with people who were upset.
- Minutes from team meetings showed that such meetings were held regularly and that staff were able to contribute to them.

Multidisciplinary working

- There was evidence of multidisciplinary working in the outpatient department; for example, nurses and medical staff ran joint clinics, and staff communicated with other departments such as radiology and with community staff when this was in the interest of patients.
- We observed doctors, nurses and allied health professionals worked well together as a team for better patient outcomes.
- We saw nurse-led clinics in chest, lungs diabetes and breast and spoke with some specialist nurses who described how their clinics fitted into patient treatment pathways.
- Nursing staff and healthcare assistants we spoke with in other clinics, such as dermatology and renal, told us the teamwork and multidisciplinary working was effective and professional.
- There was evidence of patients been referred to community-based services, such as community nursing, physiotherapy, occupational therapy and GP services.

Seven-day services

- The service ran Monday to Friday from 8.30am to 5.30pm. We were told there were no evening or weekend clinics.
- The diagnostic and imaging department offered seven-day services for patients who attended the emergency department.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients we spoke with said that they completed consent forms before treatment when this had been appropriate. We were told that clinicians asked for consent before starting any examination and explained the procedure that was to take place. Staff undertaking procedures were aware of consent implications and completed the appropriate documentation as necessary.

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- We saw evidence from staff training records that clinical staff had completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff we spoke with confirmed they had completed training and had undertaken regular updates.

Are outpatient and diagnostic imaging services caring?

Good



Staff provided caring and compassionate services. We observed patients receiving care in a compassionate manner and that they were treated with dignity and respect. Clinic room doors were kept closed, and staff knocked before entering clinic rooms to maintain patients' privacy. Patients and relatives commented positively about the care provided to them by the staff from all the clinics visited.

Patients told us doctors, nurses and other health professionals answered their questions and kept them informed of their care and treatment and this was always done in a way that they understood. We saw patients been given information about their treatment.

Staff listened and responded to patients' questions positively and provided them with supporting literature to assist their understanding of their medical conditions.

Compassionate care

- We saw staff spending time with patients, explaining care pathways and treatment plans to them. We noticed that staff sat next to the patient to speak with them. We noted that most staff treated patients with compassion, dignity and respect. However, we also saw one patient in the waiting area of the cardiac clinic left on his own in a wheel chair physically distressed and in tears. Throughout our inspection we observed patients being treated with dignity and respect.
- Staff listened to patients and responded positively to questions and requests for information. We observed staff assisting patients around different outpatient areas, guiding them to the appropriate clinic area. Staff approached patients rather than waiting for patients to request assistance, asking them if they needed assistance and pointing them to the right direction.

- The trust had started using the NHS Friends and Family Test (FFT) in October 2014 as required by NHS England. The Royal London Hospital, the FFT for October, November and December 2014 showed a combined total of 209 patients responded to the FFT, of that total 128 rated the service as extremely likely, 68 rated it likely and 9 rated it as neither likely nor unlikely. A total of 191 patients' rated the service favourably.

Understanding and involvement of patients and those close to them

- Patients we spoke with told us they felt involved and informed about their care. Patients told us they were given sufficient information to help them make any decisions. We were told by staff that treatment options were clearly explained to patients and their consent to treatment was sought before treatment began.
- Patients told us their doctors had explained their diagnosis to them and were aware of what was happening with their care and treatment. None of the patients we spoke with had any concerns with regards to the way they had been spoken to by the staff. They were very complimentary about the way in which they had been dealt with by the staff.
- Patients said they were given clear information and time to think about any decisions about their different treatment options. They also told us that treatment options had been explained to them clearly, with enough information about side effects and outcomes for them to make an informed decision.
- Staff told us that they encouraged patients to involve their families, carers and loved ones in their care; however, they respected the decision of patients when they chose not to involve others in their care and treatment.

Emotional support

- The staff we spoke with were sensitive to patients who required emotional support while attending the outpatients department, and knew of the areas within the hospital where that support might be provided. We were told that there was a counselling and bereavement office where emotional support can be provided to patients as well. Emotional support was also provided by the hospital chaplaincy department.

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- Staff explained how they ensured patients were in a suitably private area or room before breaking bad news with them. We were told that it was always possible to locate a suitable room for these discussions.
- Patients and relatives we spoke with confirmed that they had been supported when they were given bad news about their condition. Nurses were always available to help and support patients with information when they were in clinic.
- Staff were observed to be sensitive to the needs of patients who were anxious and distressed about their procedure at the imaging department. Staff were noted to allay patients' fears and anxieties about the proposed procedure, and they explained the procedure and stayed with the patient to provide support and reassurance.
- Patients we spoke with were positive about the clinics and the staff they saw; they told us they were satisfied with the professional approach of the staff.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

The service was not always responsive to the needs of their patients. There were persistent cancelled clinics. The trust had higher than the national average cancellation rates for appointments, both by patients and the hospital. We were told that actions were being taken to improve these rates by scheduling extended clinic hours and ad hoc weekend clinics.

Clinics were occasionally cancelled at short notice. There was an inconsistency in how well patients were kept informed of waiting times in some clinics. There was no information displayed about the availability of chaperone for patients in some clinics visited. Some patients were experiencing long delays in their appointment time of up to an hour or more when we visited.

The hospital failed to meet referral-to-treatment (RTT) for non admitted patients targets throughout the year, and the hospital had stopped reporting.

There were several speciality clinics such as cardiology and breast surgery as well as one-stop clinics for maternity and gynaecology specialities at the hospital run by clinical

nurse specialists. This meant patients could be seen quickly, assessed and treated at the same time without the need to go home and come back for treatment or a follow-up appointment after initial consultation.

Translation services were available through the Language Line for people with English as a second language. Most of the staff we spoke with were able to tell us how to access the Language Line.

Service planning and delivery to meet the needs of local people

- A number of the patients told us their appointment times were running late by about an hour and half on average and staff did not always keep them informed about the length of delay or reasons for clinics running late.
- We were told that there was no monitoring of clinics that were running late. Most of the staff we spoke with could not provide us with audits or monitoring that had taken place to identify the frequency of late clinics and the length of time patients waited after their allocated appointment time to be seen by a doctor or nurse. We also noted that there was no action plans in place to address these issues
- Patients we spoke with told us they sometimes waited for over two hours past their appointment time when clinics were busy. Patients who attended on a regular basis said they often waited in excess of an hour to be seen due to appointments being overrun.
- In the diagnostic imaging department we saw separate changing facilities for male and female patients. There were separate cubicles with curtains screened across to help to preserve privacy and dignity. The radiology waiting area catered for patients referred from inpatient wards, outpatient clinics and those referred directly by their GPs. The radiology department operated from Monday to Sunday. The only dissatisfaction expressed by patients we spoke with was about long waits in the department.
- The staff we spoke with had a good understanding of the population they served and they were all able to explain with confidence the requirements of the people they cared for. The hospital catered for higher than average proportion of ethnic minority with majority of the population from the Indian sub continent, and Bangladeshi being the largest single ethnic group served by the hospital.

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- Staff had access to interpreters through the language line service. Most staff told us they used this service when required. The staff were able to explain the most common languages used in the area as some of them are from the ethnic minority background.
- Arrangements to provide patients with a chaperone during appointments that required an intimate examination, or when requested were not always met. Nursing staff and healthcare assistants acted as chaperones. However because of shortage of staff, these were not always provided. We noticed each member of nursing staff worked with two to four doctors at a time, and this made it difficult to provide effective chaperone services. There was a chaperone policy, but the chaperone services was not well advertised and most patients did not know about it or how to request it.
- Car parking had been a consistent problem for most patients and some of them had to park very far from the hospital and walked in, and others used public transport to get to the hospital. There was easy access to public transport services with underground, overground and local buses stopping near the hospital within short walking distances to the main entrance.

Access and flow

- Hospital Episode Statistics data for 2013/14 showed that of 600,919 appointments made during the year 2013/14, 64% were for first and follow-up appointments. Out of the total appointments made, 17% had been cancelled by patients and 8% by the hospital. Both these figures were above the national average of 6% respectively. Staff we spoke with could not tell us the reasons for such cancellations or the action being taken to address the issues.
- The data also showed that 11% of patients did not attend their appointments, which is higher than the national average of 7%, and the trust average of 10%. We were told by trust managers that their did not attend rate was continuously monitored to enable changes and adaptations to be made to minimise waste of resources. For example, texting and phone calls had been used to remind patients of their appointment date and time. The trust managers were not able to tell us what difference had these initiative made to their did not attend rate.
- Cancer waiting times were worse than the England average for all the three measures at the trust level (1- percentage of people seen by specialist within 2 weeks,

- 2- urgent GP referral Percentage of people waiting less than 31 days from diagnosis to first definitive treatment and 3 - Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment).
- The percentage of patients with suspected cancer being seen by a specialist within two weeks of urgent GP referral was worse than the England average of 94%, the trust score was 92% in 2013/14. Also the percentage of patients waiting less than 31 days from diagnosis to first definitive treatment for all cancers was again worse than the England average of 98%. The trust score was 94%. These figures were at the trust level as the trust was not able to provide us with site specific data.
- The percentage diagnostic waiting times for patients waiting six or more weeks for diagnostic appointment was 1% compared with the national average of 2%.
- The referral-to-treatment time for non admitted patients of 18 weeks for the trust was 90%, which was worse than the Trust Operational Standard of 95% and national average of 97% for 2013/14.
- The hospital was failing to meet the national waiting time targets. The trust had suspended reporting of 18 weeks referral-to-treatment time waits in August 2014. A recovery plan was in place but staff were not confident that the plan timescales were going to be met.
- The hospital target for admitted closed pathways was 90%, however the average score for the trust was 76%; for non-admitted pathways, the trust target was 95% and their average score was 86%. The incomplete pathway target was 92% and the trust average score was 78%.

Meeting people's individual needs

- We noted that signage from the main hospital area to the outpatient clinics was not as clear as it should be; patients could not easily attend the clinic without guidance or directions from people. The lifts to various outpatient clinics were confusing at times and often difficult to navigate.
- There were a number of specialist staff available in clinic to provide information to patients. However there was no specialist information available in information leaflets for patients in different languages for many conditions, despite the majority of their patients' are from the ethnic minorities communities with Bangladeshi being the largest group.
- There was a good system in place to meet the communication needs of patients whose first language

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was not English. The outpatient clinic used the Language Line telephone interpretation service as and when it was required. Staff we spoke with told us that they also made use of staff who spoke other languages, with the patient's consent.

- Patients we spoke with were positive about the outpatient services and told us they were satisfied with the treatment they received. Patients made positive comments about nursing staff, healthcare assistants, receptionists and doctors.
- The environment in the reception area of the outpatient department allowed for confidential conversations. In many of the clinics, the waiting areas were spacious and purpose built.

Learning from complaints and concerns

- Staff said patients did not complain formally, but informally to them. Staff dealt with the patients' informal complaints to resolve them, but did not record or report them. This meant that the opportunities to identify trends and share learning were lost. However, managers told us they responded quickly when patients raised concerns or made complaints about the services and they used complaints to make improvements in the department.
- The majority of complaints were about long waits in clinic during appointments, we were not able to obtain separate complaints figures for outpatients department, and while on an inspection we observed and were not told of any actions been taken to address the issues of clinics running late or overrun. There was no learning from complaints.
- Staff told us complaints and incidents were discussed at the monthly clinical governance meetings. We were told that most complaints were about delays in clinics. Staff we spoke with were aware of the local complaints procedure, and were confident in dealing with complaints if they arose. Information about the Patient Advice and Liaison Service and how to make a complaint were available and displayed at the hospital.

Are outpatient and diagnostic imaging services well-led?

Requires improvement

The leadership required improvement to ensure that staff were well supervised, supported and that opportunities for improvement in the service were identified through audit and monitoring of the service. No performance information was available to front-line staff.

Most of the staff felt well supported by their line managers at the hospital; however, they felt their senior managers were not supportive and were sometimes not visible at the clinics.

There were a range of radiology quality assurance and governance meetings within the department to discuss issues at ground and board level. However, good service improvement initiatives within diagnostic and imaging department were limited.

Staff in diagnostic imaging department stated that they were well supported by their managers. They said managers were visible and provided clear leadership. Staff and managers told us there was an open culture within the department and that they could approach the managers at any time.

Vision and strategy for this service

- Senior managers told us their vision for the service at local level, however none of the junior managers or their staff on the ground had any idea about these visions and strategy for the service. We were not given any written information about the vision and strategy of the outpatient department. There was a lack of shared objectives and strategy to achieve an improved service.
- Most of the front-line staff we spoke with had no recognition of the trust strategy, vision or values and were not able to articulate a vision or plan for the department. Staff felt they had no control in improving the trust's performance on referral-to-treatment targets. They were unaware of the key performance indicators set for their clinics and how they performed in relation to trust targets

Governance, risk management and quality measurement

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- We saw evidence of audits undertaken locally in respect of medicines and infection control. There was no evidence that audit reports had been feedback to staff at the local level. Staff we spoke with could not provide us with evidence of any actions been taken as a result of these audits.
- There was limited data on the performance of the service in respect of cancelled clinics and delays for patients, meaning that the information on which to base improvements in the service was lacking.
- There were monthly outpatient services board meetings chaired by the senior manager and attended by the service managers, senior nurses, outpatient service managers, health records manager and central appointments manager to discuss issues relating to outpatient services. Minutes of a meeting we saw confirmed that these meetings are held, however staff told us they were not aware of any actions been taken as a results of these meetings.
- Regular governance meetings covering the whole of the department were held and there were also separate departmental meetings for each speciality. Minutes of these meetings showed that the meeting had discussed issues related to staffing levels, mandatory training, and availability of health records and data collection.
- We noted that governance arrangements and risk management were discussed regularly with staff through staff meetings. Complaints and incidents were discussed with staff at department meetings. However no apparent action had been taken as a result of the complaints about long waits.

Leadership of service

- We spoke with a variety of nurses and healthcare assistants and were told they felt well supported by their immediate managers. Staff working in the clinic told us they were encouraged in their professional development by their managers and supported to complete training. Appraisals were undertaken annually but there was no other form of formal supervision for staff on a regular basis.
- Most of the staff we spoke with were confident about approaching the senior sister, service manager or overall manager to discuss issues or for support. Staff told us they felt very positive about the overall outpatients and diagnostic imaging management team.

- Senior managers had strong views of the needs of patients and the roles staff needed to play in delivering a good patient service. Staff were comfortable and able to discuss issues with their managers and felt able to contribute ideas for effective running of the department.

Culture within the service

- There was a positive culture amongst staff; staff were committed and proud of their work. Quality and patient experience was seen as a priority and everyone's responsibility. But clinics often run late and there were no audits been undertaken on the long waits in clinics.
- Radiologists and imaging staff felt well supported and there were good opportunities for professional development. Most staff supported each other and there was good team working within the departments.
- Medical staff we spoke with told us the communication between different professionals was good and that it helped to promote a positive culture within the department.
- All staff we spoke with were professional, open and honest, and were positive about working at the hospital. Staff acted in a professional manner, they were polite and honest and respectful.

Public and staff engagement

- Staff we spoke with were positive about the quality of care they provided, the future of the service, and spoke very highly of the team they worked in. However some of them did not feel empowered to raise any issues which could not be addressed with the wider trust leadership.
- At the time of our inspection, the outpatient department had not completed a patient survey of the whole department. Most staff could not tell us when the last patient survey was conducted.

Innovation, improvement and sustainability

- We were concerned throughout outpatients about the delays in waiting times. A sister told us that one of the main challenges in the service was regular delays for patients waiting time and the overbooking of clinics, however there was no action taken at the CAG level to address the situation.
- Senior managers told us there were plans in place to improve the referral-to-treatment and quality of the patient experience in the outpatient departments and

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were confident that the improvements could be delivered. However these plans had not been fully implemented at the time of our inspection and not all staff were aware of these plans.

- Some of the staff we spoke with told us there was limited opportunity to express their concerns related to developments within the trust and how these affected their day-to-day work.

Outstanding practice and areas for improvement

Outstanding practice

- In the week following the inspection the service was running an initiative entitled “Stepping Into the Future”. This was a trial run of a new operating model that, it was hoped, would help relieve some of the flow and access issues in the service. Initiatives that would be tried would include ring fenced surgical elective beds, no non-clinical cancellations on the day, surgery not starting without an available ITU/HDU bed, and trauma and orthopaedics to concentrate on emergency admissions only.
- Senior staff were trialling the Multidisciplinary Action Training in Crises and Human Factors initiative (MATCH). This was a framework within which Never Events and Serious Incidents could be discussed in an environment characterised by mutual respect and in which lessons learnt could be quickly introduced without damaging personal relationships. It was reported that initial results had been very promising. However, staff reported that whilst there had previously been plans to introduce this across the Trust, the financial pressures meant this was on hold.
- The hospital is a pioneer in trauma care. 25% of the patients attending the trauma service as an emergency had penetrative wounds, which is significantly higher than any other UK trauma centre. The service had regular national and international visitors wanting to learn from the service. The service had worked with the Armed Forces whilst on combat operations and had taken specific learning from this and applied it to the service.
- In particular, the Trauma service in conjunction with military colleagues had developed the concept of the ‘platinum ten minutes’ based upon techniques used to help save the lives of soldiers in combat situations. Through the use of fluid, plasma, active surgical intervention and rapid assessment at the scene more patients were arriving at hospital alive.
- The Royal College of Physicians audit of stroke care rated the hospital as 97.5% for patient experience from diagnosis to rehabilitation - the highest result in London.
- A surgeon had become the first in the UK to broadcast online a live surgical procedure using a pair of Google Glass eyewear. The procedure was watched by 13000 surgical students around the world from 115 countries and they also had the opportunity to ask the surgeon questions.

Areas for improvement

Action the hospital MUST take to improve

- ensure safety is a sufficient priority in all services.
- ensure all services are well-led.
- take further action to improve and address the perceived culture of bullying and harassment.
- address the capacity issues across the hospital.
- ensure performance dashboards and information are reliable and service specific. Senior staff must have the information they need to have oversight of the services they lead.
- address the lack of data specific to services at the hospital.
- ensure governance and risk management processes are robust and embedded throughout the hospital.
- ensure incidents are investigated promptly and the learning from incidents, complaints and never events is shared across the services.
- ensure audits are carried out to identify areas for improvements and implementation is monitored.
- ensure all policies are based on current and best practice guidelines.
- urgently improve security in the maternity services.
- ensure staff carry out and document assessments of patient's needs to ensure the planning and delivery of care meets their needs.
- ensure nursing records are completed fully and accurately to ensure patient safety.

Outstanding practice and areas for improvement

- ensure there are sufficient numbers of suitably qualified, skilled and experienced medical staff to meet the needs of patients. In particular in maternity and children's services.
- ensure there are sufficient numbers of suitably qualified, skilled and experienced nursing staff to meet the needs of patients. Staffing levels must meet the Royal College of Nursing staffing guidelines and the Core Standards for Intensive Care Units.
- take definitive action to reduce the Referral to Treatment Time and ensure accurate reporting.
- reduce the number of cancelled procedures and operations.
- ensure the induction process for agency staff working in critical care needs to be consistent and monitored.
- ensure all staff have an understanding of their responsibilities under the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards. Staff in Urgent and emergency services clearly understood their role however other services were not clear.
- ensure there is enough surgical equipment for children.
- ensure the do not attempt cardio-pulmonary resuscitation (DNA CPR) form and the new DNA CPR policy are clear and in keeping with any recent ruling or guidance.
- ensure that all relevant ward staff receive training specific to managing patients at the end of their lives.
- ensure there is a policy on the consistent use of opioids.
- reduce patient waiting times in outpatient clinics.

Action the hospital SHOULD take to improve

- ensure all staff follow infection prevention and control guidance in all medical services.

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

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services
Patients needs were not always assessed and their care was not always planned or delivered to meet their needs.

Regulated activity

Surgical procedures

Regulation

Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment
Suitable arrangements were not always in place to ensure enough of the correct equipment was readily available in theatres, in particular for children.

Regulated activity

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision
Patients were not protected against the risks of inappropriate or unsafe care by the means of an effective operation of systems to regularly assess and monitor the quality of the service or identify assess and manage risks.

Regulated activity

Regulation

This section is primarily information for the provider

Compliance actions

Treatment of disease, disorder or injury

Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines

There was no policy or guidance on the consistent use of opioids which put patients at risk of drug errors or misprescribing when doctors moved between wards and failed to appreciate that the drugs had different potencies when administered by different methods.

Regulated activity

Regulation

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints

There was limited learning from complaints and in some service complaints were not dealt with appropriately or promptly.

Regulated activity

Regulation

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records

Accurate records in relation to the care and treatment of patients were not kept. Nursing documentation was inconsistent and inaccurate; the WHO Surgical Safety Checklist and the Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) were not always fully completed

Regulated activity

Regulation

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing

There were not enough staff across all staff groups and staff levels to provide safe care and treatment for patients.

This section is primarily information for the provider

Enforcement 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.