

# Barts Health NHS Trust

## Inspection report

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We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

## Ratings

### Overall rating for this trust

Requires improvement 

Are services safe?

Requires improvement 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Requires improvement 

Are services well-led?

Good 

Are resources used productively?

Requires improvement 

Combined quality and resource rating

Requires improvement 

# Summary of findings

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

## Background to the trust

Barts Health NHS Trust is one of the largest NHS trusts in the country, having been formed by the merger of Barts and the London NHS trust, Newham University Hospital NHS Trust and Whipps Cross University Hospital NHS Trust in April 2012. The trust serves a population of over 2.6 million and growing in the area of east London, characterized by significant diversity and health inequalities.

The trusts' group of hospitals provide specialist and acute health services that treat almost one million individual patients each year. The trust accounts for 1.5 percent of hospital activity in England.

The Royal London Hospital in Whitechapel is a major teaching hospital providing local and specialist services. Housed in the largest PFI building in the country, the hospital has renowned trauma team, and is the home of the London Air Ambulance. The Royal London Hospital also houses one of the largest children's hospitals in the UK, a major dental hospital, and leading stroke and renal units.

Whipps Cross University Hospital in Leytonstone is a busy general hospital with a range of services that serves a large ageing population.

Newham University Hospital in Plaistow is also a busy general hospital that includes a specialist orthopaedic centre.

Mile End Hospital is a shared facility from where the trust provides rehabilitation, outpatient, x-ray and community services.

St Bartholomew's Hospital in the City, and London's oldest hospital, is the largest cardiovascular centre in the UK and the second largest cancer centre in London.

The trust has nine other locations registered with CQC, including two stand-alone birthing centres and a number of dental and primary medical service locations. Across its multiple sites the trust has 1706 general and acute beds, 220 maternity beds and 177 critical care beds. The trust employs over 16000 staff and has a turnover of £1.4billion.

## Overall summary

**Our rating of this trust stayed the same since our last inspection. We rated it as Requires improvement**



## What this trust does

The Royal London Hospital in Whitechapel is a major teaching hospital providing local and specialist services. Whipps Cross University Hospital in Leytonstone is a large general hospital with a range of local services. Newham University Hospital in Plaistow is a large district hospital with innovative facilities such as its orthopaedic centre. St Bartholomew's Hospital in the City, is a regional and national centre of excellence for cardiac and cancer care.

The trust provided urgent and emergency services through its accident and emergency departments at the Royal London, Whipps Cross and Newham. The Royal London Hospital is a designated major trauma centre, providing a 24/7 specialist service to the north-east London area via its role within the London Trauma Network. The Royal London also provided a hyper-acute stroke unit. St Bartholomew's Hospital is one of the largest heart attack centres in the NHS. The trust had almost 500,000 emergency attendances in the last year, almost 18,000 more than the previous year.

# Summary of findings

Acute medical care was provided by consultant led teams at each site, each providing a range of ambulatory care pathways. Specialty medicine inpatient care was delivered by site based specialty teams such as respiratory, gastroenterology, diabetes, renal, rheumatology, infectious diseases, endocrine, metabolic diseases, cardiology, hepatology and endoscopy services. The trust also had five specialist elderly care wards with 102 dedicated beds for care of the older person.

Surgery services were provided across the four major hospital sites. These included vascular, hepatobiliary, colorectal, gynaecological oncology, neurosurgery, urology, ENT, maxillofacial, ophthalmology, orthopaedics, plastics and transplantation. Newham University Hospital provided high-volume orthopaedic services via the Gateway Centre. The Royal London provided specialist services aligned to the major trauma services. St Bartholomew's delivered specialist cancer and cardiac surgery.

All four major hospital sites provided adult critical care services. The Royal London Hospital had a 44-bedded unit providing specialist and general critical care services, as well as tertiary services including trauma, neurosciences, maxillofacial and ENT, vascular, renal, hepatobiliary medicine and surgery. St Bartholomew's intensive care and high dependency unit had 58 beds that allowed provision of care for the treatment of cardiology and cardiothoracic patients. Newham University Hospital had eight beds predominantly treating medical patients. Whipps Cross University Hospital had recently expanded its critical care provision to 17 beds.

Maternity, gynaecology and neonatal services were provided at Royal London, Whipps Cross and Newham, delivering care to a growing and diverse population. The trust also provided standalone midwife-led facilities linked to Newham and Royal London hospitals at the Barking and Barkantine birth centres. The trust delivered over 15,700 babies in the last year. The trust also provided the largest neonatal services in London.

Acute services for children were provided at Royal London, Whipps Cross and Newham. St Bartholomew's Hospital delivered other specialist services including the treatment of adolescent congenital heart disease. The Royal London Hospital provided specialist paediatric trauma and paediatric intensive care facilities, and is one of the largest children's hospitals in the country.

Outpatient services were provided at all hospital sites, including Mile End Hospital. The trust had around 1.48million outpatient attendances in 2017/18. The trust had the largest imaging department in England, networked across the five sites, providing x-rays, fluoroscopy, magnetic resonance imaging (MRI), computed tomography (CT), ultrasound, breast services, interventional radiology, nuclear medicine / PET CT and radiopharmacy.

The Dental Hospital, situated on the grounds of the Royal London Hospital, provided both emergency and specialist dental care services across London and the surrounding counties.

## Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

# Summary of findings

## What we inspected and why

We last inspected services at St Bartholomew's Hospital May 2017. All services were rated good at that time, and we commended the hospital for its outstanding leadership in surgery and critical care services. We therefore did not return on this occasion to reinspect services at that hospital location.

Between 11 September and 11 October, we inspected 20 core services across the three acute hospital sites and carried out a 'well-led' review of the trusts' governance and leadership.

At the Royal London Hospital, we inspected:

- Urgent and emergency services
- Medical care (including older people's care)
- Surgery
- Services for Children and Young People
- Outpatients
- Dental services (provided by the Dental Hospital)

At Whipps Cross University Hospital we inspected:

- Urgent and emergency services
- Medical care (including older people's care)
- Surgery
- Critical care
- Outpatients
- Diagnostic services

At Newham University Hospital we inspected:

- Urgent and emergency services
- Medical care (including older people's care)
- Maternity
- Critical care
- Services for children and young people
- End of life care services
- Outpatients
- Diagnostic services

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse. Several factors influenced the reasons why we inspected these specific core services. This included an assessment of concerns we had about risk and patient safety. We also returned to inspect some core services to follow up on progress against agreed action plans. Previous CQC ratings and the time since the last inspection were also taken into consideration.

# Summary of findings

Following significant concerns of the leadership, governance, patient safety and quality of care, the trust had been placed in the quality Special Measures regimen by NHS Improvement in 2015. Financial concerns in 2016 also led to the trust being placed in financial Special Measures. Our recent inspection also considered whether the trust was in a position to exit both of these improvement regimens.

## What we found

### Overall trust

Our rating of the trust stayed the same. We rated it as requires improvement because:

- All three hospitals we inspected on this occasion were each rated requires improvement overall.
- Services at Whipps Cross University Hospital had improved. The previous Section 29a Warning Notice (Health and Social Care Act 2008), issued to the surgery service had been addressed. We rated the hospital as good in the effective and caring domains, and requires improvement in the safe, responsive and well-led domains.
- The Royal London Hospital saw improvements across the services we inspected. We rated the hospital good in the effective and caring domains, and requires improvement in the safe, responsive and well-led domains.
- We were disappointed to find that concerns in the maternity services at Newham University Hospital persisted and rated the service inadequate overall and issued the trust a Section 29a Warning Notice (Health and Social Care Act 2008) to address our concerns of poor quality care and leadership. We also rated the diagnostic service inadequate for the well-led domain. Overall, we rated the hospital requires improvement in the safe, effective, responsive, and well-led domains. Caring was rated as good.
- We aggregated the rating for each domain at each location and then subsequently collated the overall aggregation to determine the trust rating across the safe, effective, caring and responsive domains. The effective and caring domains were aggregated as good, whereas the other domains were aggregated as requires improvement.
- Between 9–11 October we carried out a ‘well-led’ review of the trust. Despite recognition there remained areas for improvement, partly evidenced by the concerns we found in maternity and diagnostics services at Newham University Hospital, we found demonstrable improvements to the leadership, governance and culture of the organisation and determined the trust well-led domain as good overall.
- A follow up inspection of maternity services at Newham University Hospital on 14 and 15 January 2019 assessed progress in response to the Section 29a Warning Notice we issued to the trust. We found that appropriate steps to address these concerns had been taken and there was evidence of improvement to the safety and governance of the service.

### Are services safe?

Our rating of safe stayed the same. We rated it as requires improvement because:

- We were not assured that risk assessment tools, such as modified/national early warning score, were accurately completed or acted upon in some areas.
- Staff awareness of incident reporting and how to raise concerns had improved across most services. However, we still found examples where incident investigations were not carried out in a timely way and staff did not always receive feedback. Results from the staff survey indicated staff had a poor perception of incident investigation in the trust.
- Mandatory training compliance for staff varied across services, particularly medical staff. This included low levels of compliance in basic life support training in some services. Not all services were able to provide the relevant data.
- Midwives at Newham University Hospital regularly worked through breaks and beyond the end of their shift.

# Summary of findings

- Improvements were required in the management of medicines across services, although the trust had made significant changes following concerns we raised when we last inspected in April 2018.
- The standard of record keeping across services was variable.
- Infection control and the cleanliness of equipment was variable across services. Some areas had made sustained improvement; however, we found examples in other services where this was poor.
- Equipment was not stored safely or securely in some areas.
- Staff understanding and practice in relation to the control of substances hazardous to health (COSHH) was variable.

However, we also found:

- Staffing levels had improved across most services. Although services were still reliant on bank nurses, the use of agency nurses had decreased.
- Staff understood their role in identifying and reporting safeguarding concerns to keep patients safe. They understood how to protect patients from avoidable harm and abuse.
- Staff demonstrated an understanding of Duty of Candour regulation and we saw evidence of its application.
- Business continuity plans were in place.

## Are services effective?

Our rating of effective improved. We rated it as good because:

- Services sought to deliver care according to best available evidence, such as national guidelines.
- There was greater participation in quality improvement initiatives, such as peer reviews and accreditation schemes.
- Outcomes for people's care and treatment were routinely monitored and collected, although the data suggested that further improvements across services were required.
- Staff were predominantly aware of their responsibilities as set out in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).
- Multi-disciplinary working across services was largely effective. Although, we found examples where this could be improved.
- Specialist training opportunities, including simulations and interactive workshops had been introduced for staff to access across some services.
- Staff understanding of sepsis had improved.
- Staff engagement with health promotion was predominantly better embedded across services.

However, we also found:

- Women in maternity services at Newham University Hospital did not have timely epidurals out of hours, and at times during hours. We raised this at our previous inspection and it had still not improved.
- The end of life service at Newham University Hospital was not meeting the NICE guidelines for adults to provide palliative care services face-to-face seven days a week. This had not changed since the last inspection in November 2016.
- The recording of capacity assessments and decisions on deprivation of liberty safeguards (DoLS) in patient records was inconsistent in some areas.

# Summary of findings

- Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms were not always found to have been completed correctly at Newham University Hospital.
- The regularity and quality of internal audits were variable across services.
- Most services updated policies and procedures, although we found examples across services where they were out of date or were not easily accessible by staff.
- The trust had improved its support and training opportunities for staff, although we still found areas where staff engagement with training and routine appraisals was low.

## Are services caring?

Our rating of caring improved. We rated it as good because:

- The standard of care across core services had fundamentally improved. We found that staff were more consistent in delivering patient care with kindness and dignity.
- We saw many examples of staff offering emotional support to patients and their relatives.
- Staff across services predominantly included patients and their relatives in decisions about their care and treatment.
- Most patients and relatives that we spoke with spoke favourably about the way staff treated them. However, a few people we spoke with described examples of where they had been spoken to in a way perceived as rude.

## Are services responsive?

Our rating of responsive stayed the same. We rated it as requires improvement because:

- The trust was not meeting national waiting time standards across urgent and emergency care, although services had introduced pathways to improve this.
- Referral to treatment times (RTT) were improving, although the trust was still not meeting constitutional standards.
- Patient flow across the trust was variable. For example, out of hours and delayed discharge rates were high at Newham University Hospital critical care service; whereas, patient access and flow in surgery services at The Royal London Hospital had significantly improved since the last inspection.
- The premises and clinical environment varied across hospital location and was not always suitable for patients and their relatives.
- Timely response to complaints varied across services.

However, we also found:

- The trust endeavoured to plan and provide services that met the needs of a diverse local population.
- Teams were in place to help avoid the need for admission in the old and frail, and support the discharge process for those with complex needs who would be better cared for in the community.
- Specialist nursing teams were in place across services to provide care to patients and support staff. For example: dementia teams, psychiatric liaison, critical care outreach, palliative care team, and various oncology nurse specialists.
- Surgery services at The Royal London had addressed the concerns regarding theatre utilisation, access and flow, bed management, bed availability and had reduced referral to treatment backlogs.



# Summary of findings

## Are services well-led?

Our rating of well-led improved. We rated it as good because:

- The trust had further developed and embedded a leadership and governance structure that was better established across the hospital locations. Although there was evidence for further improvement, the structure had allowed for better oversight and improvement to the quality of care across many core services.
- Staff mostly spoke of visible and engaging leaders, at core service and hospital board level.
- Staff across core services and locations spoke of how the organisational culture had improved. We found examples of significant improvement in some services. Although, we still found areas where a negative culture that included perceived bullying persisted.
- Significant investment had been made into the trust ICT systems that had improved since our last inspection, although staff commented that some issues remained.
- Data quality had overall improved compared to previous inspection, although there was still some variability across services and locations.
- Some services had taken steps to better engagement with patients and their relatives.

However, we also found:

- The hospital management boards were at different levels of maturity. This had allowed for variations in quality of services between hospital sites as exemplified by the concerns we found in maternity services at Newham University Hospital where, despite raising several concerns at our last inspection regarding the maternity service at Newham University Hospital, we found on this inspection that many issues and concerns had not been adequately addressed.
- We had concerns at our previous inspection as to the oversight and management of risk across core services. Although, we found on this occasion that this had predominantly improved, and services had better established governance structures that improved identification of risk, we found examples where there was insufficient oversight in some core services, raising concern that the trust board did not receive sufficient assurance.
- Most clinical divisions were dynamically led and the majority of core services were developing or progressing a vision and strategy that aligned with the overall trust vision and strategy. However, we still found variations in development across services and hospital location.
- Serious incident investigations were not being completed within agreed timeframes. The trust recognised that further steps were needed to improve the review and learning process.
- The trust was not addressing all complaints within agreed timescales and there was considerable variation across sites.
- The trust had considered the efficacy of Clinical Support Services directorate and had decentralised some services to ensure better oversight; however, we found that in some areas there remained scope for further improvement to address governance, quality and cultural concerns.

## Ratings tables

The ratings tables show the ratings overall and for each key question, for each service, hospital and service type, and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.



# Summary of findings

## Outstanding practice

We found examples of outstanding practice across services. For more information, see the Outstanding practice section of this report.

## Areas for improvement

We found areas for improvement across services. For more information, see the Areas for improvement section of this report.

## Action we have taken

We issued 5 requirement notices to the trust. Our action related to breaches of 2 legal requirements at a trust-wide level and a total of 34 across the three hospital locations we inspected.

We also took enforcement action following concerns about the quality of care in maternity services at Newham University Hospital, where we issued a Section 29a Warning Notice (Health and Social Care Act 2008)

For more information on action we have taken, see the sections on Areas for improvement and Regulatory action.

## What happens next

We will check that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

## Outstanding practice

We found several areas of outstanding practice. For example:

- Staff within the pre-assessment unit at Whipps Cross University Hospital had researched the needs of patients living with a learning disability to provide more tailored support when undergoing surgery. The team had developed a patient passport which informed the surgical team about any adjustments the patient might need during their treatment.
- The Frail Elderly Unit at Whipps Cross University Hospital had achieved recognition from the tissue viability team for achieving 365 days without a pressure ulcer. A new frailty pathway reflected best practice in older people's services and had significantly improved the care and experience for this population group, particularly for the most vulnerable. This resulted in fewer bed moves at Whipps Cross University Hospital, more dedicated social care and therapies staffing and access to recreation in the hospital. The new pathway reduced pressure on key services and meant acute physicians had a structured and well-defined route to admit elderly patients who presented in emergency services.
- Staff in medical services at Whipps Cross University Hospital had significantly improved information standards and accessibility for patients. This included engaging with a specialist organisation to design a website that enabled patients with physical disabilities to plan their visit in advance based on step-free access needs and the implementation of a website that could be translated instantly into any of 100 different languages.
- A nurse on Cedar ward at Whipps Cross University Hospital had led a project and pilot scheme to improve the use of the situation, background, assessment, recommendation (SBAR) tool used to assess patient status and identify possible deterioration. The nurse, supported by the ward manager, had trialed new ways of using the SBAR tool and identified a method that decreased risk and improved response times. As a result, this was being rolled out across the hospital to all inpatient services.

# Summary of findings

- A consultant from the critical care unit at Newham University Hospital had conducted a recent audit titled, “Can nasal high flow support be used in Type 2 respiratory failure”, that identified that high flow oxygen therapy (Optiflow) had changed the outcome and quality of life in patients on the critical care unit.
- A diabetes team at Newham University Hospital was one of seven projects chosen nationally by an independent health charity in October 2017 to take their health care innovation and develop it on a larger scale to better impact patient outcomes, increasing patient attendance rates. The team were working with commissioners and NHSI with a view to rolling this out nationally.
- The trust’s investment in the Rainbow Centre at Newham University Hospital had created a coherent, well organised and child-friendly environment. Staff consistently told us the new environment and facilities made a big difference to their work and they felt reinvigorated and motivated by it. Patients and their parents told us the new environment was welcoming and comfortable.
- The CYP service at Newham University Hospital frequently cared for patients with mental health support needs, including some vulnerable and at-risk young people in crisis. The service worked in partnership with the local NHS mental health and community trust to develop a training package called ‘We Can talk’ to equip clinicians with the skills to support patients in mental health crisis when they are receiving urgent medical treatment. Young people with mental health conditions, charity organisations and mental health professionals were involved in developing the training. The trust had developed a training toolkit for hospital staff which was the only programme of its kind in the NHS.
- Trauma teams at The Royal London Hospital were widely recognised for the work and research that they carried out and the innovative approach to developing treatment. Recent developments had seen the introduction of London’s first specialist burns service attached to a major trauma centre, staffed by an expert small team of plastic surgery and burns consultants and a specialist nurse, and the launch of a successful Robotic surgery programme.
- The Grahame Hayton unit at The Royal London Hospital had launched a monthly clinic to support survivors of childhood abuse as a result of a research project which demonstrated that survivors of abuse preferred to access support from a hospital site. The unit had trained staff in interviewing survivors of abuse. Survivors could access counselling support at the clinic.
- There was outstanding practice in multidisciplinary team working throughout the children’s hospital. There was a collaborative approach between clinical specialties, departments, allied health professionals, play team and the hospital school with inclusive discussions which considered the holistic needs of the child. Staff also demonstrated good multidisciplinary partnership working with external agencies and primary care providers.
- The Dental Hospital was performing above average in certain areas for patient outcomes such as Behcet’s disease and haematology, and was providing innovative services and treatments, as well as leading many research projects looking at oral involvement of Behcet’s disease.
- The Dental Hospital exemplified excellent multidisciplinary working at all levels, within the service, the wider trust and external organisations. They had developed innovative and efficient ways to deliver joined up care.
- The Dental Hospital had an international reputation in both research and training. The hospital had a National profile for the work they conduct with Behcet’s disease and Sleep Apnoea.

# Summary of findings

## Areas for improvement

Action the trust **MUST** take is necessary to comply with its legal obligations. Action a trust **SHOULD** take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services. These are outlined in detail in the core service summaries. Action the trust **MUST** take is listed below.

### Action the trust **MUST** take to improve

#### Trustwide

- The trust must improve its response to timely investigation of serious incidents and ensure outcomes of investigations are effectively shared to promote learning, ensuring that enough staff are appropriately trained to support this process. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17)
- The trust must improve its response to assessing and investigating complaints, ensuring that enough staff are appropriately trained to support this process. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 16)

#### Whipps Cross University Hospital

- The trust must ensure governance systems around risk management in outpatients are coherent, fit for purpose and based on contemporaneously documented evidence. This must include effective use of risk registers (or equivalent) and processes to demonstrate how risk is minimised and safety improved. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17)
- The trust must ensure premises in outpatients are fit for purpose and safe with hazards mitigated appropriately. This includes risks presented by damaged or defective premises fixtures and equipment and risks presented by failed or defective fire and emergency safety systems. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 15)
- The trust must ensure senior outpatient departmental staff (such as the nurse in charge or service manager) have the resources, capacity and ability to address failures in premises and equipment to reduce the impact on patients and staff. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 15)
- The trust must ensure the premises in outpatients are secure from unauthorised access, including unauthorised smoking. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 15)
- The trust must ensure quality assurance of equipment is routinely completed including mobiles so that patients are safe from risk. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12)
- The trust must monitor the quality assurance checks and address the medical physics expert's advice for equipment to mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17)

#### Newham University Hospital

- The trust must ensure that Mental Capacity Act (MCA) assessments and Deprivation of Liberty Safeguards (DoLS) applications are adequately completed and correctly recorded. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12)
- The trust must ensure that clinical risks assessments, including National Early Warning Scores (NEWS), are adequately completed and correctly recorded in patient records. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12)

# Summary of findings

- The trust must ensure that electronic and paper records are stored securely, in line with legislation relating to data protection and patient confidentiality. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17)
- The trust must improve hand hygiene standards and clinical cleaning protocols to prevent the risk of infection in maternity services. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12)
- The trust must improve the segregation of waste and ensure safe practice in the use of freestanding sharps containers when not in use. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12)
- The trust must improve the accuracy of emergency equipment checks. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12)
- The trust must improve the standard of midwives' record keeping to ensure records meet accepted professional standards in being consistently complete and contemporaneous. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17)
- The trust must follow due process when introducing new documentation with piloting and audit. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17)
- The trust must ensure Modified Early Obstetric Warning System (MEOWS) charts are being completed accurately and at the required frequency by trained staff and that escalation is occurring as required. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12)
- The trust must ensure there are effective systems and processes to ensure continual evaluation and improvement of the maternity service. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17)
- The trust must ensure there are effective and sustainable systems and processes for the timely investigation of serious incidents and learning from these. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17)
- The trust must take a systematic approach to performance management and appraisal of midwives as a contribution to raising standards. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 18)
- The trust must improve compliance with hand hygiene on the critical care unit. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12)
- The trust must ensure that cleaning records are kept to show cleaning of the critical care unit. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 15)
- The trust must ensure that the critical care facilities comply with national guidelines (Health Building Notes: HBN 04-02 Critical Care Units: Planning and Design). (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 15)
- The trust must ensure that transfer out equipment used on the critical care unit is checked regularly. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 15)
- The trust must ensure that safety notices are in place where oxygen is stored. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 15)
- The trust must ensure that records for the maintenance of equipment, including service and portable appliance testing (PAT) are kept up-to-date. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17)
- The trust must ensure that policies and procedures available to staff are up-to-date. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12)

# Summary of findings

- The trust must improve out of hours discharge rates for critical care patients. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12)
- The trust must improve delayed discharge rates for critical care patients. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12)
- The trust must ensure staff receive formal training in syringe drivers as detailed in the policy for the use of syringe drivers. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12)
- The trust must ensure effective systems and processes are in place to determine the quality and safety of end of life care provided at ward level and by the specialist palliative care team. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17)
- The trust must ensure that Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms are completed consistently and correctly. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17)
- The trust must ensure there are quality assurance checks of equipment used by radiologists in their own homes. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17 & 15)

## The Royal London Hospital

- The trust must improve clinical oversight of the paediatric waiting room and ensure checks are completed and documented consistently. Children could deteriorate in the waiting room which posed a significant risk. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12)
- The trust must ensure staff on all medical wards are consistent in their recording of national early warning score (NEWS) scores. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12)
- The trust must ensure staff on all medical wards are consistent in their recording of patient information and that records audits are robust and address shortfalls in record keeping. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17)
- The trust must ensure that wards and departments are assessed for ligature risks. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17)

Actions the trust SHOULD take to comply with a minor breach that did not justify regulatory action are recorded in detail in the core service reports.

## Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

- The trust had developed and progressed an organisational model that had significantly improved leadership and governance across the hospital sites. This had led to improved quality in care and better engagement with staff.
- The trust board evidenced strong collaborative relationships and were committed to ensuring sustained quality improvement across the organisation.

# Summary of findings

- Effective clinical boards had been established to address variation across the trust. These were at different stages of maturity; however, they were having a positive impact on the quality of services.
- The trust had a clear vision and set of values that prioritised the delivery of safe and effective patient care that had been extensively promoted across the organisation.
- The trust had progressed a realistic strategy for achieving the priorities and developing good quality, sustainable care. Clinical strategy was being led by a motivated and engaged group of clinicians.
- The trust had worked hard to address cultural concerns raised at previous inspections. There was evidence that the organisational culture had continued to improve. Although, we found examples highlighting that the experience of bullying, harassment or abuse from colleagues in some areas still needed to be addressed.
- The trust had taken steps to improve the Board Assurance Framework (BAF) and had also begun to introduce a site based assurance framework that gave stronger oversight of strategic risks at each hospital.
- The trust had responded proactively to the cyberattack they sustained in 2017 and had both developed a comprehensive informatics strategy and had begun to invest purposefully in the information and communications technology (ICT) infrastructure.
- The trust had a positive relationship with other stakeholders who were part of the north-east London sustainability and transformation partnership, and was working collaboratively to develop strategic direction.
- The trust had in place structured processes to communicate with staff and engage with people who use services and their representatives. The trust recognised that partnership working was essential in driving the strategic direction towards improving patient care and the delivery of its services. Although, we found examples where opportunities for feedback were limited in some areas and patient engagement was low.
- The trust had strong collaborative relationships with education institutions that provided training for nurses, doctors and allied health professionals, working with them to shape and develop training programmes.
- The trust actively sought to participate in national quality improvement and innovation projects. Each of its four acute sites were involved in implementing a variety of ventures aligned to the services they provided that included active participation in clinical research studies. Although, some sites were far more engaged with this process than others.

However, we also found:

- While, the trust had in place governance processes to support the delivery of its strategy and ensure quality and performance information was reviewed and escalated appropriately, areas for improvement had been identified and the trust had worked with an external consultant to devise an action plan to address this.
- The hospital management boards were at different levels of maturity. This had allowed for variations in quality of services between hospital sites and concern that there remained insufficient oversight, as exemplified by the concerns we found in maternity and diagnostic services at Newham University Hospital. However, the trust had taken steps to address this before our inspection by appointing a new executive managing director for the hospital, and also took further immediate steps post inspection after we raised significant concerns regarding maternity services.
- Serious incident investigations were not being completed within agreed timeframes. The trust recognised that further steps were needed to improve the review and learning process. Insufficient numbers of suitably trained staff was considered a factor in this.
- The trust was not addressing all complaints within agreed timescales and there was considerable variation across sites.



# Summary of findings

- A strategy had been developed to address the complex estates issues of the trust; however, there was room for further development and alignment to the wider clinical strategy.
- The trust was committed to addressing concerns raised by the Workforce Race Equality Standards (WRES) and had initiated several actions. However, WRES metrics and our conversations with staff highlighted that these needed further time to embed.
- Further improvements were needed as to how risks were reported and presented at committee to ensure that emerging operational and quality risks were not overlooked. For example, the Quality Assurance Committee (QAC) did not refer to a risk register to ensure that trust wide risks affecting quality of care were appropriately mitigated.
- The trust had improved its financial position despite an ongoing deficit and was positively moving towards a model that gave greater control to each hospital location. However, concerns remained as to the sustainability of the trusts financial position.
- The trust had in place systems to monitor quality and performance data that was collated in to a comprehensive integrated performance report that informed the board. However, we found in some instances discrepancy in the accuracy of data collated at core service level and subsequently presented to board.
- The trust had a programme of internal and national audits; however, the trust recognised that the internal audit process could be more strategic in its approach to improving services.
- The trust had considered the efficacy of Clinical Support Services directorate and had considered how best services within the directorates remit would integrate and operate with clinical services at each hospital. However, we found that there remained scope for further improvement to address governance, quality and cultural concerns.

## Use of resources

The aim of Use of Resources assessments is to understand how effectively providers are using their resources to provide high quality, efficient and sustainable care for patients. The assessment team, according to the published framework, examined the trust's performance against a set of initial metrics alongside local intelligence from NHS Improvement's day-to-day interactions with the trust, and the trust's own commentary of its performance. The team conducted a dedicated site visit to engage with key staff using agreed key lines of enquiry (KLOEs) and prompts in the areas of clinical services; people; clinical support services; corporate services, procurement, estates and facilities; and finance.

NHS Improvement visited the trust on 6 September 2018 and met the trust's leadership team including the chief executive and the chair, as well as relevant senior management responsible for the areas under this assessment's KLOEs.

We rated the trusts' use of resources as requires improvement.

The final Use of Resources report has been published alongside this CQC quality report.



## Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

\* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

### Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement →← Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019	Requires improvement →← Feb 2019	Good ↑ Feb 2019	Requires improvement →← Feb 2019

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

## Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
The Royal London Hospital	Requires improvement ↔ Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019	Requires improvement ↔ Feb 2019	Good ↑ Feb 2019	Requires improvement ↔ Feb 2019
Whipps Cross University Hospital	Requires improvement ↔ Feb 2019	Good ↑ Feb 2019	Good ↔ Feb 2019	Requires improvement ↔ Feb 2019	Requires improvement ↔ Feb 2019	Requires improvement ↔ Feb 2019
Newham University Hospital	Requires improvement ↔ Feb 2019	Requires improvement ↔ Feb 2019	Good ↑ Feb 2019	Requires improvement ↔ Feb 2019	Requires improvement ↔ Feb 2019	Requires improvement ↔ Feb 2019
St Bartholomew's Hospital	Good Sept 2017	Good Sept 2017	Good Sept 2017	Good Sept 2017	Outstanding Sept 2017	Good Sept 2017
<b>Overall trust</b>	Requires improvement ↔ Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019	Requires improvement ↔ Feb 2019	Good ↑ Feb 2019	Requires improvement ↔ Feb 2019

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

## Ratings for The Royal London Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good ↑ Feb 2019	Good →↔ Feb 2019	Good →↔ Feb 2019	Requires improvement →↔ Feb 2019	Good →↔ Feb 2019	Good ↑ Feb 2019
Medical care (including older people's care)	Requires improvement →↔ Feb 2019	Good →↔ Feb 2019	Good ↑ Feb 2019	Requires improvement ↓ Feb 2019	Good ↑ Feb 2019	Requires improvement →↔ Feb 2019
Surgery	Good ↑ Feb 2019	Good →↔ Feb 2019	Good ↑ Feb 2019	Requires improvement ↑ Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019
Critical care	Good Dec 2016	Good Dec 2016	Outstanding Dec 2016	Requires improvement Dec 2016	Good Dec 2016	Good Dec 2016
Maternity	Requires improvement Oct 2017	Good Oct 2017	Requires improvement Oct 2017	Requires improvement Oct 2017	Requires improvement Oct 2017	Requires improvement Oct 2017
Services for children and young people	Requires improvement →↔ Feb 2019	Good ↑ Feb 2019	Good →↔ Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019
End of life care	Requires improvement Dec 2016	Requires improvement Dec 2016	Good Dec 2016	Requires improvement Dec 2016	Good Dec 2016	Requires improvement Dec 2016
Outpatients	Good →↔ Feb 2019	Not rated	Good →↔ Feb 2019	Requires improvement →↔ Feb 2019	Requires improvement →↔ Feb 2019	Requires improvement →↔ Feb 2019
Dental Hospital	Good Feb 2019	Outstanding Feb 2019	Outstanding Feb 2019	Requires improvement Feb 2019	Outstanding Feb 2019	Good Feb 2019
<b>Overall*</b>	Requires improvement →↔ Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019	Requires improvement →↔ Feb 2019	Good ↑ Feb 2019	Requires improvement →↔ Feb 2019

\*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

## Ratings for Whipps Cross University Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement ↔ Feb 2019	Good ↗ Feb 2019	Good ↗ Feb 2019	Requires improvement ↔ Feb 2019	Good ↗ Feb 2019	Requires improvement ↔ Feb 2019
Medical care (including older people's care)	Good ↗ Feb 2019	Good ↗ Feb 2019	Good ↗ Feb 2019	Good ↗ Feb 2019	Good ↗ Feb 2019	Good ↗ Feb 2019
Surgery	Requires improvement ↗ Feb 2019	Good ↗ Feb 2019	Good ↗ Feb 2019	Requires improvement ↔ Feb 2019	Requires improvement ↔ Feb 2019	Requires improvement ↔ Feb 2019
Critical care	Good ↗ Feb 2019	Good ↗ Feb 2019	Good ↗ Feb 2019	Requires improvement ↔ Feb 2019	Good ↗ Feb 2019	Good ↗ Feb 2019
Maternity	Requires improvement Dec 2016	Good Dec 2016	Good Dec 2016	Good Dec 2016	Good Dec 2016	Good Dec 2016
Services for children and young people	Requires improvement ↔ Dec 2016	Good ↗ Dec 2016	Good ↗ Dec 2016	Good ↗ Dec 2016	Good ↗ Dec 2016	Good ↗ Dec 2016
End of life care	Requires improvement Sept 2017	Requires improvement Sept 2017	Good Sept 2017	Requires improvement Sept 2017	Requires improvement Sept 2017	Requires improvement Sept 2017
Outpatients	Requires improvement ↔ Feb 2019	Not rated	Good ↗ Feb 2019	Requires improvement ↔ Feb 2019	Requires improvement ↔ Feb 2019	Requires improvement ↔ Feb 2019
Diagnostic imaging	Requires improvement Feb 2019	Not rated	Good Feb 2019	Good Feb 2019	Requires improvement Feb 2019	Requires improvement Feb 2019
<b>Overall*</b>	Requires improvement ↔ Feb 2019	Good ↗ Feb 2019	Good ↗ Feb 2019	Requires improvement ↔ Feb 2019	Requires improvement ↔ Feb 2019	Requires improvement ↔ Feb 2019

\*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

## Ratings for Newham University Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement ↔ Feb 2019	Good ↔ Feb 2019	Good ↔ Feb 2019	Good ↔ Feb 2019	Good ↔ Feb 2019	Good ↔ Feb 2019
Medical care (including older people's care)	Requires improvement ↔ Feb 2019	Requires improvement ↓ Feb 2019	Good ↔ Feb 2019	Requires improvement ↓ Feb 2019	Requires improvement ↓ Feb 2019	Requires improvement ↓ Feb 2019
Surgery	Requires improvement ↑ Apr 2017	Good ↑ Apr 2017	Good ↔ Apr 2017	Good ↔ Apr 2017	Good ↔ Apr 2017	Good ↔ Apr 2017
Critical care	Requires improvement ↔ Feb 2019	Good ↑ Feb 2019	Good ↔ Feb 2019	Requires improvement ↔ Feb 2019	Requires improvement ↔ Feb 2019	Requires improvement ↔ Feb 2019
Maternity	Inadequate ↓ Feb 2019	Requires improvement ↓ Feb 2019	Requires improvement ↔ Feb 2019	Requires improvement ↔ Feb 2019	Inadequate ↓ Feb 2019	Inadequate ↓ Feb 2019
Services for children and young people	Good ↑ Feb 2019	Good ↑ Feb 2019	Good ↔ Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019
End of life care	Requires improvement ↔ Feb 2019	Requires improvement ↔ Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019	Requires improvement ↔ Feb 2019	Requires improvement ↔ Feb 2019
Outpatients	Good ↔ Feb 2019	Not rated	Good ↔ Feb 2019	Requires improvement ↔ Feb 2019	Requires improvement ↔ Feb 2019	Requires improvement ↔ Feb 2019
Diagnostic imaging	Requires improvement Feb 2019	Not rated	Good Feb 2019	Requires improvement Feb 2019	Inadequate Feb 2019	Requires improvement Feb 2019
<b>Overall*</b>	Requires improvement ↔ Feb 2019	Requires improvement ↔ Feb 2019	Good ↑ Feb 2019	Requires improvement ↔ Feb 2019	Requires improvement ↔ Feb 2019	Requires improvement ↔ Feb 2019

\*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

## Ratings for St Bartholomew's Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good →← Sept 2017	Good ↓ Sept 2017	Good →← Sept 2017	Good ↓ Sept 2017	Good ↓ Sept 2017	Good ↓ Sept 2017
Surgery	Good ↑ Sept 2017	Good ↑ Sept 2017	Good →← Sept 2017	Good →← Sept 2017	Outstanding →← Sept 2017	Good →← Sept 2017
Critical care	Good →← Sept 2017	Good ↑ Sept 2017	Good →← Sept 2017	Good →← Sept 2017	Outstanding →← Sept 2017	Good →← Sept 2017
Outpatients and diagnostic imaging	Good Sept 2017	Good Sept 2017	Good Sept 2017	Good Sept 2017	Good Sept 2017	Good Sept 2017
<b>Overall*</b>	Good →← Sept 2017	Good →← Sept 2017	Good ↑ Sept 2017	Good →← Sept 2017	Outstanding →← Sept 2017	Good →← Sept 2017

\*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

# Newham University Hospital

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Plaistow  
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E13 8SL  
Tel: 02074764000  
[www.bartsandthelondion.nhs.uk/newham](http://www.bartsandthelondion.nhs.uk/newham)

## Key facts and figures

Barts Health is the largest NHS trust in the country, having been formed by the merger of Barts and the London NHS trust, Newham University Hospital NHS Trust and Whipps Cross University Hospital NHS Trust on 1 April 2012. The trust has three acute hospitals: The Royal London Hospital, Whipps Cross University Hospital and Newham University Hospital.

Newham University Hospital, in Plaistow, East London offers a range of acute services to a population of approximately 340,000 people living in the London Borough of Newham, with the second fastest growing population in London.

Newham is deprived, coming third out of 326 of local authorities, with 80% of the local population having a minority ethnic background and over 110 languages spoken. The population is predominantly young, with the majority of residents aged between 20 and 39.

Newham University hospital offers a full range of local service. The hospital has approximately 340 inpatient beds, with over 1700 staff working there. The emergency department received on average 460 attendances per day. The services provided include The Gateway Surgical Centre that offers elective surgery and diagnostic procedures in many different specialties, as well as housing the Trust's sports injuries clinic and fracture clinic. The hospital provides maternity services to women in the London Borough of Newham and the Barking ward of the London Borough of Barking and Dagenham. The unit delivers around 6,500 babies every year, and numbers are increasing.

Newham University Hospital provides the following services:

- Urgent and emergency care
- Medical care (including older people's care)
- Critical care
- Surgery
- Maternity
- Gynaecology
- Outpatients
- Diagnostic Imaging
- End of Life Care



# Summary of findings

## Summary of services at Newham University Hospital

**Requires improvement** ● → ←

Our rating of services stayed the same. We rated it them as requires improvement because:

- At our previous inspection we found concerns about safety and governance within the maternity service. At this inspection we found these concerns persisted and were not being addressed in a robust and timely manner. We issued a Section 29a Warning Notice (Health and Social Care Act 2008) and told the trust to take immediate steps to address the concerns.
- Risk assessments were not carried out reliably across services. National Early Warning Scores (NEWS) were not consistently recorded, and where Modified Obstetric Early Warning Scores (MEOWS) were undertaken, observations were not carried out on a schedule determined by the woman's condition.
- Emergency equipment did not always undergo appropriate checks. In maternity, emergency equipment was not always checked in line with policy, and equipment used to transfer patients to the critical care unit did not undergo regular checks.
- There were instances where patients' personal information could potentially be viewed or removed by unauthorised people. We found patient records trolleys unsecured and patient record booklets unattended in corridors, as well as computer terminals unlocked.
- We had concerns about infection control in some services. We observed poor hand hygiene by nursing and medical staff. Equipment was not always clean and ready to use.
- Midwives within the maternity service regularly worked through breaks and beyond the end of their shift.
- On the medical wards, we found that recording of capacity assessments and decisions on deprivation of liberty safeguards (DoLS) were not consistently documented appropriately in patient records. Some staff were not able to demonstrate awareness of when MCA and DoLS assessments would be necessary.
- Pain management for some patients was not always effective. In medical and end of life care services pain assessments and pain scores were not completed consistently. In maternity, we found, as we did at the previous inspection, that women did not have timely access to epidurals.
- Not all policies and procedures seen on inspection were up-to-date.
- Out of hours discharge rates in critical care remained high. Between January to September 2018, 43% of all discharges from the critical care unit took place between 10:00pm and 6:59am. Delayed discharge rates for patients ready to step down from the critical care unit also remained high. Data from January to September 2018 showed that there had been 78 delayed discharge incidents of more than eight hours, with 21 of these exceeding 72 hours. We raised the same concerns at our last inspection in 2015.
- Some non-English speaking women had maternity appointments without an independent interpreter, and friends and family were used to translate. The use of language line or advocates was not always recorded in patient notes.
- In some services there was a lack of information available in alternative languages other than English.
- The diagnostic imaging service had no schedule in place for quality assurance testing of the home computers. There was no assurance of Digital Imaging and Communications (DICOM) grey scale display function compliance.
- We found concerns that had been high on the risk register at previous inspections, had not been fully addressed in some services. For example, progress in the securing of funding for a second obstetric theatre had been extremely

# Summary of findings

slow. Just prior to the inspection, a temporary funding arrangement had enabled partial staffing of a second theatre, although the arrangement was not well understood by staff. The critical care service did not comply with building guidelines due to a lack of bed and storage space and insufficient hand-wash basins. We raised this as a concern in 2015, and at this inspection in 2018 found no action had been taken.

- Governance processes within the maternity service did not provide sufficient assurance that senior staff had a sustainable plan for improving key performance issues. The audit programme was not related to risk and did not ensure that cyclical improvement was established.
- Whilst staff mainly spoke of good working relationships with colleagues, we found that cultural concerns persisted in some areas. For example, staff working within the diagnostic service described a common theme of mistrust within staff to make an official complaint for fear of harassment.
- Despite arrangements being in place to identify risk within critical care and seeing evidence that action was being taken to mitigate risk, we found there was a lack of formalised action plans to support this. Where action was being taken to mitigate risk, it was not recorded so we were not assured that all steps were being taken, by whom and in what time frame.
- Although we found that services across the hospital were investigating incidents and sharing learning, with a reduced backlog of serious incident investigations at the time of inspection, records showed uneven performance over the year on managing incidents and some investigations were still taking too long to complete.

However, we also found:

- Despite the concerns raised during the inspection, it was notable that there had been improvements made across some services since our last inspection, particularly in relation to children and young people services.
- Throughout services we found that staff treated patients with kindness and compassion, dignity and respect. Patients felt involved with decisions made about their care and treatment.
- Staff provided emotional support where required, and signposted patients to additional support services as needed.
- The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred, or discharged within four hours of arrival in the emergency department. The department performed better than the England average and other emergency departments managed by the trust.
- Services sought to deliver care according to best available evidence, such as national guidelines.
- The hospital had established a local multidisciplinary sepsis team, which included a consultant, intensive care outreach nurse specialist, and an anti-microbial/sepsis pharmacist. The sepsis team were responsible for coordinating sepsis promotion and education at the hospital, monitoring sepsis outcomes, and delivering sepsis specific improvement projects.
- There was an effective multidisciplinary team working environment across wards and departments which supported patients' health and wellbeing.
- Teams were well motivated and focused on delivering quality care. Morale amongst staff we spoke to was generally positive.
- Across many services, staff told us that senior leaders of the service were visible, approachable and supportive.

# Urgent and emergency services

Good   

## Key facts and figures

The emergency and urgent care department (ED) at Newham University Hospital sees 155,000 patients per year. Initial assessment and streaming is delivered by an integrated team of GPs, emergency nurse practitioners (ENP), advanced nurse practitioners (ANP), emergency doctors and nurses, and emergency department assistants (EDA).

The urgent treatment centre (UTC) is overseen by the clinical director for urgent and emergency care, and staffed by ENP and GPs, plus cross cover from the emergency department medical staff. Case mix for UTC includes minor injuries, minor illness, gynaecology, paediatrics, and mental health. It is open 8am to 11pm. After closing, patients are managed by either the emergency department or the on-site out of hours GP service.

The emergency department consists of a separate paediatric area with six cubicles and one HDU (high dependency unit), an adult's area 17 cubicles including a mental health secure cubicle, and a seven-bedded resuscitation room with a dedicated paediatric bay. The site has a trauma unit, and sees the full range of adult and paediatric emergencies.

Next to the emergency department is a paediatric clinical decision unit (PCDU), adult CDU, ambulatory CDU (run by the emergency department) and the medical assessment unit (MAU). The PCDU is in the paediatric area; the adult CDU and MAU are found on the observation ward

Medical staffing consists of 10 whole time equivalent (WTE) consultants who are on-site from 8am to 10pm seven days a week. The junior doctor / advanced nurse practitioner staffing is a total of 42 WTE, comprising of junior and senior trainee doctors, clinical fellows and ANP. There is a senior trainee doctor (ST4 or equivalent) on-site at all times. The psychiatric liaison service (RAID) is found within ED 24 hours, seven days a week, staffed by psychiatry liaison nurses and psychiatry consultants. The psychiatry doctor on-call is based at the nearby mental health unit and attends to review patients in need of admission.

The total nursing establishment is 82.69 WTE (46.66) WTE in the emergency department and 30.64 (26.41) WTE in observation unit.

The service was previously inspected in January 2015 when it was rated as 'good' overall. At the time safe domain was rated as 'requires improvement' and caring, effective, responsive, and well-led domains were rated good.

Our inspection was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available and took place between 11 and 13 September 2018. We looked at 14 sets of adult patient records and 12 sets of paediatric patient records. We spoke with 42 members of staff including doctors, nurses, managers, support staff, administrative staff and ambulance crews. We also spoke with 12 patients and five relatives who were in the department at the time of the inspection. We reviewed and used information provided by the trust in making our decisions about the service.

## Summary of this service

During our previous inspection of the urgent and emergency care service, which took place in January 2015, we asked the trust to improve processes/referrals for safeguarding children in the emergency department; improve multidisciplinary working in the emergency department; and provide suitable consultant cover in the emergency department, in line with the College of Emergency Medicine recommendation.

# Urgent and emergency services

During this inspection we found that the trust took appropriate actions to address those three requirements and they improved in all three areas.

Our rating of this service stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness. Feedback from patients and relatives was generally very good and they felt they were treated with courtesy, respect, and compassion by staff. Patients felt able to speak about their worries and said staff at the hospital were compassionate.
- Staff ensured patients' privacy and dignity was respected when providing care by closing the door to side rooms and drawing curtains in bays. Doctors and nurses introduced themselves to patients and carers and explained what their role was.
- Staff involved patients and relatives in care planning and decision-making process. It was demonstrated by staff in all specialties and roles. Patients and relatives were given opportunities to ask questions and staff gave them time to do this. They were told when they needed to seek further help and what to do should their condition deteriorate after discharge from the department.
- The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred, or discharged within four hours of arrival in the emergency department. The department performed better than the England average and other emergency departments managed by the trust.
- Nurses and doctors, we spoke with had a good knowledge of safeguarding protocols and awareness of issues they should be concerned about when treating adults, children, and young adults. They spoke of appropriate examples where safeguarding protocols were initiated by members of staff. There were appropriate arrangements to ensure children and young people who harm themselves were seen and assessed by suitable mental health professionals.
- Areas we visited were tidy, clean, and uncluttered. Staff adhered to principles of infection control and prevention.
- There was sufficient consultant cover provided to meet the needs of the department.
- Junior and trainee nurses worked adequately supervised and any new staff worked supernumerary shifts. They were provided with good development opportunities and felt competent to perform tasks needed to provide effective care and treatment.
- There was a good culture of teaching and learning in the department. Doctors training was consultant led, pre-planned and tailored to the needs of the emergency department.
- Multidisciplinary team working within the department was well embedded part of the department's work. Nurses, healthcare assistants and doctors spoke of teamwork and joint working and the way in which it enhanced good working relations as well as improved patient safety.
- The ED staff understood their responsibilities in relation to patients who lacked the mental capacity to make decisions about their care and treatment and the key principles of the Mental Capacity Act 2005 (MCA). They understood their duty to act in the patient's best interests.
- People's physical, mental health and social needs were holistically assessed, and their care, treatment and support was delivered in line with legislation, standards, and evidence-based guidance, including NICE and other expert professional bodies, to achieve effective outcomes.
- Access to a psychiatric liaison team was available for patients within the hospital at all times. Mental health liaison team responded to referrals very promptly. The care records we looked at confirmed that patients had been seen within the one-hour target time.
- Staff used appropriate discharge arrangements for people with complex health and social care needs.

# Urgent and emergency services

- Staff we approached spoke positively about members of the senior management team who were visible, approachable, and aware of problems faced by the front-line staff. Divisional and local leaders were clear about their roles and knew which areas they were accountable for and to whom. They had suitable systems to allow them to effectively perform their tasks and support delivery of the service. The department used information available through performance reports and local audits to inform and improve service planning.
- Information about the outcomes of people's care and treatment routinely collected and monitored. The trust took part in external audits and benchmarked patients' outcomes against trust's emergency departments as well as nationally.
- The department had a long-term strategy that focused on providing core emergency service, focussing on the needs of emergency patients, and targeting the delivery of high quality emergency care.
- Teams were well motivated and focused on delivering quality care. Staff were positive and optimistic about the future of the trust.
- The trust engaged patients and staff. They monitored patients feedback and summarised themes to support improvement within the department.

However, we also found:

- Quality of individual patient's records was variable. Some areas were not consistently captured in paediatrics department; for example, there was no safeguarding information recorded on two records. We also noted missing information related to sepsis screening, pain scores, or early warning scores.
- Medical staff met the 85% completion target for only three out of 24 mandatory training modules.
- In the paediatric emergency department, staff used a side room to nurse children and adolescents who needed support for their mental health conditions. This room and its en-suite shower room was not risk assessed for ligature risks and had many ligature points including handles, door closures and taps.
- From May 2017 to April 2018, Newham Hospital reported a vacancy rate of 21.4% for nursing staff in urgent and emergency care services, this was higher than the trust target of 6.3%. The hospital reported a turnover rate of 16.6% for nursing staff in urgent and emergency care services, this was higher than the trust's target of 13%. Newham Hospital reported a vacancy rate of 19.2% for medical staff in urgent and emergency care services, this was higher than the trust target of 6.3%.
- Hand hygiene audits were not always undertaken.
- NEWS audits provided by the trust showed that audits within the ED were not taken regularly.
- We observed that patients did not always receive pain controlling medication promptly. Staff did not always use the pain scoring tool accurately.
- In the 2016/17 Severe sepsis and septic shock audit, Newham Hospital emergency department did not meet any of the national standards.
- From July 2017 to June 2018, the trust's unplanned re-attendance rate to A&E within seven days was worse than the national standard of 5% and worse than the England average.
- The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust did not meet the standard for five months over the 12-month period from July 2017 to June 2018.
- From August 2017 to July 2018, the trust's monthly median total time in A&E for all patients was higher than the England average.

# Urgent and emergency services

- The department's risk register was not updated with many risks placed on the risk assessment more than 2 years old. Out of 17 entries one was entered in 2013, two in 2014, and three in 2015.
- Investigators that analysed incidents root causes and contributory factors did not refer to incident specific shared learning routes. They made generic statement such as "national reporting and learning service [system] will be used for promotion of wider learning". It was not recorded if patient or their relatives had an opportunity to contribute to terms of reference or engage in the investigation process.

## Is the service safe?

**Requires improvement** ● ➡ ➡

Our rating of safe stayed the same. We rated it as requires improvement because:

- Quality of individual patient's records was variable. For example, in one case the plan for a patient referred to mental health liaison team, who was intoxicated, was not recorded. Some areas were not consistently captured in paediatrics department; for example, there was no safeguarding information recorded on two records. We also noted missing information related to sepsis screening, pain scores, or early warning scores.
- Medical staff met the 85% completion target for only three out of 24 mandatory training modules. We also noted nursing and midwifery staff exceeded the 85% completion target for 22 out of 27 mandatory training modules.
- In the paediatric emergency department, staff used a side room to nurse children and adolescents who needed support for their mental health conditions. This room and its en-suite shower room was not risk assessed for ligature risks and had many ligature points including handles, door closures and taps.
- There was no information easily available, such as large screen in the majors' area, to all ED staff that would show if ambulance was on its way or if there were someone waiting for the handover. There was also no real-time information to show how the department performed in relation to any potential delays in handover times or time taken to assess patients within the department.
- From May 2017 to April 2018, Newham Hospital reported a vacancy rate of 21.4% for nursing staff in urgent and emergency care services, this was higher than the trust target of 6.3%. The hospital reported a turnover rate of 16.6% for nursing staff in urgent and emergency care services, this was higher than the trust's target of 13%. Newham Hospital reported a vacancy rate of 19.2% for medical staff in urgent and emergency care services, this was higher than the trust target of 6.3%. The department reviewed staffing establishment in August 2018 and increased number of posts to ensure patients' needs were met.
- Hand hygiene audits were not always undertaken. It was not clear what action if any had been taken to improve the compliance and frequency of the audit.
- The department did not use a standardised system for placing hand sanitising gel dispenser near entrance to allow staff and visitors to sanitise their hands as soon as they arrived at the department or clinical area
- The nursing station in children's emergency department was located on the back of the corridor which meant staff did not have direct oversight of the waiting area. Instead nurses were provided with a camera system and a 12-inch screen, mounted under the ceiling opposite their station, which displayed small image from four cameras installed in the department.
- We saw some office equipment where labels showed the electrical safety test was overdue since June 2018 and in two cases since 2016.

However, we also found:



# Urgent and emergency services

- Paediatric nurses and doctors we spoke to had a good knowledge of safeguarding protocols and awareness of issues they should be concerned about when treating children and young adults. They spoke of appropriate examples where safeguarding protocols were initiated by members of staff. Safeguarding cases reviewed evidenced staff taking suitable actions in response to safeguarding. Nursing and midwifery staff and medical staff exceeded the 85% completion target for three out of five safeguarding training modules.
- Areas we visited were tidy, clean, and uncluttered. Disposable curtains hung around examination beds were clean and included a replacement date. The plaster room was visibly clean and fit for purpose.
- There was sufficient consultant cover provided to meet the needs of the department and varied patients' attendance levels.
- ED staff promptly arranged psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide.
- The hospital reported a turnover rate of 0% for medical staff in urgent and emergency care services, this was lower than the trust's target of 13%. Staff we spoke with told us they felt there were enough nursing and medical staff on duty to meet needs of the patients, with vacant shifts covered by temporary staff.
- Patient's risk was assessed using nationally validated tools this included assessment of sepsis, falls, or risk of developing pressure ulcers. Staff escalated appropriately to prevent patient's health deterioration.

## Is the service effective?

Good   

Our rating of effective stayed the same. We rated it as good because:

- Junior and trainee nurses worked adequately supervised and any new staff worked supernumerary shifts. Nurses we spoke to felt they were provided with good development opportunities and felt competent to perform tasks needed to provide effective care and treatment. We noted doctors and nurses had adequate training to cover the scope of their work,
- Doctors told us there was a good culture of teaching and learning in the department. Training was consultant led, pre-planned and tailored to the needs of the emergency department. All we spoke with saw it as a priority and trainee doctors said they received support to attend training sessions.
- Doctors and nurses told us that multidisciplinary team (MDT) working within the department was well embedded part of their work. Nurses, healthcare assistants and doctors spoke of teamwork and joint working and the way in which it enhanced good working relations as well as improved patient safety.
- There were appropriate arrangements to ensure children and young people who harm themselves were seen and assessed by suitable mental health professionals.
- The ED staff we spoke with understood their responsibilities in relation to patients who lacked the mental capacity to make decisions about their care and treatment and the key principles of the Mental Capacity Act 2005 (MCA). They understood their duty to act in the patient's best interests.
- People's physical, mental health and social needs were holistically assessed, and their care, treatment and support was delivered in line with legislation, standards, and evidence-based guidance, including NICE and other expert professional bodies, to achieve effective outcomes.



# Urgent and emergency services

- Patients were told when they needed to seek further help and what to do should their condition deteriorate after discharge from the department.
- Information about the outcomes of people's care and treatment routinely collected and monitored. The trust took part in external audits and benchmarked patients' outcomes against trust's emergency departments as well as nationally.

However, we also found:

- NEWS audits provided by the trust showed that audits within the ED were not taken regularly. The department did not take part in NEWS audit in April and May of 2018. In months when they had taken part the compliance with records completion and adherence to guidance was very low. For example, the department achieved only 41% in December 2017 which was the lowest score from 13 clinical areas taking part in this internal hospital audit. There were no action plans to address low compliance and improve frequency of the audit.
- We observed that patients did not always receive pain controlling medication promptly. Staff did not always use pain scoring tool accurately. In one case patient was given a high dose of pain controlling medicine, however, their records showed that they were assessed to not to be in pain.
- From July 2017 to June 2018 the trust's unplanned re-attendance rate to A&E within seven days was worse than the national standard of 5% and worse than the England average. In the latest month June 2018, trust performance was 9.3% compared to an England average of 7.9%.

## Is the service caring?

Good   

Our rating of caring stayed the same. We rated it as good because:

- We observed several interactions between staff and patients and saw staff treated patients with compassion and kindness. Feedback from patients and relatives was generally very good and they felt they were treated with courtesy, respect, and compassion by staff. Patients felt able to speak about their worries and said staff at the hospital were compassionate.
- We observed staff ensuring patients' privacy and dignity was respected when providing care by closing the door to side rooms and drawing curtains in bays. Doctors and nurses introduced themselves to patients and carers and explained what their role was. Patients told us they appreciated this.
- Patients had access to bi-lingual advocacy service located on site during the day. They could also access pastoral, psychological, and spiritual support together with a befriending service.
- We observed staff involving patients and relatives in care planning and decision-making process. It was demonstrated by staff in all specialties and roles. Patients told us that their views were considered by staff and they felt involved in decisions made by clinical teams. Staff made sure patients and relatives understood the assessments being done and the diagnosis and treatment plan. Patients and relatives were given opportunities to ask questions and staff gave them time to do this.

## Is the service responsive?

Good   

# Urgent and emergency services

Our rating of responsive stayed the same. We rated it as good because:

- The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred, or discharged within four hours of arrival in the emergency department. The department performed better than the England average and other emergency departments managed by the trust.
- The mental health liaison team responded to referrals very promptly. The care records we looked at confirmed that patients had been seen within the one-hour target time. The RAID team responded within one hour to at least 87% of referrals for each of the four months from April 2018 to July 2018. This was below the trust's [challenging] target of 95%.
- The department responded to formal complaints appropriately. Quality of responses to complaints made was good and written communication with patients and/or their carers and families was considerate, individualised and information provided in letters was comprehensive.
- ED staff could easily access advice and support in relation to patients with learning disability or autism from specialist staff. The department had good access to support from local child and adolescent mental health service (CAMHS) team.
- Staff used appropriate discharge arrangements for people with complex health and social care needs.
- Patients had access to translation services for patients for whom English was not a first language, which could be provided face-to-face by the advocacy team based at the hospital. The team could translate from many languages including Romanian, Bengali, Hindu, and Chinese.
- Access to a psychiatric liaison team was available for patients within the hospital at all times.

However, we also found:

- The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust did not meet the standard for five months over the 12-month period from July 2017 to June 2018. From July 2017 to June 2018 the trust's performance followed the national trend, although in December 2017 the median time to treatment was 55 minutes compared to the England average of 62 minutes.
- From August 2017 to July 2018, the trust's monthly median total time in A&E for all patients was higher than the England average. In the latest month June 2018, the trust's monthly median total time in A&E for all patients was 187 minutes compared to the England average of 148 minutes.

## Is the service well-led?

Good   

Our rating of well-led stayed the same. We rated it as good because:

- Staff we approached spoke positively about members of the senior management team who were visible, approachable, and aware of problems faced by the front-line staff.
- Divisional and local leaders were clear about their roles and knew which areas they were accountable for and to whom. They had suitable systems to allow them to effectively perform their tasks and support delivery of the service. Senior staff were able to make decision based on up to date performance information. They had access to daily key performance indicators data such as that related to delayed transfers of care, attendance patterns and activity level trends information, treatment and discharge waiting times.

# Urgent and emergency services

- The department had a long-term strategy that focused on providing core emergency service, focussing on the needs of emergency patients, and targeting the delivery of high quality emergency care. It clearly highlighted pathways and areas where emergency departments involvement needed to be minimised and where enhancements needed to be made.
- Teams were well motivated and focused on delivering quality care. Staff were positive and optimistic about the future of the trust. They felt proud being part of a larger organisation and felt they had good relationship with other EDs run by the trust and could use it to share learning and their experiences.
- Complaints and incidents were regularly reviewed during staff meetings and reported on and monthly divisional performance report. Staff we spoke to were aware of patterns and trends in incidents and complaints.
- The department used information available through performance reports and local audits to inform and improve service planning. This was easily available and easy to understand for staff involved in care and treatment delivery, the information was also timely and relevant.
- The trust engaged patients and staff. They monitored patients feedback and summarised themes to support improvement within the department. Staff told us they felt engaged in the day to day operation of the department and could influence changes.

However, we also found:

- The department's risk register was not updated with many risks placed on the risk assessment more than 2 years old. Out of 17 entries one was entered in 2013, two in 2014, and three in 2015.
- Investigators that analysed incidents root causes and contributory factors did not refer to incident specific shared learning routes. They made generic statement such as "national reporting and learning service [system] will be used for promotion of wider learning". It was not recorded if patient or their relatives had an opportunity to contribute to terms of reference or engage in the investigation process.

## Areas for improvement

**We found areas for improvement:**

**Actions the provider SHOULD take to improve:**

- The trust should improve quality of individual patient's records and ensure all relevant information is consistently captured. They should ensure there is quality monitoring system in place to encourage consistency.
- The trust should ensure all staff complete mandatory training modules and compliance with the trust's target is monitored consistently.
- The trust should ensure side room used to nurse children and adolescents who needed support for their mental health conditions is fully risk assessed to ensure patients' safety.
- The trust should ensure all patients needing pain controlling medication receive it promptly and that staff use pain scoring tools accurately.
- The trust should ensure patients are assessed promptly and treated, admitted/transferred/ or discharged in a timely manner to minimise patient's waiting times. They should aim to meet the timeframes prescribed by the national standards for emergency departments.
- The trust should ensure staff have direct oversight of the children waiting area.

# Medical care (including older people's care)

Requires improvement  

## Key facts and figures

Medical services involve assessment, diagnosis and treatment of adults by means of medical interventions rather than surgery.

The Medicine Division at Newham University Hospital comprises the following services:

- Older People's and Stroke Services
- Acute Medicine & Ambulatory Care
- Diabetes & Endocrinology
- Gastroenterology & Hepatology
- Respiratory Medicine
- Cardiology
- Neurology (Outpatients / Liaison Services)
- Nephrology (Outpatients / Liaison Services and satellite unit)

There is a medical admissions unit, the Observation ward, which cares for patients in the first 24 hours of a patient's admission. Consultant cover is from 8am to 7pm. All patients are reviewed with a consultant acute physician throughout the day as they are admitted.

The hospital provides medical ambulatory care between 9am and 5pm, Monday to Friday. This takes referrals directly from GPs, from ED and from ward-based teams to facilitate early discharge.

There are four inpatient wards for Older People's Service and Stroke: Thistle, Tayberry, Silvertown and Heather Ward. There are three inpatient wards for Specialist Medicine: Coronary Care Unit, Plashet Ward and Stratford Ward.

The division provides outpatients services across all specialities. The majority of these take place at Newham University Hospital. There are outpatient clinics for respiratory medicine and diabetes at our Shrewsbury Road clinic.

The division also provides diagnostics in relation to endoscopy, and respiratory function testing. In addition, cardiology diagnostics are provided at Newham University Hospital through the Bart's Health group's networked cardiology service.

The trust had 87,427 medical admissions from April 2017 to March 2018. Emergency admissions accounted for 42,691 (48.8%), 5,040 (5.7%) were elective, and the remaining 39,696 (45.4%) were day case.

Admissions for the top three medical specialties across the trust were:

- General medicine: 24,413
- Gastroenterology: 22,946
- Cardiology: 11,059

(Source: Hospital Episode Statistics)

# Medical care (including older people's care)

Medical care at Newham University Hospital was last inspected in July 2017, when it was rated good for effective, caring, responsive, and well led, and requires improvement for safe. Medical care was rated as good overall. Areas for improvement that were found during the last inspection included ensuring the nutritional and hydration needs of patients were met, ensuring premises and equipment are clean and secure, ensuring safe staffing levels, and ensuring learning from infection prevention and control audits is communicated to staff.

We carried out our inspection at Newham University Hospital medical wards from 11 to 13 September 2018. During our inspection we visited seven wards: The Observation Unit, Thistle Ward, Tayberry Ward, Silvertown Ward, Heather Ward, Plashet Ward, and the Coronary Care Unit (also Medical High Dependency Unit). We also visited the endoscopy unit, the ambulatory care unit, and the discharge lounge.

We spoke with 12 patients and three relatives, and reviewed 30 sets of patient records. We also spoke with 73 members of staff, including qualified and student nurses, matrons, consultants, doctors, senior managers, and support staff.

## Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

- A significant number of medical staff were not meeting the trust target of 85% in their mandatory training modules, including key modules such as Basic Life Support (60%), and Infection Prevention and Control (74%). The trust did not have an action plan to address this issue.
- In the 30 patient records we looked at, risk assessments were not consistently completed. Risk assessments for falls, pressure ulcers, and National Early Warning Scores (NEWS) were not consistently recorded. This meant that oversight of patient risk was not consistent, and patients may have been at unnecessary risk without sufficient safety or monitoring measures in place. It also meant patients at risk of deteriorating may not be picked up as quickly as possible.
- On several occasions we found patient records trolleys unsecured and patient record booklets unattended in corridors, as well as computer terminals unlocked. This lack of security presented a risk to patient confidentiality, as well as clinical records being lost.
- We found that recording of capacity assessments and decisions on deprivation of liberty safeguards (DoLS) were not consistently documented appropriately in patient records. The nursing records contained a proforma pathway for assessing if a patient needed a DoLS application, however this was not being used consistently. We also found staff understanding of when patients needed an assessment under the Mental Capacity Act (MCA) and DoLS application was variable. Some staff were not able to demonstrate awareness of when MCA and DoLS assessments would be necessary. Safeguarding leads for the trust stated they recognised that there were gaps in training and understanding for MCA and DoLS which was due to a lack of staff in the safeguarding team.
- Some family members of patients we spoke with were concerned that patients who needed assistance eating were not supported to do so by staff, and so were not finishing meals. We observed nursing staff taking meals to patients and discussing supporting patients to eat, but also observed patients with meals that were not able to eat without support.
- The nursing records contained a section for completion on pain and comfort. In the records we viewed we found this to be inconsistently completed or not completed. This meant that pain management for some patients may not be as effective as it could be.

# Medical care (including older people's care)

- Data provided by the trust showed that as of December 2018, appraisal rates of nursing staff on some wards in the Emergency and Acute Medicine division did not meet the trust target of 90%, with the lowest ward being 70%.
- The ECIP report stated that the ambulatory care model was in its infancy, staffing was variable and that the service ran extremely limited hours with strict exclusion criteria. We observed that the consultant presence on the ACU was extremely stretched between seeing patients and triaging referrals from GPs.
- Although the trust had an overall strategy for Newham hospital, some of which related to medical wards, there was no overall clinical strategy for the Medicines Divisions. Staff we spoke with across medical wards were unsure of the future development plans for medical wards at Newham Hospital.

However, we also found:

- The environment on the medical wards and areas we visited was visibly clean and tidy. Staff also followed the trust's infection control policy, using personal protective equipment such as gloves and aprons, and adhered to the trust's 'bare below the elbow' policy.
- Staff were aware of policies and protocols in relation to the administration of medication, and we observed adherence to these protocols. Staff recorded administration on medication charts, and performance was maintained through regular audits by the pharmacy team. Controlled drugs (CDs) were also managed safely and securely.
- Medical wards investigated all incidents and used learning from investigations to improve the delivery of care. Incidents were reported on and discussed through the divisional governance structure, and from this, actions were identified to minimise the risk of repeat occurrences. Staff also told us they were encouraged to report incidents by managers, and we found there was a positive attitude towards raising concerns.
- We observed care on medical wards during our visit and found it was delivered in line with evidence-based guidance such as those published by National Institute for Health and Care Excellence (NICE), the Royal Colleges and other relevant bodies, and was supported by local guidelines and standard operating procedures.
- Patients received screening and assessment for sepsis on medical wards and were managed in line with national guidance. A sepsis screening and management tool was in use across wards and each ward had a sepsis trolley, which allowed staff to start the sepsis 6 care bundle quickly for any patient identified as being a risk. The hospital had established a local multidisciplinary sepsis team responsible for coordinating sepsis promotion and education at the hospital, monitoring sepsis outcomes, and delivering sepsis specific improvement projects.
- Throughout our inspection we saw consistent evidence of multidisciplinary team (MDT) working across all disciplines and wards. The delivery of patient care included healthcare professionals from all backgrounds necessary, and MDT input was well reflected in patient records. During our inspection, we saw regular consultant-led multidisciplinary meetings and ward rounds attended by various disciplines. Daily MDT meetings were in use seven days a week to review patients, and we observed that they were attended by a consultant, nurse in charge, discharge co-ordinator, bed managers, junior doctors, social workers, and therapies co-ordinator.
- Staff and senior leads informed us that monthly clinical boards, which included several medical specialties, included representation from patients or family members who have used those service. Clinical staff we spoke with were very positive about the input of the patient experience contributors, and felt that they helped to ensure the patient voice was appropriately considered when discussing changes to service delivery or performance.
- There were several specialist staff available to medical wards to support patients with complex needs. This included a dementia and delirium team who supported the dementia and delirium pathway, and a specialist learning disability nurse (shared across sites) that supported patients diagnosed with a learning disability and/or autism spectrum disorders.



# Medical care (including older people's care)

- In November 2017, an Emergency Care Improvement Programme (ECIP) team, which included involvement from NHS Improvement and NHS England, were invited to review current practice in acute medicine and offer suggestions for improvement. The team visited the observations unit, clinical decisions unit, ambulatory care unit, and took time to meet with staff. The report stated that the model for the observations unit is complex but it works for the site, however capacity within the Observation Ward was a challenge for the size of the medical take. The report was also positive about the ward rounds system and medical staffing.
- Staff were generally positive about working for the trust and felt valued. Staff stated there was a strong multi-disciplinary team working culture within the organisation, and that managers were supportive and accessible. Morale amongst staff we spoke to was generally positive. Medical staff we spoke with felt there was a positive relationship between consultants and junior doctors, and that there were good opportunities for learning for junior doctors.
- There was a clear governance structure within the division and staff at all levels were clear about their roles and what they were accountable for. Medical wards had systems in place for monitoring and reporting on risk and performance at ward and divisional level.

## Is the service safe?

**Requires improvement**   

Our rating of safe stayed the same. We rated it as requires improvement because:

- A significant number of medical staff were not meeting the trust target of 85% in their mandatory training modules, including key modules such as Basic Life Support (60%), and Infection Prevention and Control (74%). The trust did not have an action plan to address this issue.
- We reviewed 20 sets of patient records and found Methicillin-resistant *Staphylococcus aureus* (MRSA) screening was not completed properly or not completed at all on medical wards. This was also identified in the previous inspection report.
- In the 30 patient records we looked at, risk assessments were not consistently completed. Risk assessments for falls, pressure ulcers, and National Early Warning Scores (NEWS) were not consistently recorded. This meant that oversight of patient risk was not consistent, and patients may have been at unnecessary risk without sufficient safety or monitoring measures in places. It also meant patients at risk of deteriorating may not be picked up as quickly as possible.
- On several occasions, we found patient records trolleys unsecured and patient record booklets unattended in corridors, as well as computer terminals unlocked. This lack of security presented a risk to patient confidentiality, as well as clinical records being lost.
- The trust provided evidence of annual self-assessment audits on each medical ward relating to “work environment and equipment”. Although overall performance in relation to meeting the environmental standards of the audit, almost all medical wards were not routinely ensuring Control of Substances Hazardous to Health (COSHH) assessments were up to date and maintained, or that appropriate mitigation for managing hazardous substances was in place.

However, we also found:

- The environment on the medical wards and areas we visited was visibly clean and tidy. Staff also followed the trust's infection control policy, using personal protective equipment such as gloves and aprons, and adhered to the trust's 'bare below the elbow' policy.



# Medical care (including older people's care)

- Staff were aware of policies and protocols in relation to the administration of medication, and we observed adherence to these protocols. Staff recorded administration on medication charts, and performance was maintained through regular audits by the pharmacy team. Controlled drugs (CDs) were also managed safely and securely.
- Medical wards investigated all incidents and used learning from investigations to improve the delivery of care. Incidents were reported on and discussed through the divisional governance structure, and from this, actions were identified to minimise the risk of repeat occurrences. Staff also told us they were encouraged to report incidents by managers, and we found there was a positive attitude towards raising concerns.
- Staff had carried out daily checks of resuscitation equipment and documented evidence of the checks in line with guidance from the Resuscitation Council. Each ward had also introduced sepsis trolleys to respond quickly to patients at risk of deterioration.
- The hospital had established a local multidisciplinary sepsis team, which included a consultant, intensive care outreach nurse specialist, and an anti-microbial/Sepsis pharmacist. The sepsis team were responsible for coordinating sepsis promotion and education at the hospital, monitoring sepsis outcomes, and delivering sepsis specific improvement projects.

## Is the service effective?

**Requires improvement** ● ↓

Our rating of effective went down. We rated it as requires improvement because:

- We found that recording of capacity assessments and decisions on deprivation of liberty safeguards (DoLS) were not consistently documented appropriately in-patient records. The nursing record contained a proforma pathway for assessing if a patient needed a DoLS application, however this was not being used consistently. We also found staff understanding of when patients needed an assessment under the Mental Capacity Act (MCA) and DoLS application was variable. Some staff were not able to demonstrate awareness of when MCA and DoLS assessments would be necessary. Safeguarding leads for the trust stated they recognised that there were gaps in training and understanding for MCA and DoLS which was due to a lack of staff in the safeguarding team.
- Although most of the policies and procedures we viewed were reviewed regularly, we found some to be out of date (e.g. policy for mandatory training).
- Some family members of patients we spoke with were concerned that patients who needed assistance eating were not supported to do so by staff, and so were not finishing meals. We observed nursing staff taking meals to patients and discussing supporting patients to eat, but also observed patients with meals that were not able to eat without support.
- The nursing records contained a section for completion on pain and comfort. In the records we viewed we found this to be inconsistently completed or not completed. This meant that pain management for some patients may not be as effective as it could be.
- Data provided by the trust showed that as of December 2018, appraisal rates of nursing staff on some wards in the Emergency and Acute Medicine division did not meet the trust target of 90%, with the lowest ward being 70%.
- Due to some MDT staff not being available out of hours, medical wards were not meeting the London Quality Standards for a clear MDT assessment within 14 hours and a treatment or management plan to be in place within 24 hours.

However, we also found:

# Medical care (including older people's care)

- We observed care on medical wards during our visit and found it was delivered in line with evidence-based guidance such as those published by National Institute for Health and Care Excellence (NICE), the Royal Colleges and other relevant bodies, and was supported by local guidelines and standard operating procedures.
- Patients received screening and assessment for sepsis on medical wards and were managed in line with national guidance. A sepsis screening and management tool was in use across wards and each ward had a sepsis trolley, which allowed staff to start the sepsis 6 care bundle quickly for any patient identified as being a risk.
- Throughout our inspection, we saw consistent evidence of multidisciplinary team (MDT) working across all disciplines and wards. The delivery of patient care included healthcare professionals from all backgrounds necessary, and MDT input was well reflected in patient records. During our inspection, we saw regular consultant-led multidisciplinary meetings and ward rounds attended by various disciplines. Daily MDT meetings were in use seven days a week to review patients, and we observed that they were attended by a consultant, nurse in charge, discharge co-ordinator, bed managers, junior doctors, social workers, and therapies co-ordinator.
- The trust had three Practice Development Nurses (PDNs) who were available to provide advice and support on available courses and education opportunities, as well as deliver training. PDNs also provided tailored support for nurses revalidating, student nurses and return to practice nurses. Staff we spoke with stated the PDNs were easy to access and supportive, and we observed PDNs working on the wards to provide bespoke training.
- Newham Hospital participated in the National Diabetes Inpatient Audit NaDIA, with the most recent available report from 2017. Although there were further areas for improvement, the hospital performance in relation to 2015 and 2016 was significantly improved, both in relation to specialist staffing and availability of service. The Newham diabetes team had also successfully bid to be one of 20 services in the UK to be part of the National Diabetes Inpatient Audit Collaborative Quality Improvement project (NaDIAQIC).
- The trust had a dedicated acute pain management team whose role was to manage the needs of patients with acute and chronic pain in the hospital. Clinical nurse specialists in this team provided support and advice to staff, as well as specialist pain management for patients if necessary.
- The trust had a public health team to identify opportunities for health promotion for patients. This team worked across site and with clinicians to identify areas for improving patients' health.

## Is the service caring?

**Good** ● → ←

Our rating of caring stayed the same. We rated it as good because:

- Across medical wards, we observed generally positive interactions between staff, patients and family members. Staff were supportive to patients and treated them with dignity and respect. Interactions between staff and patients were friendly, and staff made time to ask if patients needed anything or had any questions.
- We spoke with 17 patients during the inspection across medical wards, who were generally positive about the care they received and the staff they had met. Patients we spoke with recognised that staff were very busy and they may need to wait for a response, however patients felt staff were supportive when available.
- Patients we spoke with stated that staff respected their dignity and privacy, and we observed this on the wards we visited. Staff used curtains around beds to provide privacy for patients receiving treatment and we observed staff explaining the care that they were providing to patients.

# Medical care (including older people's care)

- There was 24/7 religious support available for medical patients and their families through the hospital multi-faith chaplaincy service. The chaplaincy service could provide access to religious services and had a prayer room/quiet room for religious observances, and could also provide support during a bereavement.
- Psychological support for medical wards was delivered by the liaison psychiatry service provided by a neighbouring mental health trust (based within the emergency department). The team consisted of medical and nursing staff as well as therapists, who were available to provide advice to staff as well as assessments for patients on wards 24/7, and were as involved in discharge planning when required.
- Most patients and their family members we spoke with stated they had been well involved in their care and their relative's care. Patients stated that their care planning included several clinicians input, but also was patient-centred.
- Staff and senior leads informed us that monthly clinical boards, which included several medical specialties, included representation from patients or family members who have used those service. Clinical staff we spoke with were very positive about the input of the patient experience contributors, and felt that they helped to ensure the patient voice was appropriately considered when discussing changes to service delivery or performance.

## Is the service responsive?

### Requires improvement



Our rating of responsive went down. We rated it as requires improvement because:

- While some wards had been decorated to help orientate dementia patients, other wards had yet to introduce this, including wards that had significant care of the elderly admissions. Staff stated that that following the refurbishment of some wards they hoped to improve ward environments in accordance with national dementia guidance.
- The stroke unit did not have specialist neuropsychology input available to provide assessments and support care planning. Staff stated they could access the psychiatric liaison service for crisis mental health support, however lack of neuropsychology meant there was a gap for assessment and rehabilitation for potentially cognitively-impaired patients.
- There had been data errors in the processes used by the hospital to collate information relating to overnight bed moves on the medical wards. Data initially suggested over 5000 patients moved wards at night between April 2017 and March 2018. We raised this as a concern and at the time of inspection the trust stated that there were significant inaccuracies in the data submitted After inspection. the trust business intelligence revaluated the total number of ward moves at night to be 2500.
- Medical wards had designated a 'dementia champion' on each ward to support the care of patients with dementia, however some of the staff did not display a sufficient understanding of what this role entailed.
- The ECIP report stated that the ambulatory care model was in its infancy, staffing was variable and that the service ran extremely limited hours with strict exclusion criteria. We observed that the consultant presence on the ACU was extremely stretched between seeing patients and triaging referrals from GPs.
- While on inspection, we were informed that an escalation ward had been opened overnight to meet increased attendances in the emergency department and on medical wards. To open the escalation area, approximately ten beds had been moved into the reception area of the ambulatory care unit, which were still there when patients were arriving for appointments. While this did not appear to present any risks to patient safety, the beds did provide an obstacle for patients attending appointments, and would have presented a challenge for patients with mobility issues.

# Medical care (including older people's care)

However, we also found:

- Medical wards at Newham Hospital provided and had access to several clinical nurse specialists to meet the needs of local patients. This included access to a dementia team, psychiatric liaison, critical care outreach, palliative care team, and various oncology nurse specialists.
- Staff on medical wards stated they could access interpreting services for patients whose first language was not English, and were familiar with the process of how to do so. Translation services could be arranged by telephone or in person.
- Staff we spoke stated they had regular support from the palliative care team to ensure specialist support was available for palliative patients. Staff stated members of the palliative care team facilitated quick support to end of life medications, rapid transfers to appropriate wards or back to their preferred place of death, and also supported training for frontline staff.
- In November 2017, an Emergency Care Improvement Programme (ECIP) team, which included involvement from NHS Improvement and NHS England, were invited to review current practice in acute medicine and offer suggestions for improvement. The team visited the observations unit, clinical decisions unit, ambulatory care unit, and took time to meet with staff. The report stated that the model for the observations unit is complex but it works for the site, however capacity within the Observation Ward was a challenge for the size of the medical take. The report was also positive about the ward rounds system and medical staffing.
- Discharges were discussed daily in board rounds and were consultant led, and needs of patients (e.g. social care needs, further tests required) were discussed as part of this process. We attended these meetings and reviewed patient records, and observed discharge planning to be multi-disciplinary and well managed. The hospital had a discharge team which supported and advised medical wards on complex discharges.
- Staff we spoke with stated they were aware of how to direct patients or visitors to the PALS team, and stated that PALS could provide advice and support to the ward on managing complaints. Staff also stated they would try to informally resolve any complaints if possible, but if not would direct the complainant to PALS.

## Is the service well-led?

**Requires improvement**  

Our rating of well-led went down. We rated it as requires improvement because:

- Although the trust had an overall strategy for Newham hospital, some of which related to medical wards, there was no overall clinical strategy for the Medicines Division. As some of the ward spaces were being refurbished, this meant there was no defined strategy for how these wards would be utilised when the refurbishment was finished.
- Staff we spoke with across medical wards were unsure of the future development plans of the medical wards at Newham Hospital. Staff stated they were not sure what the plans were for the wards once the refurbishment of other wards had been complete, or how medical specialities may be moved around. Staff we stated they were not sure if a consultation would take place regarding any future development plans.
- Some of the risks we identified on inspection were not reflected on the divisional risk register. This included inconsistent completion of patient risk assessments, inconsistent completion of mental capacity act assessments and deprivation of liberty safeguards, and medical wards not meeting targets for mandatory training.

# Medical care (including older people's care)

- As some of the concerns we identified were not identified on the risk register, medical wards did not have actions plans in place to minimise the impact of these risks. Oversight of risks on medical wards had decreased from the time of our previous inspection.

However, we also found:

- The trust had a clear leadership development strategy for recruiting, promoting, and supporting managerial or leadership staff. Recruited staff received a specific induction programme for managers and for new consultants, while there was also a six-month leadership transitions programme for internally appointed senior managers and consultants. The trust also had a career development programme to support BME staff and women into senior leadership roles. Staff we spoke to in leadership roles (both recruited and promoted internally) stated they felt well supported in their roles.
- Staff were generally positive about working for the trust and about the divisional leadership. Staff stated there was a strong multi-disciplinary team working culture within the organisation, and that managers were supportive and accessible. Morale amongst staff we spoke to was generally positive.
- Medical staff we spoke with felt there was a positive relationship between consultants and junior doctors, and that there were good opportunities for learning for junior doctors. Many of the medical staff we spoke to felt they were good working relationships by colleagues, and that they felt supported to suggest changes that may improve the delivery of service.
- There was a clear governance structure within the division and staff at all levels were clear about their roles and what they were accountable for. Medical wards had systems in place for monitoring and reporting on risk and performance at ward and divisional level.

## Outstanding practice

In October 2017, the trust was selected to be part of a £3.5 million improvement programme (offered by an independent organisation) to share expand the availability of online patient appointments across the trust. This work is due to be built upon the work of the diabetes team at Newham Hospital, which has won awards for increasing patient attendance rates and preventing inpatient admissions. The aim of the work is to expand the availability to other hospital sites, and work with partners and commissioners to develop standards of care in this area.

## Areas for improvement

**We found areas for improvement:**

**Action the provider MUST take to improve:**

- The trust must ensure that Mental Capacity Act (MCA) assessments and Deprivation of Liberty Safeguards (DoLS) applications are adequately completed and correctly recorded. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12)
- The trust must ensure that clinical risks assessments, including National Early Warning Scores (NEWS), are adequately completed and correctly recorded in patient records. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12)
- The trust must ensure that electronic and paper records are stored securely, in line with legislation relating to data protection and patient confidentiality. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17)

**Action the provider SHOULD take to improve:**

## Medical care (including older people's care)

- The trust should ensure that pain assessments are completed with patients and recorded in the patient records.

# Critical care

Requires improvement   

## Key facts and figures

The critical care service at Newham University Hospital consisted of an eight-bedded critical care unit providing care at level two (high dependency) and level three (intensive care), to adults who required a higher level of care than could be provided on the wards. The critical care service also included a critical care outreach team (CCOT) to support acutely ill patients in other areas of the hospital. The CCOT was led by three specialist nurses supported by a critical care consultant and the team were available seven days a week between 08:00am and 08:00pm. There were plans in place being actioned to increase the CCOT service to a 24-hour, seven day a week service.

The critical care service used a range of enhanced physiological monitoring systems, organ supportive therapies and complex treatments and treated all acute illnesses that necessitated a high staff to patient ratio and a highly skilled, multi-professional team. Level two patients were nursed 1:2 and level three were nursed 1:1.

Critical care was part of the hospital's surgical directorate, led locally by a clinical lead and a matron. The critical care team included five critical care consultants who led the unit for a week at a time, a matron, five teams of nurses each led by a senior nurse (band seven), a practice development nurse, physiotherapists, a dietician and pharmacist. There were also weekly tracheostomy multidisciplinary (MDT) ward rounds for admitted patients within the hospital who had a tracheostomy. The tracheostomy team included a CCOT nurse, speech and language therapist, physiotherapist, critical care consultant and ears nose and throat consultant.

There were a further two level two beds in the coronary care unit within the hospital which sat in the hospital's medical division. As critical care consultants did not lead patient care here, only support as required, we did not inspect this area. This was carried out as part of the medical core service inspection.

Between September 2017 and August 2018, there were 427 admissions to the critical care unit.

At our last inspection in 2015, we identified numerous concerns regarding staffing numbers, staff training, the premises, there was no practice development nurse in post, staff understanding regarding the Mental Capacity Act, patient flow, high number of cancelled elective operations and governance.

Between 1 October and 3 October 2018, we inspected the whole core service and looked at all five key questions. We spoke with 27 members of staff including the clinical lead, doctors, nurses, senior managers, support staff, cleaners, a dietician, pharmacist, a chaplain and physiotherapists. We reviewed the healthcare records of ten patients and spoke with seven patients and relatives.

## Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- Staff did not always clean their hands when entering the unit or before patient contact.
- Cleaning records were not kept to show whether the environment or equipment had been cleaned and when. The "I am clean" green stickers were also not used consistently to show what equipment was clean and ready to use.
- The service did not comply with building guidelines for critical care services due to a lack of bed and storage space, and insufficient hand-wash basins. We raised this as a concern in 2015 and at this inspection in 2018 found no action had been taken. Furthermore, senior managers could not provide us with assurance that these issues were going to be resolved in a timely way. We saw that these environmental concerns put patients, staff and visitors at risk.



# Critical care

- Equipment used for the transfer of patients to and from the critical care unit was not regularly checked.
- Oxygen cylinders were stored without safety notices in place.
- Records to show equipment servicing were not kept up-to-date.
- Whilst nursing staffing numbers had improved significantly since our last inspection, we found that the coordinator for the critical care unit was counted as part of the staffing numbers at times, opposed to being supernumerary as required and that six of the seven middle-grade doctors employed were locums. However, we were told that three middle-grade doctors had been appointed to post and due to start at the end of October 2018.
- Seven of the 15 policies and procedures staff had access to were either not up-to-date or not the most recent version available.
- There was no policy in place for the management of sedation.
- The trust reported a sickness rate of 5.8% for nursing staff in critical care; this was higher than the trusts target of 3%.
- The critical care unit did not use patient diaries.
- The relative's room did not meet the needs of the people who used it. It was small, dull, with a sofa bed which was marked and appeared unclean, and there were no beverage making facilities available. We raised this concern in 2015 and found minimal action had been taken to improve this area. However, following this inspection in 2018 the trust told us they had taken immediate steps to paint the room, add a lamp and table and had ordered a water cooling machine for the room.
- Out of hours discharge rates remained high. Between January to September 2018, 43% of all critical care unit discharges took place between 10:00pm and 6:59am. We also raised this as a concern in 2015.
- Delayed discharge rates for patients ready to step down from the critical care unit remained high. Data from January to September 2018 showed that there had been 78 delayed discharge incidents of more than eight hours during this time period, with 21 of these discharges exceeding 72 hours. We raised this same concern at our inspection in 2015.
- There was a lack of information available to patients and those close to them in alternative languages other than English.
- The service did not collect data to show the amount of level three admissions to the critical care unit which occurred within four hours of making the decision to admit.
- There had been no needs assessment of the local population served to support the planning of the critical care service provision.
- There was no formalised vision and strategy for the critical care service.
- There was a lack of formalised action plans in place for identified risk. This included for delayed and out of hours discharges.
- The Critical Care Outreach Team (CCOT) and the critical care follow up clinic lacked supporting operational policies and procedures.

However, we also found:

- Numerous improvements had been made following the concerns we raised in 2015. This included improvements to medical and nursing staffing numbers, a practice development nurse had been in post for the past year, the number of cancelled elective operation rates had reduced, staff understanding about the Mental Capacity Act and consent was satisfactory and better governance systems were in place.

# Critical care

- More than 85% of nursing and medical staff had completed their mandatory training which was above the trust target. This included annual training on sepsis management which incorporated the use of sepsis screening tools and sepsis care bundles.
- There were plans being actioned to increase the CCOT service to a 24-hour, seven day a week service. Staff had access to the hospital's mental health liaison service 24 hours, seven days a week.
- Staffing requirements were reviewed regularly. Medical and nursing staffing levels and skill mix was good.
- Patient's healthcare records contained holistic needs assessments and were complete, containing all the information staff needed to deliver safe care and treatment to patients.
- Medicines were stored and disposed of safely. Medicines were prescribed and administered in line with relevant standards for medicines management.
- Incidents were reported and investigated appropriately, with lessons learnt, identified and changes to practice made where required.
- Data showed that safety performance over time was good. For example, data from the NHS Safety Thermometer for August 2018 showed 100% harm free care.
- People's care was assessed and planned based on evidence-based practice, with service participation in national benchmarking clinical audits.
- There was a designated dietician for the unit who was available Monday to Friday, with robust protocols in place for staff to follow out of hours. People's nutrition and hydration needs were identified, monitored and met.
- People's pain was assessed regularly and managed effectively, including for those with difficulties communicating.
- Outcomes for people's care and treatment were routinely monitored and collected, generally showing intended outcomes of people being achieved or, if not met, information was used to improve outcomes.
- Staff had the skills, knowledge and experience to deliver effective care, support and treatment. There were competencies in place for all nursing levels and 67% of nurses had completed the post registration award in critical care nursing.
- Staff, teams and services throughout the hospital were involved in assessing, planning and delivering care and treatment for people using the critical care service. We saw that the multidisciplinary team (MDT) consistently worked well together.
- There was consultant presence seven days a week, with an on-call rota out of hours where a consultant was present within 30 minutes as needed. There was physiotherapy support seven days a week and pharmacist support available 24 hours a day, seven days a week.
- Staff consistently treated people using the service and those close to them with kindness and compassion. There were also additional support services available for people living with dementia, a mental health concern or learning disability who required this.
- As much as possible people who used the service or those close to them were actively involved in making decisions about their care, support and treatment. Advocacy services were available.
- People's privacy and dignity needs were always respected including during physical or intimate care and examinations.

# Critical care

## Is the service safe?

**Requires improvement**   

Our rating of safe stayed the same. We rated it as requires improvement because:

- At our last inspection in 2015 we raised concerns about the premises. In 2018 we found that the service still did not comply with guidelines for critical care services due to a lack of bed and storage space and insufficient hand-wash basins. We saw that these environmental issues put patients, staff and visitors at risk. Senior managers could not provide us with assurance that these issues were going to be resolved in a timely way.
- Staff did not always clean their hands when entering the unit or before patient contact.
- Cleaning records were not kept to show whether the environment or equipment had been cleaned and when. The “I am clean” green stickers were also not used consistently to show what equipment was clean and ready to use.
- Equipment used for the transfer of patients to and from the critical care unit was not regularly checked. Two bags containing transfer out equipment had not been checked since 2017.
- Oxygen cylinders were stored without safety notices in place.
- The equipment maintenance record was not kept up-to-date. 32 pieces of equipment were displaying as not up-to-date with servicing requirements, of which 12 were considered high risk and 20 medium risk pieces of equipment. This included a ventilator and a renal replacement therapy machine. Senior managers confirmed that all equipment was safe and up-to-date with servicing requirements. The trust told us they would take immediate action to ensure that servicing records were updated.
- The trust reported a sickness rate of 5.8% for nursing staff in critical care; this was higher than the trusts target of 3%.
- The medical vacancy rate was 72.2% which related to middle grade doctors and one consultant post. Records however showed that regular locum staff were used to fill vacant shifts and that vacant posts were actively being recruited to.

However, we also found:

- More than 85% of nursing and medical staff had completed their mandatory training which was above the set target. This included annual training on sepsis management which incorporated the use of sepsis screening tools and sepsis care bundles, and adult and children’s safeguarding.
- There were plans being actioned to increase the Critical Care Outreach Team (CCOT) service to a 24 hour, seven day a week service. Staff had access to the hospital’s mental health liaison service 24 hours, seven days a week.
- Staffing requirements were reviewed regularly. Medical and nursing staffing levels met staffing Guidelines for the Provision of Intensive Care Services (2015) and skill mix was good.
- Patient’s healthcare records contained holistic needs assessments and were complete, with all necessary information staff needed to deliver safe care and treatment to patients.
- Medicines were stored and disposed of safely, and medicines were prescribed and administered in line with relevant standards for medicines management, such as Nursing and Midwifery Council (NMC) Standards for Medicine Management.
- Incidents were reported and investigated appropriately, with lessons learnt identified and changes to practice made where required.

# Critical care

- Data showed that safety performance over time was good. For example, NHS Safety Thermometer data for August 2018 showed harm free care was rated 100%.

## Is the service effective?

Good  

Our rating of effective improved. We rated it as good because:

- We found that improvements had been following the concerns we raised at our inspection in 2015 including the appointment of a practice development nurse for the service and better staff understanding of the Mental Capacity Act.
- People's care was assessed and planned based on evidence-based practice, with service participation in national benchmarking clinical audits.
- There was a designated dietician for the unit who was available Monday to Friday, with robust protocols in place for staff to follow out of hours. We saw that people's nutrition and hydration needs were identified, monitored and met.
- People's pain was assessed regularly and managed effectively, including for those with difficulties communicating.
- Outcomes for people's care and treatment were routinely monitored and collected, either showing intended outcomes of people being achieved or, if not, information was used to improve outcomes.
- Staff had the skills, knowledge and experience to deliver effective care, support and treatment. There were competencies in place for all nursing levels and 67% of nurses had completed the post registration award in critical care nursing with further staff planned to start this training in 2019.
- Where required staff, teams and services throughout the hospital were involved in assessing, planning and delivering care and treatment for people using the critical care service. We saw that the multidisciplinary team (MDT) consistently worked well together.
- There was consultant presence seven days a week, with an on-call rota out of hours where a consultant was present within 30 minutes as needed. There was physiotherapy support seven days a week and pharmacist support available 24 hours a day, seven days a week.
- Staff demonstrated they understood consent, the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) and acted in accordance with relevant legislation and guidance. We saw that mental capacity assessments were carried out for people using the service where required.

However, we also found:

- Seven of the 15 policies and procedures we checked were not the most recent version available. This was because staff accessed printed versions of policies in staff folders, which had passed their review date.
- There was no policy in place for the management of sedation.
- We found that patient's short risk assessment for rehabilitation records were not always completed and where they were, not in a timely way.

## Is the service caring?

Good   

# Critical care

Our rating of caring stayed the same. We rated it as good because:

- Staff consistently treated people using the service and those close to them with kindness and compassion. There were additional support services within the trust available for people living with dementia, a mental health concern or learning disability who required this.
- As much as possible, people who used the service or those close to them were actively involved in making decisions about their care, support and treatment. Advocacy services were available.
- People's privacy and dignity needs were always respected including during physical or intimate care and examinations.

## Is the service responsive?

Our rating of responsive stayed the same. We rated it as requires improvement because:

- At our last inspection in 2015 we raised concern about patient flow and the relatives room not being fit for purpose. In 2018, we found that necessary improvements had not taken place as out of hours discharge rates and delayed discharge rates remained high. Between January to September 2018, 43% of all critical care unit discharges took place between 10:00pm and 6:59am which is unsafe and there were 78 delayed discharge incidents of more than eight hours during, with 21 of these exceeding 72 hours. We also saw that the relatives room continued to not meet people's needs as it was small, dull, the chair/sofa bed had markings on which appeared unclean and there were no beverage making facilities available.
- The critical care unit did not use patient diaries.
- There was a lack of information available in alternative languages other than English.
- The service did not collect data to show the amount of level three admissions to the critical care unit which occurred within four hours of making the decision to admit.
- There had been no needs assessment of the local population to support the planning of the critical care service provision.

However, we also found:

- Patients who were able to eat and drink could choose their meals from a selection of menus. These included vegan, gluten-free, kosher and halal choices. We saw that different textured food was also available.
- The critical care unit visiting times were flexible if a patient was very unwell or those close to people had exceptional circumstances.
- There was a robust complaints procedure in place and complaints were handled effectively, in a timely way.

## Is the service well-led?

**Requires improvement**   

Our rating of well-led stayed the same. We rated it as requires improvement because:

# Critical care

- There were still improvements required in relation to the premises not being fit for purpose and patient flow which we raised as concerns in 2015. We did however find that these concerns were beyond the hands of local management, who demonstrated they had acted to mitigate risk and escalate concerns to senior hospital managers on numerous occasions.
- We found new concerns at this inspection which related to the safety, effectiveness and responsiveness of the service. This included concerns with staff hand hygiene, the checking history of equipment and there was no policy in place for the management of sedated patients, all of which we have discussed within this report.
- Despite arrangements being in place to identify risk and seeing evidence that action was being taken to mitigate risk, we found there was a lack of formalised action plans to support risk management. This included no formalised action plans in place for delayed and out of hours discharges which were long standing risks. Where action was being taken to mitigate risk, it was not recorded so we were not assured that all steps were being taken, by whom and in what time frame.
- There was no formalised vision or strategy for the critical care service.
- We found that some services were being delivered without policies and procedures in place to support them. This included for the Critical Care Outreach Team (CCOT) and the critical care follow up clinic services, which lacked suitable policy and procedure.
- Many paper-based policy and procedures which were used by staff needed updating as they did not reflect current versions available.

However, we also found:

- Numerous improvements had been made to the service following the concerns we raised at our inspection in 2015. This included appointment of new medical and nursing leaders who staff spoke remarkably highly of, including a practice development nurse. Staff across all levels told us they felt well supported, respected and valued and described a positive working environment, and staffing numbers, governance, staff understanding about the Mental Capacity Act and staff training compliance had all improved significantly.
- A culture was observed which encouraged openness and honesty at all levels.
- There were robust systems in place to identify and monitor risk, issues and performance. This included a robust service risk register and performance dashboard.
- Staff, people who used the service and those close to them, were actively encouraged to be involved with decisions about the service. We saw that such views were used to improve service provision.
- Following our inspection, on 17 October 2018 senior hospital managers told us that they had taken some immediate action in relation to the new concerns we raised. This included the introduction of daily hand hygiene audits for the critical care unit. They had also made aesthetic improvements to the relatives' room and carried out a review of policy and procedure throughout the service to ensure that these were up-to-date and accessible to staff.

## Outstanding practice

- The service carried out weekly "safety briefings" which were communicated at the beginning of each shift to nursing staff. These were safety updates relative to the critical care service.
- Numerous staff praised the practice development nurse (PDN), who they recognised as making significant improvements to the service in the past year. This PDN had introduced study days and the critical care service newsletter.

# Critical care

- Staff of all levels told us how effective and what a positive difference the clinical lead had made since coming into post.
- After a junior doctor coming up with the idea, the critical care team since completed “ten by ten” training sessions which were brief, succinct learning sessions which happened daily.
- A consultant from the critical care unit conducted a recent audit titled, “Can nasal high flow support be used in Type 2 respiratory failure”, which identified that “high flow oxygen therapy (Optiflow) has changed the outcome and quality of life in our patients in the wards”. We saw that these results had been published in the “American Journal of Respiratory and Critical Care Medicine” earlier this year and the results had led to agreed changes in practice locally.
- The service had started running staff simulation training for a variety of subjects. Records showed that a tracheostomy simulation morning was held in August 2017 and a fire evacuation simulation happened in September 2018, which some staff told us they had participated in.

## Areas for improvement

### **We found areas for improvement in this service:**

#### **Actions the trust MUST take to improve:**

- The trust must improve compliance with hand hygiene on the critical care unit (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12)
- The trust must ensure that cleaning records are kept to show cleaning of the critical care unit. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 15)
- The trust must ensure that the critical care facilities comply with national guidelines (Health Building Notes: HBN 04-02 Critical Care Units: Planning and Design). (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 15)
- The trust must ensure that transfer out equipment is checked regularly. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 15)
- The trust must ensure that safety notices are in place where oxygen is stored (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 15).
- The trust must ensure that records for the maintenance of equipment, including service and portable appliance testing (PAT) are kept up-to-date. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17)
- The trust must ensure that policies and procedures available to staff are up-to-date. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12)
- The trust must improve out of hours discharge rates for critical care unit patients. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12)
- The trust must improve delayed discharge rates for critical care unit patients. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12)

#### **Actions the provider SHOULD take to improve:**

- The trust should consider using the “I am clean” green stickers consistently as per the trust policy and procedure.
- The trust should consider implementing patient diaries for critical care unit patients.



# Critical care

- The trust should improve the relative's rooms so as it meets the needs of people who use it.
- The trust should consider making patient and relative literature available in other languages.
- The trust should consider developing a vision and strategy for the critical care service.
- The trust should consider developing policies and procedures to support the CCOT and critical care follow up clinic services.
- The trust should ensure that there are formalised action plans in place for identified risk.

# Maternity

Inadequate ● ↓

## Key facts and figures

Newham University Hospital provides maternity services to women in the London Boroughs of Newham and Barking and Dagenham. In 2017/18, Newham Hospital had 6,204 births. Most maternity services are located together in one purpose built section of the hospital, where ante-natal, intrapartum and postnatal care is provided. The booking and antenatal clinics take place at the other end of the hospital where there are 6 ultrasound rooms.

All expectant women attended the hospital for their first appointment. Community midwifery services deliver antenatal and postnatal care in local areas. Specialist clinics are run at the hospital for women with additional conditions such as diabetes or mental health issues. Fetal and maternal medicine is available for women with specific needs.

A consultant led delivery suite on the first floor has 15 delivery rooms and a midwifery-led birthing unit has 10 rooms. A four-bedded recovery/observation unit caters for women who require close monitoring. This area is staffed by nurses and midwives with specialised training.

There is one permanent theatre, and under a temporary arrangement a second theatre is available in the day time. At night the main theatre team must be called to open the second obstetric theatre. Women also have the choice of birth at home or in a standalone birthing unit. Barking birth centre was not inspected as part of this inspection.

Larch ward, on the ground floor, has two sections, an 11-bed antenatal ward and a postnatal ward with 33 beds. There are two bays for transitional care. There is a further bay that staff can open if the ward is very busy. Six single rooms can be used by women with a medical need, or as amenity rooms for which a fee is paid.

A maternity day assessment unit to which women can walk in, is open between 8am and 8pm to assess women over 18 weeks of pregnancy, and triage is open 24 hours a day. An early pregnancy unit is open 9am to 5pm on weekdays and 9-2pm at weekends for women with complications of early pregnancy. A maternity helpline is available from 10am to 8pm.

On average, 40% of women were assessed as “low risk” at booking, and 24% of women delivered in birthing units under midwifery led care in 2017/18.

The obstetric unit is the recommended place of birth for women with complicated pregnancies, those who go into labour early and for women requesting epidural analgesia in labour.

The service was supported by a local neonatal unit that cares for babies born from 27 weeks’ gestation who need breathing or feeding support or short term intensive care, sometimes before being transferred to neonatal intensive care unit which provides the highest level of care to babies.

We carried out a comprehensive inspection of the maternity service in November 2016. We undertook a focused inspection of maternity services in July 2017 to follow up concerns about the maternity services identified at inspection in November 2016. The service was judged to be requiring improvement overall.

We carried out an announced inspection of the maternity service between 11 and 13 September 2018. We also carried out an unannounced inspection at night on 19 September 2018. During our inspection, we visited all clinical areas in the service including delivery suite, theatres, clinics and antenatal and postnatal wards, the maternity assessment unit (MAU) and early pregnancy assessment unit (EPAU), and one community midwifery centre. We spoke with 10 women and their relatives and over 45 members of staff, including midwives, consultants, anaesthetists, senior managers, student midwives, pharmacist, housekeepers, receptionist, matrons and support staff. We observed care

# Maternity

and treatment and reviewed a random sample of 20 medical care records and 10 prescription charts. We observed an incident review meeting, a midwife handover and two multidisciplinary handovers. We received comments from people who told us about their experiences and we reviewed performance information about the Newham's maternity service.

## Summary of this service

Our rating of this service went down. We rated it as inadequate because:

At our last two inspections we were concerned about the safety of patients and the management of the service for the following reasons:

- There had been a backlog of overdue incidents, including serious incident investigations and uncompleted follow up action. Learning had not been disseminated in a timely way and processes were not in place to monitor progress and use learning to continually evaluate and improve services.
- Not all women received timely treatment and pain relief.
- Serious incident reviews and incident reports had highlighted incomplete patient records as an ongoing problem.
- Patient records, including cardiotocography (CTG) documentation, were not comprehensively and consistently completed and processes were not in place to evaluate this at the time of the inspection, although a sample audit was completed post inspection.
- Consultant cover had been a concern and midwives, particularly on the delivery suite were overstretched and the midwife coordinator on the delivery suite was not supernumerary.
- Senior midwives were not visible around the maternity unit.
- The use of the Modified Early Obstetric Warning System (MEOWS) was inconsistent.
- There was no permanent staffing for a second obstetric theatre to use at times when the main obstetric theatre was busy, so some women experienced waiting times for caesareans and other procedures.
- Women and babies were at risk of unauthorised access to the units.
- Delivery suite coordinators did not have supernumerary status.
- Mandatory training rates, including safeguarding training were below trust targets.

During this inspection we found:

- Although some of our previous concerns had been rectified, overall, change had been both slow and inconsistent, and new areas of concern were evident in relation to infection control, basic skills of midwives and governance.
- Although some of our previous concerns had been rectified, overall change had been both slow and inconsistent, and new areas of concern had arisen particularly in relation to infection control and governance.
- Governance processes did not provide sufficient assurance that senior staff had a sustainable plan to improve all performance and safety issues within the service. There had been uneven performance across the year in keeping abreast of complaints and investigations, and particularly implementing follow up actions from serious incidents to prevent recurrence.
- Management of the maternity service was reactive in response to adverse events and lacked robust systems to ensure staff maintained consistently high standards.

# Maternity

- At the last inspection, serious incident reviews and incident reports had highlighted incomplete patient records as an ongoing problem. We reviewed patient records as well as incident reports and found incomplete documentation and retrospectively completed records. This was not identified on the risk register despite clear evidence from incidents that it was an issue, and there was no comprehensive plan for improvement. An improvement plan was produced after the inspection.
- Serious investigation reports were still overdue and the service was not up to date with actions following from serious incidents, although the backlog had reduced.
- There was a temporary funding arrangement for partial staffing of a second obstetric theatre. This had started two weeks before the inspection, despite being top of the risk register since 2013. It was too early to assess whether the arrangements were effective. Some staff would be taken from the high dependency unit to provide staffing when needed.
- Systems to ensure emergency equipment was available and in date were not effective.
- We found examples of inadequate cleaning of clinical items, poor waste management practices, poor staff hand hygiene and weak adherence to uniform policy among midwives.
- Processes to ensure confidentiality was maintained were not effective. Records were not held securely at all times. For example, we saw patient notes left unattended and test results in an open room.
- The response to the friends and family test was low and the hospital performed poorly in the CQC maternity survey. Their maternity safety thermometer assessment of women's perception of safe care was lower than other maternity services.
- Although early warning scores were being used their effectiveness was hampered by staff not adhering to the scheduled frequency.

However, we also found:

- Some areas of concern at the previous inspection had been addressed. For example, there was higher compliance with mandatory training rates, including safeguarding training, delivery suite coordinators were usually supernumerary, staff had a better understanding of mental capacity, consultant cover had improved through a new appointment, CTG traces were securely filed and senior midwives were more visible around the hospital.
- Women received evidence-based care from staff. The unit had specialist midwives, which ensured that women received specialist care suited to their needs.
- Baby security had improved as the reception desks at both entrances from the corridor were now manned 24 hours a day and visitors had to sign in and out. Babies wore an electronic tag which would sound an alarm if they were taken out of the unit.
- There were effective systems to safeguard women and their babies from harm once vulnerabilities had been identified.
- Community midwives covered specific geographical areas thereby ensuring women had access to midwives in their local area.

## Is the service safe?

**Inadequate**  

Our rating of safe went down. We rated it as inadequate because:

# Maternity

- At previous inspections, serious incident reviews and incident reports had highlighted record keeping in patient notes as being below accepted standards. Although we saw some well completed records, standards were inconsistent and not all records were contemporaneous and complete, so the service had not achieved sustained improvement.
- Some staff told us that emergency equipment checks were often cursory and not carried out daily in line with policy. This was evidenced by a spot check of resus equipment on 31 August 2018 (reported as an incident) which had revealed the defibrillator had not been checked for 9 days and a piece of equipment (laryngoscope) was missing from the resuscitation trolley for 31 days.
- At the last inspection, we had concerns about the lack of use of modified early obstetric warning score (MEOWS). Although these were now used, maternity care assistants had no training in carrying them out, and observations were not carried out on a schedule determined by the woman's condition.
- We had concerns about infection control including the cleanliness of clinical equipment. Midwives and doctors not carrying out hand hygiene as they moved around the unit. Hand sanitiser dispensers were not well placed. A number of midwives did not adhere to the uniform policy (including wearing nail varnish and jewellery and keeping hair off the shoulders).
- Waste segregation arrangements did not follow trust policy and we saw overflowing sharps bins and numerous items disposed of in the wrong containers.
- The need for a second theatre in a unit of this size had been rated very high risk since 2013. Just prior to the inspection, a temporary funding arrangement had enabled partial staffing of a second theatre, with an agreement to draw on other staff from the delivery suite. The arrangement was not well understood by staff and was not sustainable.
- Although safeguarding arrangements were robust for the cases identified, there was the potential to miss cases because of language issues, late booking and the transience of some of the population. Not all women were seen alone during the antenatal period. We saw no evidence of any risk assessment tools for exploring child sexual exploitation when mothers were under 18 years.
- The temperatures in some parts of the unit, particularly kitchens were too high to ensure a safe fridge temperature.
- Some medicines were stored inappropriately. We found mixed IV fluids on an unlocked post-partum haemorrhage trolley, and boxes of pessaries for induction of labour in an unlocked freezer in an unlocked room. The log showed no record of these medicines being in the freezer.
- There were several instances where patients' personal information could potentially be viewed or removed by unauthorised people. Patient records were not all stored in lockable cabinets and we saw records left out on tables, stored in unlocked rooms and records without file covers so confidential information was visible.
- Community midwives were not provided with personal safety devices when they were working alone.
- At both the last inspections we observed midwives were overstretched, and we found this on this inspection too: midwives on the delivery suite did not get breaks and worked beyond the end of their shifts. Midwifery skill mix was also a concern. The shortage of experienced midwives affected the amount of supervision they could give to the high proportion of less experienced staff.
- At the previous inspection, there had been a concern about compliance with correct procedures for filing cardiotocography (CTG) records. Although the filing was now secure, we found several CTG traces where staff had not signed, dated and recorded the end time of the CTG on the CTG trace in line with the policy.

# Maternity

- There had been some reduction in the size of the backlog of incidents requiring investigation, but two recent investigations had far exceeded the 60 day time limit. An uneven pattern of compliance over the year indicated the process was not being resourced appropriately to maintain standards.
- Despite the improvement in mandatory training rates midwifery performance did not consistently meet national standards.

However, we also found:

- The service now had systems in place for tracking delays in reporting, investigating and acting on incidents and serious adverse events, and complaints. Other areas of improvements were that delivery suite coordinators were usually supernumerary, CTG traces were securely filed and senior midwives were more visible around the hospital.
- An additional consultant had been appointed to improve medical staffing levels, and another medical appointment had been approved and was covered by a locum pending a permanent appointment.
- Baby security had been tightened though the use of electronic baby tagging and the need for visitors to register with reception before entering the postnatal ward or triage.
- There was a dedicated high dependency (HDU) bay within the delivery suite staffed by nurses and midwives trained in HDU care.

## Is the service effective?

**Requires improvement**  

Our rating of effective went down. We rated it as requires improvement because:

- At the previous inspections, we found that women did not have timely epidurals out of hours. At this inspection, staff working in the delivery suite said waiting times had not improved, and we saw evidence of some long waits, including in working hours.
- Appraisal rates for midwives, other than those working on the delivery suite were low.
- Consent for procedures other than caesarean section was sometimes accepted on the basis of family or friends' translation rather than using language line or an interpreter. There was no written consent for a photograph of a serious wound in medical notes.
- Little general health promotion material was displayed in the antenatal clinics or booking clinic areas, or on the wards to encourage women to live healthier lives and manage their own wellbeing.
- The service did not meet its own target for the rate of caesarean section and had a limited strategy to reduce unnecessary caesarean sections.
- There was room for improvement in multidisciplinary working on the delivery suite.

However, we also found:

- The trust had effective systems in place to ensure policies, protocols and clinical pathways were reviewed regularly and reflected national guidance and legislation. A trust-wide maternity guidelines group oversaw the updating of the maternity guidelines.
- Most women were receiving one to one care and the rate of births in midwifery-led units (24%) was higher than the national average of 14%.

# Maternity

- Bookings within the first 10 weeks of pregnancy were rising (now 57%), above the national average of 56%.
- We observed good multidisciplinary work in safeguarding.
- At a previous inspection we had concerns about staff understanding of mental capacity. Managers had addressed this through mandatory training on the mental capacity act and deprivation of liberty safeguards and understanding had improved

## Is the service caring?

**Requires improvement** ● ➡ ➡

Our rating of caring stayed the same. We rated it as requires improvement because:

- The Friends and Family Test response rate was too low to form a reliable judgement of women's experiences of maternity care at the trust.
- Feedback we had from women about the care they received was mixed. Whilst a number of women and their families spoke favourably of the care they received, some women remarked on experiences of rude or tactless staff.
- Responses to the CQC inpatient survey 2017 were worse than other trusts for 14 out of 16 questions, and the results to patient safety questions in the safety thermometer were lower than many hospitals.
- The information on women's' perception of safety in the Safety thermometer indicated that the proportion of women who were left alone at a time that worried them and with concerns about safety during labour and birth that were not taken seriously were higher, even on the limited data sample, than national standards.
- No women we spoke with were aware of the option to give birth at a different hospital across geographical boundaries. However, staff said they had leaflets that informed women of all four choices of birth place.

However, we also found:

- Specialist staff offered emotional support to women and their families. The support provided included the sensitive management of loss for women suffering miscarriages or stillbirth.
- Staff involved patients and those close to them in decisions about their care and treatment.

## Is the service responsive?

**Requires improvement** ● ➡ ➡

Our rating of responsive stayed the same. We rated it as requires improvement because:

- At the last inspection, time taken to respond to complaints was slow and dissemination of learning from complaints was inconsistent. This was still the case. The hospital took an average of 61 days to investigate and close complaints and there was a backlog.
- There were few leaflets on display and by comparison with other maternity units serving similar populations there was very little information translated into other languages.
- Continuity of midwifery care was only just being introduced. Women having consultant led care did not yet have continuity of midwife care.
- Women could not register for antenatal care online but had to complete a form at the hospital.



# Maternity

- Some non-English speaking women had maternity appointments without an independent interpreter, and friends and family were used to translate. The use of language line or advocates was not always recorded in patient notes.
- There was not a community midwife centre in each area of the borough and the group practice team (covering the E20 postcode) were based in the hospital, so many women had to travel outside their local area for antenatal care.

However, we also found:

- There was evidence that low risk women starting antenatal care now would receive better continuity of care. The group practice had the potential to provide good continuity of care to a small number of women throughout the whole maternity pathway.
- The early pregnancy assessment unit (EPAU) offered a one-stop service with a full range of medical and surgical treatment options to manage miscarriage and ectopic pregnancy
- There were effective arrangements to support women with specific and individual medical and social needs, and staff were seen to be non-judgemental.
- Women deemed low risk could choose to birth at home, at a freestanding birth centre or at the hospital midwifery-led suite.
- Discharge arrangements on the postnatal ward had been a concern at the previous inspection as women were regularly discharged without discharge paperwork. This process had improved. 97.3% of women were discharged with a completed discharge summary in March 2018.

## Is the service well-led?

**Inadequate**  

Our rating of well-led went down. We rated it as inadequate because:

- At our previous inspection we found concerns about safety and governance within the maternity service. At this inspection we found these concerns persisted and were not being addressed in a robust and timely manner. We issued a Section 29a Warning Notice (Health and Social Care Act 2008) and told the trust to take immediate action. Following our inspection, the trust presented us with a comprehensive improvement plan which included strengthening their leadership and governance arrangements, and told us how they were addressing specific concerns found at the time of inspection. A follow up inspection on 14 and 15 January 2019 assessed progress in response to the Section 29A warning notice and found that that staff had made immediate improvements to the main concerns. These areas would need sustained focus, but we no longer considered safety and governance to be inadequate.
- There was no clear vision for the service.
- Management of the maternity service was reactive in response to adverse events or external enquiries. At times the service focused on solving immediate issues without risk assessing the consequences of these actions on the wider service, and there was no governance around such local changes.
- Governance processes did not provide sufficient assurance that senior staff had a sustainable plan for improving key performance issues. The CTG audit in response to the last CQC inspection was overdue by six months.
- There was still no permanent, trust-approved, funding for staffing a second obstetric theatre.

# Maternity

- Senior leaders demonstrated knowledge of the service's performance at a high level and some of the challenges, but showed insufficient awareness of weaknesses in some basic processes. There was little evidence of effective ward level leadership.
- Although the backlog of serious incident investigations had reduced, the two most recently completed investigations had taken eight and six months to complete and actions to embed learning had not been completed. This was too slow to ensure women and babies were safe. Records showed uneven performance over the year on managing incidents and complaints.
- As at the previous inspection, we found the quality of data variable. The hospital gave us conflicting information about the same topic at different times. Those carrying out audits and reviewing incidents reported they were hampered by the quality of documentation and data that was missing altogether. There were insufficient audits of processes to ensure quality was maintained.
- There were risks not on the risk register. For example, performance rated as requiring attention on the maternity and governance dashboards was not identified as a risk on the risk register.
- Communication to staff was more about discrete events rather than sharing a performance overview and engaging staff in improvements. This had been noted in previous inspections. Neither performance dashboards nor the risk register were displayed for staff.
- We received mixed feedback about midwifery leadership and support for staff. Despite some improvements in staff engagement, some staff sought us out on inspection to complain about cliques, favouritism and passive bullying and a perception of unwillingness to listen to staff concerns and investigate them properly.

However, we also found:

- Medical leadership and teamwork appeared good and junior doctors felt they had good training opportunities and were well supported.
- We were told after the inspection that engagement events were planned to involve as many staff as possible in developing a vision for the service and sharing improvement ideas
- Morale of staff working in the birth centre and the group practice was high and they were proud of their achievements in midwifery led births.

## Outstanding practice

- A small pilot 'group practice', in which team of midwives provided continuity of care for women through antenatal, intrapartum and postnatal care for women, had potential as a new model of care. They carried a caseload of a group of women with and without risk factors. The women could expect to see their named midwife for the majority of their antenatal, intrapartum and postnatal care. This would benefit about 2% of women increasing to 10% by 2020.
- The proportion of women birthing under midwifery led care was 25% which is above the national average.

## Areas for improvement

**We found areas for improvement:**

**Actions the provider MUST take to improve:**

- The trust must improve hand hygiene standards and clinical cleaning protocols to prevent the risk of infection. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12)

# Maternity

- The trust must improve the segregation of waste and ensure safe practice in the use of freestanding sharps containers when not in use. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12)
- The trust must improve the accuracy of emergency equipment checks. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12).
- The trust must improve the standard of midwives record keeping to ensure records meet accepted professional standards in being consistently complete and contemporaneous. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17)
- The trust must follow due process when introducing new documentation with piloting and audit. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17)
- The trust must ensure Modified Early Obstetric Warning System (MEOWS) charts are being completed accurately and at the required frequency by trained staff and that escalation is occurring as required. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12)
- The trust must ensure there are effective systems and processes to ensure continual evaluation and improvement of services. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17)
- The trust must ensure there are effective and sustainable systems and processes for the timely investigation of serious incidents and learning from these. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17)
- The trust must take a systematic approach to performance management and appraisal of midwives as a contribution to raising standards. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 18)

## **Actions the provider SHOULD take to improve:**

- The trust should continue to progress the business case for a permanent fully staffed second obstetric theatre.
- The trust should improve governance systems to ensure effective oversight of all risks to the service.
- The trust should develop a vision jointly with staff
- The trust should act to improve temperature control in clinical and non-clinical rooms with fridges.
- The trust should review the content of mandatory training to ensure it supported midwives in meeting professional standards.
- The trust should ensure staff label blood samples as soon as taken.
- The trust should ensure confidentiality of women's records in all areas.
- The trust should ensure staff, women and their families have better access to information in other languages, particularly when consent is required. Staff should stop using friends and families for translation in clinical situations.
- The trust should continue to seek feedback from women about all aspects of the service and use this to make improvements.

# Services for children and young people

Good  

## Key facts and figures

Newham University Hospital is a district general hospital in Plaistow in the London Borough of Newham, East London. The hospital is part of Bart's Health NHS Trust, one of the largest providers of healthcare in the UK. The trust cares for more than 16,000 children and young people each year.

Children and young people's services at Newham University Hospital are consultant-led. Children and young people are admitted for a range of medical and surgical conditions, including oncology, general surgery and ear, nose and throat (ENT) services. Admissions are via the paediatric emergency department, outpatients and waiting lists.

The Rainbow Centre for children and young people opened in February 2017 after a major refurbishment funded by Bart's Charity. The centre's accommodation consists of children's outpatients, day care and inpatient beds. There are five outpatient consulting rooms and two six-bedded bays for day care. Inpatients has seven cubicles, two six-bedded bays and a two-bedded stabilisation unit. All single rooms are en-suite.

The Neonatal Unit (NNU) is a designated level 2 NNU within the North Central and East London Neonatal Network. The NNU had three levels of care that a baby may require: intensive care (two cots), high dependency care (four cots) and special care (17 cots). The level of care provided within the unit allows for all categories of neonatal admissions apart from babies who require complex or long term intensive care.

We visited the children and young people services over three days during our announced inspection. We looked at all neonatal and paediatric clinical areas including the inpatient, outpatient and day care areas of the Rainbow Centre. We also visited all areas of the NNU and paediatric operating theatres.

We observed care and treatment in all areas and we looked at a sample of 10 patient records. We spoke with approximately 40 members of staff, including nurses, doctors, allied health professionals, managers and support staff. We also spoke with 15 patients and their relatives who were using the service at the time of our inspection. We reviewed and used information provided by the organisation in making our decisions about the service.

## Summary of this service

Our rating of this service improved. We rated it as good because:

- The service had taken steps to address the requirement notice set at the previous inspection and there were improvements to all the previous concerns we reported.
- The trust had invested heavily in the new Rainbow Centre and the new environment was clean, tidy and very well-maintained. New equipment on the unit was well-maintained. Infection prevention and control (IPC) was managed safely and effectively, all clinical areas were visibly clean and staff complied with current IPC guidelines.
- There was a good overall safety performance across paediatric and neonatal services and there was culture of learning to ensure safety improvements. Learning was shared from incidents.
- There were appropriate systems for staff to monitor and escalate deteriorating patients. Staff had a good understanding of safeguarding and there were robust security measures in place to prevent unauthorised access to both the Rainbow Centre and neonatal unit. Medicines and Controlled Drugs were stored appropriately and patient records were completed to a good standard.

# Services for children and young people

- Staffing was generally well managed and nurse staffing levels had improved since our previous inspection. Medical staffing was stable, but there was a need for more consultant doctor capacity.
- Care pathways for CYP services were delivered in line with referenced national clinical guidelines. The service conducted routine quantitative and qualitative audits to review and benchmark practice. The hospital participated in local and national clinical audits for which the service performed well against other similar hospitals.
- There were appropriate processes in place to ensure that patients' nutritional and pain relief needs were met.
- Staff reported a supportive and developmental environment with good learning opportunities to maintain and develop their skills and knowledge. Student nurses and doctors in training reported a supportive educational environment with good supervision. There was an effective multidisciplinary team (MDT) working environment which supported patients' health and wellbeing.
- Clinicians were involved in some national research projects as well as local public health promotion initiatives.
- Staff were caring and child-centred and they interacted with patients, their family members and carers in a polite and friendly manner. Children and young people were spoken with in an age appropriate way. The people we spoke with during the inspection were very happy with their care and treatment. Staff spent time with children to help make their experience more comfortable, relaxed and home-like. There were appropriate and sensitive processes for end of life care. The service signposted patients and their families to local services and support groups.
- There were improvements to the post-operative recovery area which was decorated with child friendly transfer images on the walls in a consistent theme with other areas of the CYP service. There were new dedicated family rooms in the Rainbow Centre.
- Flow within children and young people services from admission, through theatres, wards and discharge was mostly managed effectively.
- There was comprehensive provision to meet the individual needs of children and young people, including vulnerable patients and those with specific needs. The hospital had introduced a learning disability 'passport' system to record individual patients' specific needs. There was specific equipment for staff to use to help engage and care for children and young people with learning disabilities. Staff had sufficient access to appropriate translation and advocacy services.
- Parents and families could seek support and advice from a community lead practitioner and could access a family support worker. The hospital play therapist provided a comprehensive programme of play support to children across all paediatric areas. There was sufficient provision of clear and accessible patient literature.
- Most CYP specialities were meeting referral to treatment targets (RTT) and CYP services received very few formal complaints.
- The hospital provided a wide variety of child friendly food and snacks with specific menus for children and young people. The children's outpatients' department was flexible with appointment times and parents told us this better suited their needs.
- There was trust-wide strategy for CYP services which incorporated the Rainbow Centre and neonatal unit. There was an established and stable service leadership team and staff told us they were visible, approachable and supportive. There was improved leadership capacity in the Rainbow Centre with dedicated matrons for the Rainbow Centre and NNU. There was an inclusive and constructive working culture within the services.
- Governance and risk management processes were effective, documentation was completed appropriately and concerns were escalated. There was clear representation of children and young people services at hospital board level.

# Services for children and young people

- There were some examples of innovative practice, including dedicated blood gas analyser machines in the Rainbow Centre and NNU for instantaneous blood test results. The CYP service had also co-designed tailored training for clinicians to equip them with skills to support young people in mental health crisis.

However, we also found:

- Completion of some mandatory training modules, particularly for medical staff was slightly below trust targets. Managers were aware of this and plans were in place to address it.
- Medicines management was generally good; however, at the time of the inspection there was no system for recording the balance of FP10 forms against what was available. We notified the trust pharmacy team and a check process was subsequently put in place.
- Some staff in the NNU told us there was a need for further investment in new equipment on the unit.
- Some doctors in training found the work intensity and acuity challenging and some felt they were working to the limits of their competency and capacity.
- There was limited access to dedicated on-site paediatric allied health professions. Senior staff were aware of this and there were plans to increase staffing in this area.
- Consent processes in CYP services did not always follow best practice as direct consent of the child was not always sought.
- The route from paediatric theatre back to the Rainbow Centre was not optimal, from a patient perspective, as patients had to be transported through the Rainbow Centre reception, which could potentially be distressing for some children.
- Most CYP outpatients' clinics were delivered in the Rainbow Centre, however some services were provided in the main hospital outpatients area which was not a child friendly environment. Senior leaders of the service were aware of this and were working to further consolidate CYP outpatients provision in the Rainbow Centre.
- The hospital had some transition pathways for young people moving from CYP to adult services, however for some services this was more structured than others. Some teenagers we spoke with did not have transition plans in place.
- There were isolated examples of potential risks which were not recorded on the service risk register.
- There were some isolated comments from nurses in the Rainbow Centre and NNU about perceived bullying and harassment and not feeling supported or listened to when they raised concerns, but this was not representative of most of the feedback we received from staff.

## Is the service safe?

Good  

Our rating of safe improved. We rated it as good because:

- At our previous inspection, we found some concerns with infection prevention and control (IPC) processes. During this inspection, we found no concerns with hygiene and IPC was managed safely and effectively. All clinical areas were visibly clean and staff complied with current IPC guidelines.
- At our previous inspection, there were some concerns with maintenance of the CYP estate. Since our last inspection the trust had invested heavily in the new Rainbow Centre and the new environment was clean, tidy and very well-maintained. However, staff in the NNU told us there was a need for further investment in new equipment on the unit.



# Services for children and young people

- There was a good overall safety performance across paediatric and neonatal services and there was culture of learning to ensure safety improvements. Learning from incidents was shared in several ways.
- There were appropriate systems for staff to monitor and escalate deteriorating patients. The service used a paediatric early warning score system which incorporated a sepsis identification tool.
- Staff had a good understanding of safeguarding and were aware of their responsibilities. The service had good multi-agency partnerships to share relevant safeguarding information.
- Equipment was checked regularly and medicines including Controlled Drugs were stored appropriately.
- The patient records and documentation we reviewed across the Rainbow Centre and NNU were completed to a good standard.
- There were robust security measures in place to prevent unauthorised access to the Rainbow Centre and NNU.
- Staffing was generally well managed and nurse staffing levels, turnover rates and sickness levels had improved since our previous inspection. Medical staffing was stable, but there was a need for more consultant doctors across paediatrics and neonates to ensure the service met local targets and could respond to increasing demand.

However, we also found:

- At our previous inspection of the service in November 2016, we set a requirement notice for the service as we found incidents were not always investigated in a timely way. During this inspection, we found most incidents were still not investigated within the 14 day timeframe set by trust policy. However, the service had taken steps to improve and some delays were outside the control of the service.
- Completion of some mandatory training modules, particularly for medical staff was slightly below trust targets. Managers were aware of this and plans were in place to address it.
- Medicines management was generally good, however at the time of the inspection there was no system for recording the balance of FP10 forms against what was available. We notified the trust pharmacy team and a check process was subsequently put in place.
- Some staff reported isolated instances where resuscitaires in the neonatal unit did not have all necessary equipment on them

## Is the service effective?

**Good**  

Our rating of effective improved. We rated it as good because:

- At our previous inspection of the service in November 2016, there was not a robust plan of clinical audit in place to monitor adherence to evidence based practice in the CYP service. During this inspection we found there was an audit plan for routine quantitative and qualitative audits to review and benchmark practice. The trust's central clinical effectiveness unit monitored completion of audits. The results of audits were shared at clinical governance meetings.
- At our previous inspection, some staff on the NNU were not aware of the UNICEF Baby Friendly accreditation programme to support breast feeding. During this inspection the service was completing approval for the programme and had invested in new resources and training to support it.
- At our previous inspection, we found expressed breast milk was not always stored separately from other products. During this inspection, we saw expressed breast milk was stored in separate fridges and freezers.



# Services for children and young people

- At our previous inspection, we found some instances of inadequate post-operative pain management for children. During this inspection, we found effective processes in place to ensure patients' pain relief needs were met and patients told us nurses were responsive to their pain relief needs. Pain was assessed and recorded as part of routine observations.
- At our previous inspection, the rate for paediatric readmissions was higher than the England average. Data for this inspection showed the readmission rate had reduced to 0.5%, in line with the England average of 0.6%.
- The trust's care pathways for CYP services were delivered in line with referenced national clinical guidance. There were effective processes for the identification and implementation of new clinical guidelines.
- Staff could easily access protocols, policies and guidance for clinical and other patient interventions and care on the intranet. Policies were within date and appropriately referenced current good practice and national guidelines.
- There were appropriate processes in place to ensure that patients' nutritional needs were met.
- The hospital participated in several local and national clinical audits for which the service performed well against other similar hospitals. The service was also involved in some research projects.
- Staff reported a supportive and developmental environment with good learning opportunities to maintain and develop their skills and knowledge.
- There was an effective multidisciplinary team (MDT) working environment which supported patients' health and wellbeing. There was effective dialogue and joint working within the service and with other services in the hospital, such as maternity and paediatric emergency department.
- The hospital delivered a full inpatient service for children and young people over seven days with on-site consultant paediatrician availability until 7pm each day per week.
- Senior leaders of the service had a good understanding of local population needs and were planning service delivery to meet those needs. Clinicians were involved in local public health promotion initiatives.
- Student nurse and doctors in training reported a supportive educational environment with good supervision. However, some doctors in training told us they found the work intensity and acuity challenging and they were working to the limits of their competency and capacity.

However, we also found:

- There was limited access to dedicated on-site paediatric allied health professions. Senior staff were aware of this and there were plans to increase staffing in this area.
- Consent processes in CYP services did not always follow best practice. Recorded consent for treatment was completed in full, however direct consent of the child was not always sought. Instead we saw evidence of parental/ carer consent in records. Also, we did not find evidence of consent for day-to-day interventions by clinicians.

## Is the service caring?

Good   

Our rating of caring stayed the same. We rated it as good because:

- Throughout the inspection, we observed staff were caring and child-centred. All clinical staff interacted with patients, their family members and carers in a caring, polite and friendly manner. There was good rapport between nurses and patients.

# Services for children and young people

- All the people we spoke with during the inspection were very happy with the care and treatment provided by the service.
- Staff spent time with children to help make their experience more comfortable, relaxed and home-like, for example by spending time in play and craft making sessions.
- NHS Friends and Family Test (FFT) results were consistently good across children and young people service areas.
- There were appropriate and sensitive processes for end of life care for neonates and children and young people, including emotional support.
- The service signposted patients and their families to local services and support groups to help them build links with others facing similar challenges.
- Staff made sure children and young people were spoken with in an age appropriate way so they understood their treatment and had opportunities to ask questions.

## Is the service responsive?

**Good** ● ↑

Our rating of responsive improved. We rated it as good because:

- At our previous inspection of the service in November 2016, paediatric theatre recovery facilities were not child-friendly. During this inspection, we found improvements to the recovery area which were decorated with child friendly transfer images on the walls in a consistent theme with other areas of the CYP service.
- At our previous inspection, we found limited provision for parents and carers visiting the ward. Since then, the new Rainbow Centre had spaces for parents, carers and family members to use with dedicated 'family rooms' where they could take a break or make food and hot drinks.
- At our previous inspection, there was insufficient provision of patient literature and guidance materials in paediatric and neonatal services. During this inspection we saw there were patient literature stands throughout the Rainbow Centre and neonatal unit (NNU), which provided clear and accessible information on a variety of different subjects. However, one parent in the NNU told us that it would have been useful to have an information pack on arrival to help provide guidance about the service so they knew what to expect.
- The service had comprehensive provision to meet the individual needs of children and young people using services at the hospital, including vulnerable patients and those with specific needs.
- The hospital had introduced a learning disability 'passport' system. It identified individual patients' specific needs. The service was also trialling a clinic for children with learning disabilities to better support their needs with more targeted care.
- There was specific equipment for staff to use to help engage and care for children and young people with learning disabilities, for example multisensory toys.
- Parents and families could seek support and advice from the community lead practitioner and could access a family support worker.
- The hospital play therapist provided a comprehensive programme of play support to children across all paediatric areas.

# Services for children and young people

- There was timely access to children and young people services and most specialities were meeting referral to treatment targets (RTT).
- CYP services received very few formal complaints. All complaints were investigated and closed within the timeframe set in the trust complaints policy.
- Staff had sufficient access to appropriate translation and advocacy services to support patients with English as an additional language.
- The hospital provided a wide variety of child friendly food and snacks and there were specific menus for children and young people. The menus included options for specific cultures, tastes and specific needs.
- The children's outpatients' department was flexible with appointment times and parents told us this better suited their needs.
- The flow within children and young people services from admission, through theatres, wards and discharge was mostly managed effectively and children and young people were transferred from the theatre recovery area to the ward without unnecessary delays.

However, we also found:

- The route from paediatric theatre back to the Rainbow Centre was not optimal, from a patient perspective, as patients had to be transported through the Rainbow Centre reception past the outpatients waiting area. This could potentially be distressing for some children, both as visitors and patients. However, we recognise the limitations of the hospital estate.
- Most CYP outpatients' clinics were delivered in the Rainbow Centre, however some services were provided in the main hospital outpatients area. This environment was not optimal for the care of children and young people as there was no play provision and it was not child friendly. Senior leaders of the service were aware of this and were liaising with other departments in the hospital to make more suitable provision and consolidate CYP outpatients provision in the Rainbow Centre.
- The hospital had some transition pathways for young people moving from CYP to adult services, however for some services this was more structured than others. Some teenagers told us they did not have transition plans in place.

## Is the service well-led?

**Good** ● ↑

Our rating of well-led improved. We rated it as good because:

- At our last inspection of the service in November 2016, there was no clearly documented strategy for CYP services at the hospital. Since then an overarching, trust-wide strategy for CYP services had been developed which incorporated the Rainbow Centre and neonatal unit at Newham University Hospital and articulated plans for the service.
- At our previous inspection, we found agendas for governance meetings did not always reflect the governance meetings terms of reference. During this inspection we reviewed governance documentation and found standardised agendas with regular items for discussion which reflected the terms of reference. Governance meetings were minuted to record all actions and discussion points.

# Services for children and young people

- At our previous inspection, we found some identified risks were not recorded on the service risk register in a timely way and mitigating actions were not clearly documented. During this inspection, we found that senior leaders and managers had good understanding of risks to the service and these were appropriately documented in risk management documentation with named leads and actions. Risks were reviewed each month and there were clear action plans to address them.
- There was an established and stable leadership team in the CYP service. Staff told us senior leaders of the service were visible, approachable and supportive.
- There was an inclusive and constructive working culture within the services with dedicated staff who were positive, knowledgeable and passionate about their work and passionate about caring for children and young people.
- There was clear representation of children and young people services at hospital board level.
- There was improved leadership capacity in the Rainbow Centre since our previous inspection with the recruitment of a new matron. Nurses consistently told us this had resulted in more support for senior nurses.
- There was a dedicated matron for the Neonatal Unit (NNU). Nurses in the NNU told us this was advantageous as it meant neonatal matters were well understood and equally represented in decision making.
- Staff told us there was good communication from the trust and hospital leadership team and they felt that CYP was well represented in the hospital by the divisional senior team.
- There were some examples of innovative practice, including dedicated blood gas analyser machines in the Rainbow Centre and NNU for instantaneous blood test results. The CYP service had also co-designed tailored training for clinicians to equip them with skills to support young people in mental health crisis.

However, we also found:

- There were isolated examples of potential risks which were not recorded on the service risk register. For example, the high temperature of the NNU medications room.
- There were some isolated comments from nurses in the Rainbow Centre and the NNU about perceived bullying and harassment and not feeling supported or listened to when they raised concerns, but this was not representative of most of the feedback we received from staff.

## Outstanding practice

- The trust's investment in the Rainbow Centre had created a coherent, well organised and child-friendly environment. Staff consistently told us the new environment and facilities made a big difference to their work and they felt reinvigorated and motivated by it. Patients and their parents told us the new environment was welcoming and comfortable.
- The trust's investment in new resources for the Rainbow Centre provided some state of the art equipment. For example, the stabilisation room was very well equipped and was well designed with sufficient space for staff and equipment to move around as patients were being stabilised.
- There were dedicated indoor and outdoor play spaces for young children. The outdoor area included a garden zone, a 'chill out' hut for teenagers, and a dedicated secure space for parents to store their buggies away from the clinical area. The ward also had a dedicated adolescents' room to provide a separate space for older children.

# Services for children and young people

- The service had invested in dedicated blood gas analyser machines for the Rainbow Centre and Neonatal Unit. This meant clinicians could obtain instantaneous blood test results. All nurses, doctors and health care assistants in both units were trained to use the machines and this made test response times much more rapid. This was not frequently seen in other units of this size in other NHS trusts.
- The CYP service frequently cared for patients with mental health support needs, including some vulnerable and at-risk young people in crisis. The service worked in partnership with the local NHS mental health and community trust to develop a training package called 'We Can talk' to equip clinicians with the skills to support patients in mental health crisis when they are receiving urgent medical treatment. Young people with mental health conditions, charity organisations and mental health professionals were involved in developing the training. The Trust had developed a training toolkit for hospital staff which was the only programme of its kind in the NHS.

## Areas for improvement

### **We found areas for improvement:**

#### **Action the provider SHOULD take to improve:**

- The trust should ensure all staff in the service complete required mandatory training to improve compliance with the trust's target for completion.
- The trust should review consent training and processes to ensure all clinicians understand their responsibilities for obtaining and recording the direct consent of children and young people in patient records (in cases where the child can consent), including consent for routine clinical interventions.
- The trust should review staffing levels to ensure there are sufficient numbers of consultant doctors in paediatric and neonatal service.
- The trust should introduce measures to record the balance of FP10 forms.
- The trust should review doctor in training rotas to ensure there is sufficient capacity and competency for the complexity and volume of clinical activity in the Rainbow Centre and neonatal unit.
- The trust should ensure there is sufficient access to dedicated on-site paediatric allied health professions, including but not limited to physiotherapy and speech and language therapy.
- The trust should ensure parents in the NNU have access to information and resources that provide guidance about the service.
- The trust should review the route from paediatric theatre back to the Rainbow Centre to ensure it is optimised.
- The trust should further consolidate paediatric outpatients' clinics in the Rainbow Centre.
- The trust should improve the environment in the main hospital outpatients' unit so it is more child friendly.
- The trust should review transition pathways for young people moving from CYP to adult services and improve provision where gaps are identified.
- The trust should engage different grades of staff working in the service to identify potentially unrecorded risks and ensure all such risks are recorded and escalated as appropriate.
- The trust should ensure all staff are supported and listened to when they raise concerns.

# End of life care

Requires improvement   

## Key facts and figures

End of life care (EoLC) encompasses all care given to patients nearing the end of their life and following death. Patients received care in any ward or within any service in a trust. It includes aspects of essential nursing care, specialist palliative care, bereavement support and mortuary services.

The definition of end of life includes patients who are 'approaching the end of life' when they are likely to die within the next 12 months. This includes patients whose death is imminent (expected within a few hours or days) and those with:

- advanced, progressive, incurable conditions,
- general frailty and co-existing conditions that mean they are expected to die within 12 months,
- existing conditions that put them at risk of dying if there is a sudden acute crisis in that condition,
- life-threatening acute conditions caused by sudden catastrophic events.

End of life care was provided on most wards at Newham University Hospital (NUH), which is a 344 bed district general hospital. There were 529 patient deaths at Newham University Hospital between April 2017 and March 2018.

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

During our inspection, we spoke with five patients and their relatives. We also spoke with 29 members of staff, which included the consultant lead for palliative care, the SPC team, mortuary staff, chaplain, general nursing staff, medical staff, bereavement officer and porters. We observed care and treatment within the wards, reviewed 13 care records and 28 Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) forms. We reviewed the trust's performance data relating to end of life and palliative care.

## Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- Whilst the service had an education strategy for end of life care, the trust did not follow the national standard for end of life care training for all staff, as end of life care training was not mandatory. End of life training was mandated by the National Care of the Dying Audit of Hospitals (NCDAH) 2014-2015 across all staff groups.
- There was no robust system to identify review and learn from information that related to end of life care or performance measures for the specialist palliative care team to report on.
- Alarm checks of the DHU temperatures out of hours and at weekends were not being monitored by security staff on a two-hourly basis as detailed in the 'Newham Mortuary Temporary Body Fridges Alarm Escalation Procedure Out of Hours'. However, the trust provided evidence to show that the checks undertaken exceeded best practice guidance according to the Human Tissue Authority.

# End of life care

- Most of the ward staff we spoke with had not received formal training in syringe drivers.
- Incidents related to deceased patients were reported but not discussed at the end of life steering group. It was not clear how learning from these incidents were shared with the wider service.
- Pain assessments and pain scores were not completed consistently.
- The end of life service was not meeting the National Institute for Health and Care Excellence (NICE) guidelines for adults to provide palliative care services face-to-face seven days a week. This had not changed since the last inspection in November 2016.
- Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms were not always completed correctly. This meant that the trust could not be assured that DNACPR decision were made appropriately and were in line with national guidance.
- Although we saw evidence that palliative and end of life care patients had plans of care which included the patients preferred place of death, the service had not consistently collected data to evaluate this.
- Although the Compassionate Care Plan was in place, there was variation in how consistently this was completed.
- Medical staffing in the SPCT was 0.9 whole time consultants (WTE). This was an increase of 0.4WTE since the last inspection. The trust recognised that consultant levels were still below the 'Helping to deliver commissioning objectives' (Dec 2012) based upon the total number of hospital beds.

However, we also found:

- The trust had further developed the end of life care strategy and an action plan for delivery was in place.
- Staff we spoke with told us the specialist palliative care team were very visible and accessible and worked collaboratively with staff on the wards in providing end of life care. Staff were positive about the support provided by the specialist palliative care team.
- The specialist palliative care team were knowledgeable about their role and responsibilities regarding the safeguarding of vulnerable adults and children.
- During our last inspection we found poor standards of cleanliness and upkeep in the mortuary. At this inspection we found end of life care facilities provided for the use of patients and their families were visibly clean, tidy and well maintained. this included the multi-faith rooms and the viewing room. Cleaning schedules in the DHU were now in place.
- Medicines were readily available to patients requiring treatment for palliative and EoLC. The specialist palliative care team worked closely with medical staff on the wards to support the prescription of anticipatory medicines. Since the last inspection a clinical nurse specialist in palliative medicine had been trained as a non-medical prescriber.
- The specialist palliative care team had access to the liaison psychiatry service provided by a neighbouring mental health trust
- End of life care policies and procedures were based on national guidance and the trusts strategy was based on the 'Ambitions for palliative and end of life care: a national framework for local action 2015 – 2020'.
- The service had enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- Staff treated people with dignity, respect and kindness. Staff were seen to be considerate and empathetic towards patients. Feedback from relatives was very positive about the staff and felt they could ask staff questions about their loved one's care and treatment.



# End of life care

- Staff provided emotional support to patients to minimise their distress.
- Staff involved patients and those close to them in decisions about their care and treatment. Feedback from relatives confirmed the staff communicated with them and their relative in a way that helped them understand their care, treatment and condition.
- The trusts bereavement policy took account of different faiths and cultures in how to deal with death.

## Is the service safe?

**Requires improvement** ● ➡ ➡

Our rating of safe stayed the same. We rated it as requires improvement because:

- Most of the ward staff we spoke with had not received formal training in syringe drivers.
- Incidents related to deceased patients were reported but not discussed at the end of life steering group. It was not clear how learning from these incidents were shared with the wider service.
- Medical staffing in the SPCT was 0.9 whole time consultants (WTE). This was an increase of 0.4WTE since the last inspection. The trust recognised that consultant levels were still below the 'Helping to deliver commissioning objectives' (Dec 2012) based upon the total number of hospital beds.
- Alarm checks of the DHU temperatures out of hours and at weekends were not being monitored by security staff on a two-hourly basis as detailed in the 'Newham Mortuary Temporary Body Fridges Alarm Escalation Procedure Out of Hours'. However, the trust provided evidence to show that the checks undertaken exceeded best practice guidance according to the Human Tissue Authority.

However, we also found:

- The specialist palliative care team (SPCT) were knowledgeable about their role and responsibilities regarding the safeguarding of vulnerable adults and children.
- During our last inspection we found poor standards of cleanliness and upkeep in the mortuary. At this inspection we found end of life care facilities provided for the use of patients and their families were visibly clean, tidy and well maintained. this included the multi-faith rooms and the viewing room. Cleaning schedules in the mortuary were now in place.
- Medicines were readily available to patients requiring treatment for palliative and EoLC. The specialist palliative care team worked closely with medical staff on the wards to support the prescription of anticipatory medicines. Since the last inspection a clinical nurse specialist in palliative medicine had been trained as a non-medical prescriber.
- The SPCT had access to the liaison psychiatry service provided by a neighbouring mental health trust.

## Is the service effective?

**Requires improvement** ● ➡ ➡

Our rating of effective stayed the same. We rated it as requires improvement because:

- Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms were not always completed correctly. This meant that the trust could not be assured that DNACPR decision were made appropriately and were in line with national guidance.

# End of life care

- Pain assessments and pain scores were not completed consistently.
- The end of life service was not meeting the National Institute for Health and Care Excellence (NICE) guidelines for adults to provide palliative care services face-to-face seven days a week. This had not changed since the last inspection in November 2016.

However, we also found:

- End of life care policies and procedures were based on national guidance and the trusts strategy was based on the 'Ambitions for palliative and end of life care: a national framework for local action 2015 – 2020'.
- The service had enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- The end of life care service had an audit programme to collect information about patients care and treatment.
- Mental capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) training was covered as part of the adults safeguarding level 2 training

## Is the service caring?

**Good** ● ↑

Our rating of caring improved. We rated it as good because:

- Staff treated people with dignity, respect and kindness. Staff were seen to be considerate and empathetic towards patients. Feedback from relatives was very positive about the staff and felt they could ask staff questions about their loved one's care and treatment.
- Staff provided emotional support to patients to minimise their distress.
- Staff involved patients and those close to them in decisions about their care and treatment. Feedback from relatives confirmed the staff communicated with them and their relative in a way that helped them understand their care, treatment and condition.

## Is the service responsive?

**Good** ● ↑

Our rating of responsive improved. We rated it as good because:

- The last inspection in November 2016 found there was a lack of facilities for dying patients and their relative. We found this had improved.
- The SPCT responded in an effective and timely way to referrals.
- The service worked well with GPs and community teams to ensure rapid discharge for palliative patients.
- The trusts bereavement policy took account of different faiths and cultures in how to deal with death.

However, we also found:

- Although we saw evidence that palliative and end of life care patients had plans of care which included the patients preferred place of death, the service had not consistently collected data to evaluate this.

# End of life care

- Whilst the service had a procedure in place for the prioritisation of side rooms for patients who were end of life care, the use of single rooms was prioritised for patients who required isolation and patients at the end of life were sometimes cared for on open wards.
- Although the Compassionate Care Plan was in place, there was variation in how consistently this was completed.

## Is the service well-led?

**Requires improvement** ● ➡ ⬅

Our rating of well-led stayed the same. We rated it as requires improvement because:

- The service could improve the way it collected, analysed and used information to evaluate the effectiveness and performance of end of life care services.
- Whilst the service had an education strategy for end of life care, the trust did not follow the national standard for end of life care training for all staff, as end of life care training was not mandatory. End of life training was mandated by the National Care of the Dying Audit of Hospitals (NCDAH) 2014-2015 across all staff groups.
- There was no robust system to identify review and learn from information that related to end of life care or performance measures for the specialist palliative care team to report on.

However, we also found:

- The trust had further developed the end of life care strategy and an action plan for delivery was in place.
- Staff we spoke with told us the specialist palliative care team were very visible and accessible and worked collaboratively with staff on the wards in providing end of life care. Staff were positive about the support provided by the specialist palliative care team.

## Outstanding practice

**We found areas for improvement:**

**Action the provider MUST take to improve:**

- The trust must ensure effective systems and processes are in place to determine the quality and safety of end of life care provided at ward level and by the specialist palliative care team. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17)
- The trust must ensure that Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms are completed consistently and correctly. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17)

**Action the provider SHOULD take to improve:**

- The trust should ensure there is a system to identify, review and learn from incidents that relate to end of life care.
- The trust should ensure the national standard for end of life care training is mandatory for all staff.
- The trust should ensure the 'Newham Mortuary Temporary Body Fridges Alarm Escalation Procedure Out of Hours' is followed.

# End of life care

- The trust should ensure pain assessments and pain scores are completed consistently.
- The trust should ensure the Compassionate Care Plan is completed consistently.
- The trust should ensure the end of life care service consistently collects data to evaluate the number of patients who were supported to die at their preferred place of death.
- The trust should ensure it meets the NICE guidelines for adults to provide palliative care services face-to-face seven days a week.

# Outpatients

Requires improvement



## Key facts and figures

Outpatient services at Bart's Health NHS Trust is provided at all five hospital sites: The Royal London Hospital, Whipps Cross Hospital, St Bartholomew's Hospital, Mile End Hospital and Newham University Hospital. The trust saw around 1.48 million outpatient attendances in 2017/18.

Up until mid August 2018 there was a mixed operating model, however responsibility and management for outpatients was devolved to hospital sites from this time. This included central appointments, phlebotomy, clinic reception and out-patient nursing. Management of medical records was retained by Clinical Support Services (CSS).

St Bartholomew's Hospital and Newham University Hospital manage most of their new patient bookings with CSS providing reception of clinics and medical records. This model is under review with an aim to offer a standardised site based operating model for outpatient services across the trust. A team manage outpatient services across the sites with around 500 front line booking, reception, nursing, phlebotomy and medical records staff, who are site based but managed by the central team.

While CSS manage large elements of the booking and reception functions, responsibility for referral to treatment time and income generation sits with the hospital sites. A key focus for 2018/19 is the national requirement for all trusts to stop accepting paper referrals from GPs, and instead accept bookings only via the Electronic Referral Service (ERS). The trust is due to go live with this process July-September 2018.

## Summary of this service

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings. We rated the service as requires improvement because:

- The hospital was not undertaking medical records audits but we were told by the general manager that they planned to do this soon. This had been raised in our last inspection. Further to our inspection, we were however provided with data to show that the service was monitoring notes availability, showing results of 95% and 94% in March and June respectively, against a target threshold of 95% - 98%.
- Medical records did not always arrive with a patient's referral letter.
- The service was not participating in any national audits.
- The only local audits that the service was participating in were hand hygiene and medicines management audits.
- Data showed that the service still had a high ratio of follow-up patients to new patients.
- Though the service had introduced some targeted work to address the high DNA (did not attend) rate, the rate was still higher than the England average and was the highest out of all hospitals within the trust.
- The West Wing waiting area, which was run by a different division, did not provide adequate space or privacy for patients, despite this being raised as an issue in the last inspection.
- Though the trust had only started reporting RTT again since April 2018, the performance of RTT from this date to August 2018, showed results of 85% against a trust target of 92%.

# Outpatients

- Though risks were being effectively managed, the service only had one risk on their risk register, despite high DNA rates and follow-up rates.
- The service had just entered into a new site based structure, which meant that it was difficult for us to appraise the leadership.
- Though the service had plans to monitor patient outcomes in the near future, they were not currently being monitored at the time of our inspection.

However, we also found:

- Improvements had been made in compliance with Infection Prevention and Control training, though compliance will still slightly under target threshold. Hand gel sanitisers were visible, full and in use across the outpatient areas that we had visited. The Health Central Outpatients Department, had week-on-week 100% hand hygiene compliance between May 2018 and August 2018.
- Staff were 100% compliant in Safeguarding Adults Training Level 1 and 2. Staff were also 100% compliant in Level 1, 2 and 3 Safeguarding Children Training.
- Improvements had been made with staff being able to access the electronic system to report incidents, as well as receiving feedback following incidents that had been submitted.
- All staff members bar one had received an appraisal, with clear objectives being set out, which hadn't been the case previously. The remaining appraisal date had been organised.
- We saw episodes of good care with patients and carers being in full understanding of what was being explained to them.
- Patient satisfaction forms showed that patients were extremely likely to recommend the service to friends and family if they needed similar care or treatment.
- Patient waiting times were clearly articulated to patients, both on a notice board and through nurse announcements.
- The trust was performing better than the England average for cancer waiting times.
- Between September 2017 and August 2018 there were 3 complaints which went through the formal complaints process. In addition there were 20 complaints received through PALS. For the formal complaints, all were responded to within 25 days.
- The culture within the outpatient's service was described by staff and managers as good, with senior staff being described as very supportive.
- Under the new structure for outpatient services, several new meetings had been devised such as an Outpatients Transformation Board, where any decisions or changes to the new site-based structure would be discussed.

## Is the service safe?

**Good** 

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings. We rated it as good because:

# Outpatients

- Improvements had been made in compliance with Infection Prevention and Control training, though compliance will still slightly under target threshold. Hand gel sanitisers were visible, full and in use across the outpatient areas that we had visited. The Health Central Outpatients Department, had week-on-week 100% hand hygiene compliance between May 2018 and August 2018.
- Staff were 100% compliant in Safeguarding Adults Training Level 1 and 2. Staff were also 100% compliant in Level 1, 2 and 3 Safeguarding Children Training.
- Of the 16 items of equipment that we had looked at, 15 had received a PAT testing. For the item that hadn't, we observed the sister in the department take immediate action.
- Improvements had been made with staff being able to access the electronic system to report incidents, as well as receiving feedback following incidents that had been submitted.
- Staff were seen to be present in patient waiting areas and we saw examples of patients who needed assistance, who were approached very promptly by a member of staff.
- There were few vacancies in the service and where there were, they had been recruited into. Nursing staff generally felt that that staffing levels had improved.

However, we also found:

- The hospital was not undertaking medical records audits but we were told by the general manager that they planned to do this soon. This had been raised in our last inspection. Further to our inspection, we were however provided with data to show that the service was monitoring notes availability, showing results of 95% and 94% in March and June respectively, against a target threshold of 95% - 98%.
- Medical records sometimes did not always arrive with a patient's referral letter, which would then constitute an incident form needing to be completed.

## Is the service effective?

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings. We do not currently rate effective as a domain for outpatient services.

- Staff spoken to, in addition to data submitted by the hospital indicated that with exception of one member of staff, all others had received an appraisal, with clear objectives being set out, which hadn't been the case previously.
- We saw several episodes where effective multidisciplinary working was taking place between professionals and respectful interactions between clinicians and nursing staff.
- There was 100% compliance from staff in MCA and DoLS training.
- One stop clinics were held in the following specialities: dementia, breast, transient ischaemic attacks and diabetes for new appointments.

However, we also found:

- The service was not participating in any national audits.
- The only local audits that the service was participating in were hand hygiene and medicines management audits.
- Data showed that the trust still had a high ratio of follow-up patients to new patients.



# Outpatients

## Is the service caring?

**Good** 

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings. We rated it as good because:

- We saw episodes of good care with patients and carers being in full understanding of what was being explained to them.
- Patient satisfaction forms showed that patients were extremely likely to recommend the service to friends and family if they needed similar care or treatment.
- We spoke with 10 patients who all confirmed that all staff from clinicians to receptionists were all very nice and polite.
- We observed that privacy and dignity of patients was respected at all times in the consulting rooms.

## Is the service responsive?

**Requires improvement** 

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings. We rated it as requires improvement because:

- Though the service had introduced some targeted work to address the high DNA rate, the rate was still higher than the England average and was the highest out of all hospitals within the trust
- The West Wing waiting area, which was run by a different division, still did not provide adequate space or privacy for patients, despite this being raised as an issue in the last inspection.
- Though the trust had only started reporting RTT again since April 2018, the performance of RTT from this date to August 2018, showed results of 85% against a trust target of 92%.

However, we also found:

- Between September 2017 and August 2018 there were 3 complaints which went through the formal complaints process. In addition there were 20 complaints received through PALS. For the formal complaints, all were responded to within 25 days.
- Patient waiting times were clearly articulated to patients, both on a notice board and through nurse announcements
- Information regarding chaperoning services was being displayed both in the waiting areas and clinic rooms within the department. We also observed an example of where a patient had been offered a chaperone and utilised having one for the duration of their appointment.
- The trust was performing better than the England average for cancer waiting times.

## Is the service well-led?

**Requires improvement** 

# Outpatients

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings. We rated it as good because:

- Though risks were being effectively managed, the service only had one risk on their risk register, despite high DNA rates and follow-up rates.
- The service had just entered into a new site based structure, which meant that it was difficult for us to appraise the leadership.
- Though the service had plans to monitor patient outcomes in the near future, they were not currently being monitored at the time of our inspection.

However, we also found:

- The culture within the outpatient's service was described as good, with senior staff being described as very supportive.
- Under the new structure which outpatients now sat under, several new meetings had been devised such as an Outpatients Transformation Board, where any decisions or changes to the new site-based structure would be discussed.
- The service now had a strategy in place which all staff were aware of.

## Areas for improvement

**We found areas for improvement:**

**Actions the provider SHOULD take to improve:**

- The trust should ensure that medical records audits are being undertaken to check for legibility and completeness of patient's notes.
- The trust should ensure that they are measuring patient outcomes for the service.
- The trust should take steps to improve the DNA rate.
- The trust should take further steps to improve RTT performance.
- The trust should ensure that complaints are investigated and closed on time in line with the trust's policy.
- The trust should review the risk register process.

# Diagnostic imaging

**Requires improvement**



## Key facts and figures

The imaging department at Newham University Hospital performs approximately 11,500 examinations per month, and provides a service to GPs, mental health, out-patients, in-patients and a 24/7 service to the emergency department, theatres and wards.

The trust provides clinical services for:

- Ultrasound
- Computed Tomography (CT)
- Magnetic Resonance Imaging (MRI)
- Plain Film X-ray
- Fluoroscopy
- Nuclear Medicine
- Endoscopic retrograde cholangio-pancreatography (ERCP)
- Mammography

Our inspection was announced and took place between 19th and 20th September 2018. We returned for an additional unannounced day on the 3rd October. We spoke with 22 members of staff including nurses, porters, service managers, administrative staff, radiographers, specialist doctors and radiologists. We also spoke with 12 patients and relatives who were in the department at the time of the inspection and looked at eight sets of patient records.

We reviewed and used information provided by the trust in making our decisions about the service.

We previously inspected diagnostic imaging jointly with outpatients, so we cannot compare our new ratings directly with previous ratings.

## Summary of this service

We rated it as requires improvement because:

- Staff we spoke with from different areas in the diagnostic imaging department could not describe with confidence learning from a recent incident. Some staff referenced a radiation incident in 2015 involving overexposure. However, no more recent incidents could be described.
- The service had no schedule in place for quality assurance testing of the home computers. There was no assurance of Digital Imaging and Communications (DICOM) grey scale display function compliance.
- During our inspection we found that hospital in-patients were transported into the department without qualified escorts. We escalated this to the department lead who agreed it was unsafe practice. The department lead decided to rectify this.

# Diagnostic imaging

- There were long-standing concerns on the risk register about equipment and environment which were not addressed in a timely manner. Staff were under pressure due to extra patients being imaged on remaining working equipment. The service told us remaining kit requiring replacement was considered and prioritised based on risk.
- On inspection, we saw patients from the different modalities were in the scanning workstation area often together prior to examination. This led to issues regarding infection control, privacy and dignity, data protection, and patient and staff safety.
- We found radiographers did not have clear oversight of who or what types of examinations non-medical referrers were able to request.
- The radiation protection team had identified that there were a high number of non-medical referrers who didn't have imaging referral as part of their scope of practice. This increased risks to patients receiving an incorrect examination and radiation they did not need to be exposed too.
- Regular audits against IR(ME)R procedures and clinical audits in CT and ultrasound were not undertaken. This meant that the department was unable to demonstrate they were meeting the necessary requirements.
- On inspection we saw band five radiographers were working outside their scope of practice regarding protocolling, working unsupervised and they were at times in charge of the department. We were told there was no possibility of promotion, little or no CPD time or ability of space to conduct feedback regarding the examinations they had completed.
- We found that the service did not have a systematic programme of clinical and internal audit to monitor quality, operational and financial processes and systems to identify where action should be taken.
- Staff we spoke with described an over-busy work setting that was not sustainable. We noted there was a common theme of mistrust within staff to make an official complaint for fear of harassment.
- The lack of internal audit meant that potential issues were not discussed at governance meetings.

However, we also found:

- Patients we spoke with were positive about the support they received from staff throughout the diagnostic imaging department.
- We observed that radiographers and medical staff took time to explain to patients and relatives the progress of their procedure. Patients and relatives told us they were kept informed of what was happening and understood what tests or scans they were waiting for.
- Radiologists described good working between themselves and GP services to ensure that patients were managed appropriately. Staff gave examples where patients received a well-coordinated patient-centred experience because of good communication between primary care (the day-to-day healthcare of patient, typically provided by a GP) and the hospital.
- During inspection, we observed excellent teamwork. Staff were patient orientated and were willing to assist each other to complete tasks. All staff spoke highly about their direct line manager and the department lead.

## Is the service safe?

**Requires improvement**



We rated it as requires improvement because:

# Diagnostic imaging

- Equipment brought into the department weekly was left outside clinic rooms within the corridor. This was a hazard within the corridors.
- On inspection, we saw patients from CT and MRI were in the scanning workstation area often together prior to examination. This led to issues regarding infection control, data protection, and patient and staff safety.
- Patients being cared for on medical wards were brought into the department without qualified escorts. On inspection we saw an elderly and confused patient with a naso-gastric (NG) tube unaccompanied. We escalated this situation to the department lead and other managers who agreed that the incident was unsafe and unacceptable and dealt with the situation immediately.
- We saw that the title and professional registration number of the reporter were not being routinely entered at the end of clinical radiology reports, as per Royal College of Radiology (RCR) standards. This was rectified and addressed during the time of inspection.
- We did not find evidence that clinical audits were being undertaken within the service to ensure that the requesting referral of an x-ray or other radiation diagnostic test, for example by GPs or other clinicians, was made in accordance with IR(ME)R or (MHRA) safety recommendations.
- Staff we spoke with could not describe with confidence learning from a recent incident.

However, we also found:

- Staff were knowledgeable about the trust's safeguarding policies and their role and responsibilities. Staff could give examples of what constituted a safeguarding concern and how they could raise an alert.
- All areas within the department were visibly clean. We observed staff cleaning equipment after use. Staff completed daily cleaning logs of equipment and placed.
- All imaging rooms were clearly signposted with "Do Not Enter" warning lights to ensure staff or patients did not enter rooms whilst imaging was taking place.
- Staff knew what appropriate action to take if a patient became unwell or distressed while waiting for, or having a scan.
- We saw that medicines were stored safely and securely with access only by authorised staff.

## Is the service effective?

We do not currently rate effective in diagnostic imaging. However, we found:

- Clinical audits were not being undertaken routinely to ensure that the requesting referral was made in accordance with IR(ME)R or The Medicines and Healthcare Products Regulatory Agency (MHRA) safety recommendations.
- We requested minutes of audit meetings. The trust was unable to provide this information.
- We were unable to confirm 50% attendance rate to the discrepancy meetings as per RCR standards. The trust was unable to provide minutes from these meetings.
- The World Health Organisation (WHO) Surgical Safety Checklist: for radiological interventions was not in use for interventional procedures within the department. The service did not undertake WHO surgical safety checklist audits.
- There was reliance dependent on a single imaging department assistant to cannulate who covered both CT and MRI. In the event of the imaging department assistants' absence this was completed by those radiographers who had been signed off as appropriately trained to cannulate.

# Diagnostic imaging

However, we also found:

- Patients we spoke with told us they knew what procedure they were having and that staff always asked for consent before proceeding.
- Emergency services were available 24 hours a day, seven days a week for MRI, CT and plain X-ray. This included portable machines (such as plain film X-ray and ultrasound) for use in theatres.
- Radiologists described a good working relationship with other specialities in the hospital to ensure that safe and logical clinical decisions were made about patients care and welfare.
- There was evidence of CPD for radiographers, however, this was not consistent in all areas and for all staff. Although training sessions and lunchtime learning events were held, we were told that staff found it difficult to attend.

## Is the service caring?

**Good** 

We rated it as good because:

- Staff communicated in a caring and supportive manner. Feedback from patients confirmed that staff were friendly, approachable and professional. We observed the staff answer patient and carer queries with clarity.
- Confidentiality was respected in staff discussions with patients and those close to them.
- Staff provided emotional support to patients to minimise their distress. Staff spent time reassuring patients and explained the procedure in depth with reasoning.
- Staff understood the importance of chaperones and provided them upon request.
- Patients felt involved in planning their care, making choices and informed decisions about their care and treatment. We observed staff communicating in a way that people could understand and was appropriate and respectful.

However, we also found:

- Patients' dignity could not be maintained at all time. During inspection we observed a patient on a trolley part exposed waiting in the centre of the waiting room next to seated patients
- The co-location of MRI and CT compromised patients' privacy and dignity.

## Is the service responsive?

We rated it as requires improvement because:

- Some patient waiting areas were small and not patient centred. The waiting area for accident and emergency x-ray was particularly small with no designated area for paediatric patients (children) or patients in trolleys to wait.
- It was difficult to fully segregate male and female patients who had changed into hospital gowns while waiting for their examination.
- Staff told us patients were encouraged to bring friends or relatives to appointments to help translate, instead of utilising translation services.
- We were told complaints were reviewed and discussed at the monthly governance meetings. However, we saw no consistent evidence of this in meeting minutes provided to us.

# Diagnostic imaging

However, we also found:

- The service was currently performing better than the England average for the percentage of patients receiving their diagnostic imaging tests within six weeks
- All the diagnostic imaging areas had an established extended day, on-call and or a seven-day working pattern. This enabled patients to be seen at times to suit their needs.
- DM01 (diagnostic waiting times) data provided by the trust displayed consistent achievement of 100% at NUH from September 2017 to August 2018.

## Is the service well-led?

**Inadequate**



We rated it as inadequate because:

- Staff stated that leadership of the clinical support services were not visible or approachable.
- Staff described themselves as highly stressed in a hardworking environment.
- Staff described a culture of fear if they were to raise any concerns. There was a common theme of mistrust within staff to make an official complaint for fear of harassment. Staff were unwilling to elaborate further for fear of reprisal.
- Modality leads did not have scheduled time to perform management duties and were part of the on-call rota so could be away from work for several days during the week leaving their modalities without management to support more junior members of staff.
- We found there were long-standing concerns on the risk register about equipment and environment which had not been addressed. The service told us remaining kit requiring replacement was considered and prioritised based on risk.
- The service had no schedule in place for quality assurance testing of the home-based computers. There was no assurance of Digital Imaging and Communications (DICOM) grey scale display function compliance.
- Staff we spoke with discussed how because of being busy they had to perform tasks which were above their banding which made them feel uncomfortable. We were told that band five radiographers were “Left to run the department” and authorised CT scans which radiologists deemed inappropriate due to lack of training and experience.
- During our examination of electronic records, we noted that some plain film scans appeared not to have been reported on by a radiologist. Although there was a standard operating procedure in place to monitor unreported scans, we had concerns that the systems in place did not record or highlight these patients effectively and there was a risk of patient harm due to the lack of processes.
- Radiologists described a stressful environment for reporting of on call studies and meeting demands of CT/MRI investigations, particularly outpatient two week wait patients.

However, we also found:

- The diagnostic imaging department was part of the trust’s clinical support services. The diagnostic imaging team was established with experienced staff that provided clinical and professional leadership by supporting and appraising junior staff.



# Diagnostic imaging

- The service had a systematic programme of clinical and internal audit to monitor quality, operational and financial processes and systems to identify where action should be taken. The lack of internal audit meant that potential issues were not discussed at governance meetings.
- Despite the cultural concerns, all staff we spoke with were positive about the local site based manager. Staff told us the site manager was very responsive and well respected.
- All staff reported that local leadership within the department was very strong, with visible, supportive and approachable modality team leaders.
- During inspection, we observed excellent teamwork. Staff were patient orientated and were willing to assist each other to complete tasks.

## Areas for improvement

### **We found areas for improvement:**

#### **Actions the trust MUST take to improve:**

- The trust must ensure there are quality assurance checks of equipment used by radiologists in their own homes. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 15)

#### **Actions the provider SHOULD take to improve:**

- The trust should address the cultural issue of fear of harassment and reprisal within the department as a priority.
- The trust should consider a more robust and sustainable solution to ensure patients within the CT and MRI console area are unable to view other patients' examinations on the screen or see other patients having procedures.
- The trust should undertake clinical audits within the service to ensure that the requesting referral of an x-ray or other radiation diagnostic test are made in accordance with IR(ME)R or (MHRA) safety recommendations.
- The trust should ensure patients transported into the department from medical wards have adequate qualified escorts.
- The trust should prioritise radiographers undertaking cannulation training.
- The trust should undertake regular audits against IR(ME)R procedures.
- The trust should support reporting radiographers to report regularly within normal working hours.

# Whipps Cross University Hospital

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[www.whippsx.nhs.uk](http://www.whippsx.nhs.uk)

## Key facts and figures

Whipps Cross University Hospital was founded around the 1900s during World War 1 where the infirmary was used to treat wounded troops. The Hospital also housed London's first hyperbaric unit. A redevelopment of the site planned for 2012 (costing £350m) was abandoned after the withdrawal of one potential PFI partner. Subsequent plans to redevelop the hospital in stages has also been put on hold whilst financial turnaround is in progress. The redevelopment of the A&E Department finished before the 2012 Summer Olympics on the 9 May 2012.

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

The hospital serves a diverse local population of more than 350,000 people from Waltham Forest, Redbridge, Epping Forest and further afield. The area has a wide variation in levels of deprivation and health needs, ranging from the most deprived five per cent to amongst the most affluent 30 per cent of electoral wards in England. Waltham Forest comes 15th out of 326 with nearly 48% of the population from minority ethnic communities.

Each site has a Hospital Management Board and a senior leadership team, led by the Executive Managing Director, with a site Medical Director, Nursing Director and Director of Operations.

The trust is managed by a board of directors comprising nine executive and eight non-executive directors. The trust has seven clinical board which includes Cancer, Cardiovascular, Children's Health, Emergency Medical, Surgery and Women's.

### Key achievements for 2016/2017:

- 475,159 Emergency cases (18,118 more than last year)
- 1,486,151 outpatient appointments (32,288 more than last year)
- 16,452 births
- 43,449 people coming through the doors every week (1,123 more than last year)
- 201,590 in-patient operations and procedures (11,521 more than last year)

# Summary of findings

The CQC last inspected critical care, medical care and the emergency department when it last undertook a comprehensive inspection of the hospital in July 2016. Since then, we conducted two inspections of the hospital's surgical services in May 2017 and April 2018. We also inspected the hospital's outpatient and diagnostic services and End of Life in May 2017.

## Summary of services at Whipps Cross University Hospital

### Requires improvement

Our rating of services stayed the same. We rated it them as requires improvement because:

- Since our last inspection of acute services at Whipps Cross Hospital in 2016, 2017 and 2018, the trust had addressed or shown improvement for most of the previously reported concerns and requirement notices, for which we commend them. Evident improvements included significantly improved standards of care, dignity and privacy in medical care, the improved culture around medicines management, and improved record keeping in surgery. However, we found several areas of improvement to address such as the pockets of bullying in the emergency department and the maintenance of equipment and the environment.
- Although the trust had improved referral to waiting times (RTT) in the surgical service, further improvement was required to ensure the trust was meeting the national standard. In outpatients, only one specialty met the national RTT target.
- In outpatients, we also found substantial waiting lists for clinic appointments with relatively high cancellation and did not attend rates. Although rebooking and follow-up practices varied between specialties, individual specialties such as ophthalmology scheduled ad-hoc clinics to reduce waiting lists and meet local demand.
- Patient flow within the hospital remained an ongoing challenge and impacted other services such as bed occupancy in critical care. In the surgical service, late starts, patients discharge out of hours and cancelled operations had not improved.
- The trust did not meet the Department of Health's standard of 95% for time to treatment and decision to admit, transfer or discharge. Performance between January and July 2018 (86%) was worse than the England average but just above the London average (85.8%).
- Although the trust had improved the culture in areas such as the eye treatment centre in outpatients and medical care services, we found pockets of bullying in the emergency department which the leadership team did not have oversight of.
- Staff feedback on development opportunities varied between each service. In medical care, doctors in training were very positive about the support and teaching they received whilst outpatients staff told us they had inconsistent access to training and development opportunities.
- The trust did not provide up to date monitoring data for mandatory training, staff vacancies, sickness and turnover rates and appraisal completion rates for outpatient services. Similarly, in diagnostics, the trust did not provide a breakdown of mandatory training compliance rates for nursing or medical staff by module.
- Although the trust had shown improvement in staffing levels in some services, the trust still had challenges with staffing in some of the services we inspected. The emergency department had high nursing and consultant vacancy rates. Managers told us processes in human resources (HR) had contributed to delays for the appointed nurses from overseas to start.

# Summary of findings

- The availability of equipment continued to present challenges for staff in some services. The diagnostic service had a significant amount of aging equipment which was prone to breakdown which had resulted in clinic delays and early closure. Surgical staff witnessed similar issues in accessing equipment or getting broken equipment repaired despite the trust making a significant investment in replacing equipment which urgently needed replacing.
- The diagnostic service had no schedule in place for quality assurance testing of the home computers and did not complete regular quality assurance checks on equipment including mobiles, despite being advised to do so by the medical physics expert's advice.
- Although senior leaders and service managers had, for the most part, a good understanding of risks to the service, the trust did not have oversight of some issues despite them being logged on the risk register. Service leads did not mitigate risks appropriately in some instances. Radiographers raised concerns about personal safety at night due to the location of an equipment. Although the service lead was aware of this and had acquired an additional machine, the location had still not been determined.
- Although the fire safety group and operations team had improved fire safety in the hospital, we found partially blocked fire escapes routes on Cedar ward and Faraday ward and a lack of assurance around fire safety within outpatients, including poor organisation we observed during an evacuation.
- The trust's response rate to the NHS Friends and Family Test (FFT) had been lower than the national average. Staff told us the low response rates were due to the trust recently changing to an electronic method of collecting FFT data and individual teams had developed initiatives to address this.

However, we also found:

- The trust had addressed the warning notice issued for medicines management in the April 2018 inspection of surgical services. In most cases, we found improvement in the storage of medicines and Controlled Drugs and improved staff awareness of policies overall. However, further improvements were still required for example with tracking the dispensing of pre-packs.
- Most staff had good awareness of incident reporting, how to raise concerns and duty of candour. There was an open culture of incident reporting and a willingness to learn from incidents for most services except for outpatient services.
- There were comprehensive, clearly defined and embedded processes to protect people from abuse. Staff were knowledgeable about safeguarding and were confident to escalate concerns. Staff were aware of their responsibilities as set out in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).
- All areas of the hospital we inspected were visibly clean, tidy, and clutter free with adequate supplies of personal protective equipment (PPE) available for use when required. Although we observed good compliance with infection prevention and control across the hospital, hand hygiene audit results for the emergency department required significant improvement.
- The trust had introduced measures to better anticipate and manage patient risks including an improved integration of the national early warnings scores (NEWS) system. Although staff had good knowledge of what to do in the event of a patient deteriorating, we found inconsistent NEWS documentation in patient records in the emergency department.
- Throughout our inspection, we saw consistent evidence of effective multidisciplinary team (MDT) working across all disciplines and wards. Ward staff worked closely with staff across acute and community services as well as practitioners in the local health economy.
- Staff demonstrated compassion to patients and their relatives in all the services we inspected. Patients told us they felt listened to by health professionals and felt informed and involved in their treatment and plans of care. However, there were some isolated incidents where patients felt staff were too busy to provide the support they needed.

# Summary of findings

- Most people using the trust's services were treated with dignity and respect with significant improvements in medical care. However, we found patient dignity and privacy was compromised in the GP x-ray department changing area and in outpatients where there was a lack of screens for procedures such as taking blood pressure.
- Staff delivered patient care in line with good practice and evidence-based guidance from relevant bodies. Most of the staff we spoke with told us they could easily access policies and guidelines on the trust intranet.
- Dedicated teams provided care to patients living with dementia or a learning disability and support to staff using national resources to aid communication. Although, the trust had recently refurbished three medical wards to national dementia friendly standards, the emergency department and outpatients' environments were not dementia friendly.
- The trust had only one learning disability clinical nurse specialist across all the trust sites. However, staff within the pre-assessment unit took innovative steps and had developed a patient passport having researched the needs of patients living with a learning disability.
- Although the estates remained a challenge for the trust and obtaining funding for site re-development was an ongoing piece of work, the trust had still made improvements to the environment to provide a better and safer patient experience. However, the outpatients' environment required further improvement.
- The trust's nurse education team provided specialist training opportunities to clinical staff, including simulations and interactive workshops. Some services had practice development nurses (PDN) who provided training to update nursing skills.
- The trust had a range of services available to support patients. For example, bereavement services, 24-hour chaplaincy and access to translation and advocacy services for patient where English was their second language.
- The service dealt with concerns and complaints appropriately and investigated them in the required time frame including future actions and any learning for staff.
- Most staff we spoke with felt they were listened to by service and trust leadership and felt they could approach managers if they needed support.
- A patient forum provided oversight of care standards and presented their experiences in board meetings in line with the trust's engagement strategy.
- Most of the services we inspected had shown improvements in implementing a strategy for the service. Services such as critical care, the emergency department and medical care had developed a strategy with staff involvement and with external partners with a focus on the frail elderly.
- Leadership structures were clearly embedded for most services except for outpatient services. The trust had made notable improvements in the governance structure in the surgical and medical service.

# Urgent and emergency services

Requires improvement   

## Key facts and figures

Urgent and Emergency services at Whipps Cross University Hospital serve the local community 24 hours a day, seven days a week. There were 135,765 attendances between August 2017 and August 2018. Of these, 102,239 (75%) were adults and 33,526 (25%) were children. Seventy per cent of adult attendees were over 70 years of age.

The emergency department comprised of the following areas:

- An urgent care centre (UCC) which acted as a bridge between primary care and the emergency department. Patients in the UCC were potentially manageable in a primary care setting or managed according to a number of locally approved pathways. The UCC was managed by a neighbouring foundation trust.
- Initial Assessment area, where patients were streamed to other parts of the emergency department.
- Majors area for the assessment and treatment of major illness with 24 cubicles and two additional cubicles for sensitive examinations.
- Resuscitation area with six resuscitation cubicles, one of which was a dedicated paediatric bay.
- Clinical Decision Unit with seven beds.
- A paediatric emergency department with five cubicles and two five-bedded areas; one where patients waited to be triaged by a nurse or seen by a doctor and the other which was a clinical decision unit.

Patients presented to the department either by ambulance through a dedicated ambulance only entrance or by walking into the reception area.

The service was previously inspected in July 2016 and was rated as 'requires improvement' overall. At the time, safe, responsive and well-led domains were rated as 'requires improvement' and good in effective and caring.

Our inspection was announced (staff knew we were coming) to ensure that everyone we needed to speak with was available and took place between 11 and 13 September 2018. We looked at 14 sets of adult patient records, two sets of paediatric patient records and six sets from the mental health liaison service. We spoke with 39 members of staff including doctors, nurses, managers, support staff, administrative staff and site security staff. We also spoke with eight patients and two relatives who were in the department at the time of the inspection. We reviewed and used information provided by the trust in making our decisions about the service.

## Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- We found at the last inspection there was inconsistent recording of national early warning scores (recording NEWS) to identify deteriorating patients. During this inspection, we found there was poor use of NEWS, as well as pressure ulcer risk assessments and hourly vital signs.
- Similar to the last inspection, the departmental performance averaged 86% which was below the Department of Health's standard for emergency departments that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department.
- Matron's audits showed there was poor hand hygiene practice in the department.

# Urgent and emergency services

- There was no re-audit planned of the lower performing standards in 2016/17 Royal College of Emergency Medicine (RCEM) audits.
- Some staff told us they felt bullied at times by the way in which senior staff pressured them in order to meet key performance targets.

However, we also found:

- At the last CQC inspection in December 2016, there was no dedicated place of safety room which could be used by patients detained under the Mental Health Act or with mental health conditions. During this inspection we found the trust had developed a room which provided a better and safer patient experience.
- There was an improved leadership and clinical governance structure in place that continued to address outstanding departmental issues.
- Staff were encouraged to raise concerns and to report incidents and near misses. The division effectively shared learning from incidents and good practice with staff through regular meetings, e-mails and departmental newsletters.
- Emergency department staff appropriately managed, administered and monitored rapid tranquilisation.
- We saw how staff showed understanding and a non-judgmental attitude when talking about patients with mental health needs, learning disabilities, autism or dementia.
- There was evidence of increased admission avoidance in the over 65 patient group which was linked with increased multidisciplinary working in the emergency department.

## Is the service safe?

**Requires improvement** ● ➔ ➜

Our rating of safe stayed the same. We rated it as requires improvement because:

- There was inconsistent patient record documentation similar to the findings in the previous CQC inspection. This included national early warning scores (NEWS) to identify deteriorating patients; pressure ulcer risk assessment and hourly vital sign records.
- Medical staff were not fully compliant with mandatory training.
- Matron's audits indicated recent hand hygiene results varied between 40% and 65%
- There were high nursing (41%) and consultant (31%) vacancy rates. Shifts were filled with agency, bank and locum staff.

However, we also found:

- We found at the last CQC inspection in December 2016, there was no dedicated place of safety room which could be used by patients detained under the Mental Health Act or with mental health conditions. During this inspection we found the trust had developed a room which provided a better and safer patient experience.
- There was improved incident reporting and shared learning. Serious incident details and learning were e-mailed out to all staff and included in the emergency department newsletter and as a theme of the fortnight, discussed in safety huddles.



# Urgent and emergency services

- The trust had a rapid tranquilisation (RT) policy and flow-chart in place that included the physical healthcare observations required in relation to administration of RT. Records showed that staff appropriately administered and monitored RT.
- All the infection prevention and control standard operating procedures we reviewed were up to date and accessible by staff on the hospital intranet.

## Is the service effective?

**Good** ● → ←

Our rating of effective stayed the same. We rated it as good because:

- We commented in the last CQC inspection in July 2016 that there was poor multidisciplinary (MDT) with other professionals and departments. This was improved and evident in the day-to-day operation of the department. We observed how doctors and nurses communicated with each other and saw that other specialties came to the department to offer support and review their patients. There was evidence of multidisciplinary training with other specialties, for example orthopaedics, anaesthetics and allied healthcare professionals.
- There was improved screening of patients over 75 years old for dementia. This was facilitated by members of the admission avoidance team.
- Staff followed national professional standards and guidelines to achieve the best possible outcomes for patients receiving care and treatment.
- The department undertook local Commissioning for Quality & Innovation (CQUIN) projects to improve patient experience; for example study of pain score in adults and increased use of fascia-iliaca pain block (FIB).
- Policies were regularly updated and based on National Institute for Clinical Excellence and best practice guidelines. They were accessible to staff on the trust intranet.
- Practice development nurses held regular daily teaching sessions in the department for all available staff. They were proactive in planning and initiating learning development to meet varied training needs for staff.
- Appraisal rates for nursing staff (97%) and non-registered support staff (95%) were above the trust standard of 90%.
- Staff we spoke with had a good working knowledge of the law around consent and consent was documented in patient records.
- A Quality, Innovation, Productivity and Prevention (QIPP) study of pain score in adults was carried out. The Royal College of Emergency Medicine best practice guidance states that 'patients in severe pain should have the effectiveness of analgesia re-evaluated within 30 minutes of receiving the first dose of analgesia'. Results showed 64% of patients had their pain re-evaluated compared with the initial score of 54%.
- Patients and relatives were frequently offered water, tea and coffee from a trolley situated in a corner of the emergency department.

However, we also found:

- There was no re-audit done of the lower performing standards in 2016/17 Royal College of Emergency Medicine (RCEM) Moderate and acute severe asthma audit and 2016/17 Consultant sign-off audit.

# Urgent and emergency services

- A re-audit of paediatric pain assessment and management in the emergency department showed deteriorated results from the initial audit. Forty one percent of patients had their pain score documented at triage compared with original audit result of 62%. Practice development nurses planned to include pain reassessment and pain scoring in training for all paediatric ED nurses.

## Is the service caring?

**Good** ● ➡ ➡

Our rating of caring stayed the same. We rated it as good because:

- Medical, nursing and support staff introduced themselves to patients before commencing an examination.
- All members of staff took great care to ensure patient dignity was not compromised including in public waiting areas. They closed cubicle curtains and patients on trolleys in public areas were covered with a blanket.
- Doctors and nurses introduced themselves to patients and carers before undertaking an examination.
- We saw several examples of staff being caring and supportive to patients and their relatives.
- Patients we spoke with felt involved in their care and expressed confidence in the care received. Patients felt involved in the decision making process of their care.
- Staff demonstrated understanding and a non-judgmental attitude when talking about patients with mental health needs, learning disabilities, autism or dementia.

However, we also found:

- The urgent and emergency care Friends and Family Test performance between December 2017 and July 2018 was between 70% and 80% which was worse than the England average (87%) from December 2017 to July 2018. This was based on generally low response rates, for example, 8% of patients and relatives gave feedback in August 2018.
- The emergency department environment lacked dementia friendly decoration or equipment such as a clock in the emergency department.

## Is the service responsive?

**Requires improvement** ● ➡ ➡

Our rating of responsive stayed the same. We rated it as requires improvement because:

- The department did not meet the Department of Health's standard for emergency departments which states that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department.
- Performance between January and July 2018 (86%) was worse than the England average.
- From August 2017 to July 2018, the trust's monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was generally worse than the England average.
- From August 2017 to July 2018, the median total time in the emergency department for all patients was higher than the England average.

However, we also found:

# Urgent and emergency services

- During the last inspection, we found the needs of frequent attender patients and those with mental health needs were not always prioritised. During this inspection, we confirmed there was a clinical champion for frequent attenders. They devised an action plan for this patient group which included weekly multidisciplinary meetings with the admission avoidance team and liaison with outpatient department and community based services.
- Emergency department staff worked closely with the admissions avoidance team and frailty assessment unit to provide a safe and effective service to frail elderly patients. There was evidence of increased admission avoidance in this patient group as a result.
- Operational guidelines for the clinical decision unit were appropriately applied which meant it was responsive to the needs of patients who were discharged to home as soon as possible.

## Is the service well-led?

Good  

Our rating of well-led improved. We rated it as good because:

- At the last inspection, we found that there was no strategic plan in place for the emergency department. Since then, a new leadership structure was initiated with strengthened local decision making and improved links to board level. The ED strategy was shared with us and included workforce development and improved performance.
- At the last inspection, we found that there were risks on the register with no clearly indicated actions to reduce any of these risks recorded. This was no longer the case; there was improved oversight and regular updating of risks which outlined ways in which the risks were reduced.
- There was a defined clinical governance structure in place, introduced since the time of the last inspection. This included a framework of governance meetings which addressed outstanding departmental issues, including risk and patient safety.
- Leaders were realistic about the challenges they faced in order to continue to improve the delivery of service and make it more sustainable.
- Most members of staff told us they were familiar with all the leadership team, who were visible and often around the department.
- There was a sense amongst most staff that they were an integral part of the overall continued improvement of the department. They told us they did their best to promote the trust values of 'WeCare' (welcoming, engaging, collaborative, accountable, respectful and equitable).
- We found that clinical and nursing staff we spoke with were aware of the top departmental risks and were similar to those listed by the leadership team.
- Innovative multidisciplinary practice around early intervention in the patient pathway evidenced improvements in patient's functional levels and independence. This resulted in admission avoidance for a significant number of patients.

However, we also found:

- The senior leadership team was relatively new and some members needed more time to become fully familiar with the operational aspects and governance expectations of the department.
- Members of the leadership team were unaware of situations where staff felt bullied and experienced rudeness and general poor behaviour from certain line managers.

# Urgent and emergency services

## Areas for improvement

**We found areas for improvement:**

**Actions the provider SHOULD take to improve:**

- The trust should ensure there is improved patient record documentation.
- The trust should continue taking steps to improve hand hygiene.
- The trust should ensure that the environment within the emergency department is dementia friendly.
- The trust should seek to improve their four-hour performance.
- The trust should actively work towards eliminating bullying in the department.

# Medical care (including older people's care)

Good  

## Key facts and figures

Acute medical care provision at Whipps Cross Hospital is provided by a dedicated acute physician team, including acute geriatricians, and delivers medical care to a 60 bedded Acute Assessment Unit (AAU) and provides acute medical cover for the Emergency Department (ED) in hours. Out of hours medical cover is rostered via an on-call system. Weekend ward rounds and discharge rounds are undertaken by an Acute/Medical Consultant team. The acute medical referrals are supported by a 10 bedded Frail Elderly Unit (FAU), with a dedicated team, admission avoidance service and acutely run Ambulatory Care Unit (ACU) in hours and weekends. Inpatient medical and elderly ward base comprises of six speciality medical wards, with a total of 107 beds.

Specialty medicine inpatient care is delivered by specialty teams such as respiratory, gastroenterology, diabetes and endocrine and cardiology, as well as rheumatology and neurology providing inpatient care by referral.

Elderly Care is delivered by a dedicated team of geriatricians (five elderly wards with a total of 102 beds). The Elderly Medical team also support the inpatient rehab ward with 19 beds. The Acute Stroke Unit has 19 inpatient beds and a dedicated stroke team. An ortho-geriatrician also supports orthopaedic wards. Elderly patients, if required post discharge, are followed up by multi-disciplinary team at Connaught Day Hospital for on-going assessment and treatment. All medical and elderly wards have dedicated consultant-led ward/board rounds on a daily basis.

The trust had 87,427 medical admissions from April 2017 to March 2018. Emergency admissions accounted for 42,691 (48.8%), 5,040 (5.7%) were elective, and the remaining 39,696 (45.4%) were day case.

Admissions for the top three medical specialties across the trust were:

- General medicine: 24,413
- Gastroenterology: 22,946
- Cardiology: 11,059

*(Source: Hospital Episode Statistics)*

Care and treatment was provided through 16 medical specialties or services and we included the endoscopy service in our inspection.

We last inspected this service in July 2016 and rated each domain as requires improvement, with a requires improvement rating overall. We told the trust they must:

- Improve bed management and discharge processes.
- Ensure patients who had an infectious condition were appropriately managed in ward areas.
- Improve compliance with venous thromboembolism assessments.
- Improve the organisational culture and reduce instances of bullying.
- Ensure patients were treated with care, compassion, dignity and privacy.
- Act on patient's pain needs.
- Improve staffing levels.
- Ensure staff received appropriate training, support and opportunities for professional development.

# Medical care (including older people's care)

- Ensure good governance systems were embedded in practice.
- Ensure ward-based staff receive sufficient handover, to include infectious patients.
- Ensure all patients are screened for malnutrition.

We also told the trust they should make 14 other improvements including improving standards of practice in relation to the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS).

We carried out our announced inspection at Whipps Cross Hospital medical wards from 11 to 13 September 2018. We carried out an unannounced inspection on 29 September 2018. We found the trust had made progress in improving these areas, including significant improvements in the working culture, privacy and dignity of patients and governance processes.

During our inspection we inspected all medical inpatient wards, the acute assessment unit, the ambulatory care unit and the discharge lounge. We included Sycamore ward and Rowan ward in our inspection. Both are surgical wards that regularly provide care for medical patients as outliers. We also met with senior staff from the end of life care team and the HIV service.

We spoke with 51 members of staff in each medical service at representing a range of roles and levels of seniority. This included agency and locum staff and staff providing services to patients and visitors through third party contractual arrangements. We also spoke with 23 patients and nine relatives and carers and two volunteers. We reviewed local and national audit data, trust policies and patient records. We reviewed over 170 other items of evidence.

## Summary of this service

Our rating of this service improved. We rated it as good because:

- Following our last inspection in July 2016, we issued a requirement notice requiring the service to act to remedy breaches to Regulation 17 (2) (a) and 17 (2) (b), in relation to assessing, monitoring and improving quality and safety. We also issued seven actions the provider should take to improve. During this inspection, the service had dealt with or shown improvement for most of the previously reported concerns.
- Staffing levels across most services had shown improvement and some were recruited fully to establishment. Where recruitment remained challenging for specific wards, leadership teams had developed initiatives to make existing staffing levels more reliable.
- Staff delivered care and treatment in line with national guidance and standards and reviewed trust policies to ensure they were always up to date. Specialist teams benchmarked care using national audits and implemented action plans where standards fell short. The hospital had achieved a maximum level A in the Sentinel Stroke National Audit Programme (SSNAP) between December 2017 and June 2018.
- There was extensive evidence of well-structured, cross-discipline engagement and professional development that contributed to a better skilled workforce and more specialist services for patients.
- There was substantial evidence of improvement work as a result of audits, engagement and feedback. Where specialist teams identified opportunities for learning, they implemented action plans that were ambitious, innovative and evidence-based.

# Medical care (including older people's care)

- There was a demonstrable focus on ensuring safeguarding was a key focus of every member of staff and of all care delivered in the hospital. This was evident from the highly visible, proactive work of the safeguarding team to increase training and discussions and to update the trust policy in a way that would be useful to staff.
- Patients and their relatives described staff that were kind, attentive and friendly. They noted how well doctors included them in discussions about their care and that staff adapted communication styles to help them understand.
- Staff at all levels of responsibility were empowered and confident and demonstrated substantive positivity about a new working environment and culture that recognised their contribution. This was a significant improvement from our last inspection in 2016 and staff offered numerous, wide-ranging examples of how the work culture had improved.
- Senior ward and divisional staff used incidents, complaints and performance track records to identify opportunities for learning. They implemented this thoroughly, with training, supervisions and structured team meetings. This was evident in all areas we inspected and included specialist teams such as the pain team and safeguarding teams.
- Staff based service development and reconfiguration on the needs of the local population and had a demonstrable, detailed understanding of these. This included facilitating more streamlined working with community providers and colleagues and establishing greater input of social care professionals in care planning.
- Senior divisional staff had acted on feedback from staff survey results to improve the health and wellbeing of their teams, provide more opportunities for professional development and establish opportunities for frequent structured meetings with colleagues.

However, we also found:

- Vacancy rates for some clinical roles were significantly higher than trust targets, although the impact on services was minimised with the use of long-term locum doctors.
- Trust operations staff worked closely with the security team but there were areas of persistent risk in relation to security.
- Fire safety and operations staff had significantly increased and improved practical training but there was a need for more consistent oversight on some wards.
- Pharmacy and ward teams had not established an effective system for the removal of expired or excess stock of controlled drugs.

## Is the service safe?

**Good**  

Our rating of safe improved. We rated it as good because:

- Completion of mandatory training was consistently good. Nurses met or exceeded the trust's 85% target for completion of all subjects and medical staff met or exceeded this for 20 out of 24 subjects, with the remaining four within 3% of the target. All required staff exceeded the trust's minimum requirements for the completion of safeguarding training. This reflected a significant improvement from our last inspection.
- Safeguarding practices were embedded and we saw consistently good examples of action to protect vulnerable people from harm. The safeguarding lead was reviewing trust policies in response to feedback from community safeguarding staff, which reflected a culture of openness and learning.



# Medical care (including older people's care)

- The fire safety group and operations team had significantly improved fire safety in the hospital through more advanced training, the establishment of first responder teams and a proactive approach to learning from incidents elsewhere.
- During our last inspection we identified concerns around the consistent completion of venous thromboembolism (VTE) assessments. During this inspection, we found this had improved as medical services consistently met the 95% trust target for VTE risk assessments.
- The ageing estate presented significant challenges to staff in maintaining good standards of infection control, which they demonstrated through following best practice guidance.
- Several processes were in place to assess and respond to patient risk, including a patient response team and improved integration of the national early warnings scores (NEWS) system. Staff had addressed areas for improvement we found during our previous inspection.
- Although the nurse vacancy rate was higher than the trust target, there had been a significant improvement in recruitment and retention since our last inspection in 2016. For example, in January 2017 the AAU had a nurse vacancy rate of 50%. In September 2018 the service was fully recruited. This represented a significant improvement from our last inspection.
- Data from the NHS Safety Thermometer indicated a trend of reductions in falls, hospital-acquired pressure ulcers and catheter acquired urinary tract infections. Some wards had no instances of these for over 12 months and staff said this reflected better risk assessment processes led by more stable staff teams.
- Most ward areas were visibly clean and well maintained, with regular thorough cleaning by a dedicated team. This team consistently completed checklists to evidence their work and patients commented on the cleanliness of their care environment unprompted during our conversations with them.
- Incident reporting systems were well established and we saw examples of effective learning from the outcomes of investigations.

However, we also found:

- There was limited evidence of sustained improvement from the annual records audit and there was a need for significant improvement in some aspects of preadmission documentation.
- Medical staffing in the stroke unit was reliant on locum doctors and there was a lack of clinical ownership and support as a result.
- On-call consultant cover for cardiology out of hours was provided on a remote, off-site basis and there was limited on-call cover from doctors above foundation level. However, established escalation processes were in place to manage patient risk.
- There were some gaps in security oversight in some parts of the hospital, including around fire escape routes and access to clinical areas.
- Completion rates for life support training amongst nurses was variable.
- Not every ward complied with best practice standards of storage and management of controlled drugs (CDs), including non-compliance with the Misuse of Drugs (Safe Custody) Regulations (1973) on Acacia ward.
- Although staff implemented an action plan for the outcomes of serious incident investigations, there was a lack of assurance these were always followed through. This included a gap of at least six months in signing off the action plan following an incident involving the sub-optimal care of the deteriorating patient.

# Medical care (including older people's care)

## Is the service effective?

**Good**  

Our rating of effective improved. We rated it as good because:

- Staff delivered care and treatment that adhered to national standards and guidance, including from the National Institute of Care and Excellence and royal colleges relating to individual specialties.
- Multidisciplinary teams used a system of reviews and assessments to ensure patients who were cared for as outliers on wards outside of the clinical specialty had appropriate care.
- During our last inspection we found gaps in education and learning provision. At this inspection we found staff had significantly improved this. The nurse education team provided specialist training opportunities to clinical staff, including simulations and interactive workshops. A consultant lead in education improved teaching and learning opportunities for junior doctors, including through participating in audits and research.
- The end of life care team was leading a substantial training and development programme for staff across medical services. This addressed previous feedback from relatives and aimed to improve staff application of mental capacity assessments.
- The pain team had acted on results from a pain management audit that indicated a need for improved staff training and engagement.
- During our last inspection, staff did not consistently assess patients for malnutrition. At this inspection, staff had embedded more consistent processes in managing nutrition and hydration, including in the use of the malnutrition universal scoring tool (MUST).
- A dedicated admission avoidance team worked in acute medicine and worked with clinical teams to identify alternative opportunities for care to avoid unnecessary hospital admissions.
- Staff spoke positively of the appraisal process and said they received structured, meaningful support from their line manager to progress.
- Multidisciplinary teams across specialties worked together to review patients regularly and ensure their care and treatment plan remained appropriate. Reviews were frequent, comprehensive, well-coordinated and included community and social care professionals.
- Consultant cover was provided in all specialist services seven days a week with varying levels of cover from other medical staff. Out of hours cover was provided through an on-call system. Social workers, physiotherapists and occupational therapists were on site seven days per week.
- Health promotion was embedded in all areas of the hospital and staff provided tailored support and signposting to patients and their visitors. Individual teams organised health promotion events and awareness days, such as for World Sepsis Day and HIV Testing Week.
- Staff training, knowledge and practice of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS) was good and appropriate to their individual role and level of seniority.

However, we also found:

- Patients had a higher than expected risk of readmission for elective and non-elective admissions than the national average.

# Medical care (including older people's care)

- A shortage of allied health professionals at weekends in Peace ward, which provided stroke services, meant patients did not always have sufficient therapy.

## Is the service caring?

**Good** ● ↑

Our rating of caring improved. We rated it as good because:

- During our last inspection, we found staff did not always ensure patient dignity and privacy. At this inspection, we found significantly improved standards of care, dignity and privacy. Staff demonstrated attention to detail in providing care that was personalised, kind and treated people with respect.
- Dignity was a clear focus in all wards we inspected. Staff ensured patients were comfortable and noticed when a situation may compromise their dignity or privacy and took subtle, appropriate action.
- Feedback from patients and their relatives was consistently very good and they spoke emphatically and positively about how staff treated them. Patients noted staff provided emotional support when they were feeling sad or anxious and always found time to talk to them.
- The response rate to the NHS Friends and Family Test had been lower than the national average and individual teams had developed initiatives to address this.
- Staff were patient and resourceful in communicating with patients with complex needs or barriers to verbal communication, including those living with dementia or a learning disability.
- Counselling, bereavement and multi-faith chaplaincy services were readily available.
- Patients and relatives described non-clinical staff as very caring, friendly and welcoming. Patients told us they had built positive relationships with housekeeping and catering staff and that they looked forward to talking to them every day. This provided patients with companionship and reduced the risk of social isolation.
- We found numerous examples of how staff went out of their way to provide care to patients over and above their clinical needs. This included, braiding a patient's hair to make them feel more presentable and arranging a birthday cake for a patient with no family.

However:

- Although patients told us doctors always involved them in care and treatment planning, this was not always documented in medical records. This was reflected in audit results and in our review of a sample of patient records.

## Is the service responsive?

**Good** ● ↑

Our rating of responsive improved. We rated it as good because:

- Between April 2017 and March 2018, the average length of stay for medical elective patients was lower than the national average and was similar to the national average for non-elective patients.
- Between January 2018 and August 2018, the hospital reduced the number of patients who were moved at night.

# Medical care (including older people's care)

- Specialist services demonstrated their understanding of the needs of the local population through service development reconfiguration. This included an expansion of the end of life care team, direct links with the British Red Cross for social support on discharge and reconfiguring stroke and rehabilitation beds.
- Three wards had been refurbished to national dementia friendly specification, including the provision of day rooms painted in colours known to help patients establish coordination and reduce anxiety. Future upgrades for other wards included plans to adapt the environment for patients living with dementia.
- Staff had developed a series of admission avoidance, fast track discharge and specialist care pathways. This ensured patients received appropriate care when they were treated as outliers in wards outside of their specialist service and helped to coordinate discharge for patients who could be better cared for in the community. This represented a significant improvement from our findings at our last inspection.
- Significant work had been completed to develop a dedicated frailty pathway and promote more integrated older people's services with community and social care colleagues. This had resulted in demonstrably more individualised care for older people in the hospital that addressed their specific physical and social needs.
- A dedicated patient ambassador was based on each ward and provided a link between the clinical team and the senior facilities contractors, including through ensuring patients had access to food and drink options.
- Dedicated teams provided care to patients and support to staff living with dementia or a learning disability. They supported ward staff to use national resources to aid communication and provided extended support to carers.
- A range of services were available to support patients in their recovery that were additional to clinical treatment, including complementary therapy and sleep therapy. Therapies teams were developing additional opportunities for young people to help them self-manage their conditions and provided relatives and patients with relief from the impact of their treatment.
- Ward managers and senior divisional staff tracked complaints and addressed themes or trends, in addition to investigating each individual complaint. There was evidence of learning and changed processes as a result of complaints.

However, we also found:

- Although staff identified novel and individual methods of communicating with patients who did not speak English, they did not always use safeguarding processes to protect patients when family members translated for them.
- Demand exceeded the capacity of the service in endoscopy for emergency referrals and patients could wait up to 48 hours to be seen. However, staff had adapted the service to ensure it was flexible to mitigate this as far as possible.
- Patients who required procedures under the cardiology specialty had to be transferred elsewhere in the trust. This resulted in waits of up to five days for some patients and added significant pressure to nurse teams.
- Although the trust had improved and expanded the emergency care system, clinical staff described significant challenges in managing the flow of patients through the AAU.

## Is the service well-led?

**Good**  

Our rating of well-led improved. We rated it as good because:

- Leadership structures were clearly embedded and staff felt they worked well to support the delivery of good standards of care. Junior staff had access to leadership development pathways.

# Medical care (including older people's care)

- Divisional and specialist services teams had developed their own strategies based on the trust's overarching vision and strategy and transformation priorities. This enabled teams to drive forward the trust's goals whilst adapting these to their own service and patient's needs.
- Senior staff were acting on staff survey results and had arranged a series of engagement events. This included the end of life care team who had implemented an action plan and significantly improved training and interaction with ward teams as a result.
- Staff reported broad improvements in satisfaction and wellbeing, including amongst junior doctors and through better integration of the acute medical team.
- Each ward used a monthly quality, safety and performance monitoring system to identify areas of good and improving practice and areas to focus on. Staff demonstrated how they used this system effectively as part of a whole-team performance approach.
- The trust had significantly improved governance structures and processes since our last inspection in 2016. This included a series of monthly governance, safety and committee meetings and individual ward meetings held at least monthly.
- During our last inspection we found a culture of bullying and harassment. At this inspection there was a demonstrable improvement in staff morale and positivity in the working culture and we found no reports of bullying. All staff had contributed to this by facilitating improved, supportive working relationships with each other and senior teams had implemented a sustained redevelopment of engagement strategies.
- The fire safety and operations team had introduced significantly more advanced risk management practices for each ward to consider development work, learning from major incidents at other trusts and individual staff knowledge.
- A patient forum provided oversight of care standards and presented their experiences in board meetings. This was part of the trust's engagement strategy, which included several ways patients could be involved with the trust.
- The hospital had significantly improved information resources during work to comply with the NHS Accessible Information Standard, including for patients with visual impairments and learning disabilities.
- The trust had recognised a number of wards and individuals for exceptional standards of work and innovative contributions. For example, the Syringa ward team had received three awards, including a Barts Health Heroes award, a Health and Care Top 70 Stars of 2018 award and a patient-led care award for consistently achieving recommendation feedback above 90%.
- Redevelopment and transformation teams had worked as advocates and lobbyists for the hospital's development and future. They had engaged teams across the site and all staff we spoke with said they were excited about the hospital's future and the opportunities this presented for the local population.

However, we also found:

- Clinical staff told us it was sometimes difficult to access policies using the intranet and although they had raised this with the trust there had been no improvements.

## Outstanding practice

- A new frailty pathway reflected best practice in older people's services and had significantly improved the care and experience for this population group, particularly for the most vulnerable. This resulted in fewer bed moves, more dedicated social care and therapies staffing and access to recreation in the hospital. Wider plans for this development included a fully integrated elderly care system with the local authority.

# Medical care (including older people's care)

- Staff had significantly improved information standards and accessibility for patients. This included engaging with a specialist organisation to design a website that enabled patients with physical disabilities to plan their visit in advance based on step-free access needs and the implementation of a website that could be translated instantly into any of 100 different languages.
- A nurse on Cedar ward had led a project and pilot scheme to improve the use of the situation, background, assessment, recommendation (SBAR) tool used to assess patient status and identify possible deterioration. The nurse, supported by the ward manager, had trialed new ways of using the SBAR tool and identified a method that decreased risk and improved response times. As a result, this was being rolled out across the hospital to all inpatient services.

## Areas for improvement

### **We found areas for improvement:**

#### **Areas we told the trust they SHOULD improve:**

- The trust should ensure all clinical staff have access to policies and standards online.
- The trust should ensure the AAU is protected from the risks of unauthorised visitors.
- The trust should ensure there are effective systems in place for clinicians to carry out handovers when patients are moved between hospital sites.
- The trust should ensure ward staff take a proactive role in maintaining emergency escape routes free from obstruction and in line with the practical fire safety training that has already been delivered.
- The trust should review the medical cover of cardiology out of hours to ensure patient safety is assured and junior doctors had adequate support.

# Surgery

Requires improvement   

## Key facts and figures

Whipps Cross hospital is part of Barts Health NHS Trust which is currently in quality and financial special measures. Whipps Cross University Hospital provides a range of elective (planned) and emergency surgical services to people living in the London Borough of Waltham Forest. The service includes a range of specialties - orthopaedics, general surgery, vascular surgery, colorectal surgery, urology, upper gastro-intestinal trauma, ear, nose and throat (ENT) and ophthalmic surgery.

The trust had 54,372 surgical admissions from April 2017 to March 2018. Emergency admissions accounted for 15,410 (28.3%), 29,246 (53.7%) were day case, and the remaining 9,716 (17.8%) were elective.

The operating theatres are located in three separate areas within the hospital. There are 12 operating theatres in total. Two theatres are dedicated to ophthalmology. Four theatres are used to carry out day-case procedures and two were designated emergency theatres that were available for operations 24 hours a day, seven days a week. The ophthalmic unit is a separate stand alone unit, including outpatients and theatres. There are 125 acute surgical inpatient beds including 27 trauma orthopaedic beds with 12 elective orthopaedic beds. Additionally, there are 28 day-case beds on Plane Tree ward.

During our last inspection in April 2018, Poplar and Sage wards were used as 'surge' beds. These beds were re-designated to accept patients from a range of specialties, admitted as emergencies over the busy winter period. The trust told us this was a temporary measure and the wards would return to their original functions once winter pressures had subsided. On this inspection, we found Sage ward had returned to providing elective orthopaedics in May 2018 and Poplar ward was caring for short stay surgical patients. The 14 additional beds opened on Poplar ward over the winter had been kept open.

We visited Hope ward (elective admissions unit), Poplar ward (short stay for elective surgery), Primrose ward (male patients), Rowan ward (female patients), Sage ward (elective orthopaedic), Sycamore ward (emergency orthopaedic) and Plane Tree ward (surgery day case). We also visited theatres, anaesthetic rooms, the pre-operative assessment unit, pain treatment room, recovery areas and the discharge lounge.

During the inspection we spoke with 27 patients. We observed care and treatment and looked at a sample of 14 patient records across the wards and theatres. We also spoke with 26 staff including allied healthcare professionals (AHPs), nurses, health care assistants (HCAs), doctors, consultants, ward managers, matrons and members of the senior management team. We reviewed and used information provided by the organisation in making our decisions about the service.

## Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- Following our last inspection in April 2018, we issued the trust a warning notice requiring the service to make significant improvements to medicines management on surgical wards and to ensure the trust's medicines management policy was followed in relation to medicines storage and expired medicines. We also issued ten actions the provider should take to improve. During this inspection, the service had dealt with or shown improvement for some of the previously reported concerns. However, there were still some areas for improvement such as consistent adherence to the trust policy and having a process to record 'take away' medicines dispensed by nurses on the wards.



# Surgery

- During our last inspection, we found high vacancy rates for nursing staff and most surgical wards remained dependent on temporary staff. On this inspection, although we found the trust had completed a recruitment campaign which had reduced vacancy rates, the nursing vacancy rate still remained higher than the trust's 6.3% target.
- On our last inspection, we found the facilities used by the pain service were not fit for purpose. During this inspection, we found the pain service was still located in the same unsuitable area. The trust told us they had plans to relocate the service in the future once the next phase of theatre upgrading was completed.
- During our last inspection, we found the consent process for surgical procedures was not completed in line with trust policies and best practice. On this inspection, we were informed that the trust was undertaking a trust wide review to understand what changes were required. A report was due to be completed later in September 2018 and so was not available at the time of our inspection.
- On our previous inspection, we told the trust that they should improve the flow of patients across the hospital to reduce late and cancelled operations. On this inspection, we found there had been no significant improvement.
- Trust data for referral to treatment waiting times (RTT) for all surgical specialities between September 2017 to July 2018 showed that overall RTT was 81.6%. Although this was a slight improvement from the last inspection figure (79.7%), it was lower than national standards.
- On our last inspection the service planned to develop a surgical assessment unit (SAU) where they could assess and prioritise patients before they were admitted to a ward. On this inspection, this remained unchanged as managers had not found a suitable location. Although the trust told us they recognised that there was a risk of delay in medical staff reviewing the most acutely ill surgical patients and had introduced various methods to mitigate the risk; staff we spoke with acknowledged the triage arrangements but told us they felt the risk remained.
- During the last inspection, we found staff did not have access to reliable equipment and there was no agreed replacement programme in place for theatre equipment. On this inspection staff told us there were still issues accessing equipment or getting broken equipment repaired.
- Although the trust had recently made a significant investment in equipment which urgently needed replacing such as the anaesthetic machines, the division's risk register showed 25 out of a total of 47 risks related to theatre equipment which was obsolete or at the end of their life.
- Theatre utilisation rates between March 2018 and August 2018 across the main theatres varied between 70% and 72% against the trust's target of 85%. Although performance had remained consistent to the rate from our previous inspection (70%) further improvement was required to meet the trust target.
- Trust data showed that between January 2018 and August 2018, 2528 (16%) of patients were discharged out of hours (between 8pm and 8am). The trust's performance had deteriorated as the previous figure between April 2017 and December 2017 was 13%.
- Although the service had introduced an Enhanced Recovery Programme to improve the pathway for surgical patients, the programme was limited to one surgical speciality. This meant the potential to improve patient care and length of stay was not being fully embedded throughout the service.

However, we also found:

- The trust had recognised the need to complete a strategic review of services provided at Whipps Cross including surgery. The review was in its early stages, however, managers from the hospital were involved in developing plans for the service which more closely met the needs of the local population and provided high quality, effective pathways.

# Surgery

- During our last inspection we found inconsistent completion of patient care records and had concerns around secure storage of records. On this inspection, we found this had improved as the records we checked were completed accurately and stored securely.
- There was effective multidisciplinary team (MDT) working to support patients' health and wellbeing with good access to services such as pain and tissue viability.
- Staff recognised the importance of providing good standards of patient care regardless of how busy they were. Most of the patients and relatives we spoke with told us all staff, whether permanent or temporary, were compassionate and caring.
- Staff told us they felt more supported following the recruitment to vacant posts in the senior leadership team.
- The service had strengthened governance structures with new clinical leads for each speciality and more administrative support.
- The service had made progress against the improvement plan developed following our previous inspection. Progress against some issues, for example, medicines had been achieved within a short time period.

## Is the service safe?

**Requires improvement**  

Our rating of safe improved. We rated it as requires improvement because:

- We found the trust had addressed the previous inspection's warning notice for medicines management by improving many of the issues we identified as concerns. However, there were still some areas for improvement such as consistent adherence to the trust policy and having a process to record 'take away' medicines dispensed by nurses on the wards.
- During the last inspection, we found staff did not always have access to reliable equipment and there was no agreed replacement programme in place for theatre equipment. During the factual accuracy process, the trust provided us with a medical equipment replacement log which showed the business case status for equipment replacement but did not show when equipment would be replaced or if the necessary funding had been allocated. During this inspection, staff told us there were still issues accessing equipment or getting broken equipment repaired.
- During our last inspection, we found the facilities used by the pain service were not fit for purpose. Although on this inspection we found equipment such as the theatre table had been replaced, we found the pain service was still located in the same unsuitable area.
- During our last inspection, we found the high vacancy rates for nursing staff and most surgical wards remained dependent on temporary staff. On this inspection, although we found the trust had completed a recruitment campaign which had reduced vacancy rates, the nursing vacancy rate still remained higher than the trust's target of 6.3%.
- On our last inspection, the service planned to develop a surgical assessment unit (SAU) where medical staff could assess and prioritise patients before they were admitted to a ward. On this inspection, the leadership team acknowledged that it had not been possible to identify the correct location for a SAU. The trust recognised there was a risk of delay in medical staff reviewing the most acutely ill surgical patients and mitigated this risk through a variety of methods such as the availability of a dedicated consultant led team and pathways for identifying patients at risk. Although staff we spoke with acknowledged the triage arrangements, staff told us they felt the risk remained.

# Surgery

- During the last inspection, we found that not all the ward and theatre environments were in a good state of repair. On this inspection we found four operating theatres had been refurbished since our previous inspection but further work was required to upgrade the remaining theatres. The leadership team told us there were plans to upgrade the remaining theatres as part of a rolling improvement programme.

However, we also found:

- The service used the national early warning scoring system (NEWS) in theatres and on the wards for identifying deteriorating patients. Although we did not see specific training provided in sepsis identification and treatment, staff told us they covered sepsis awareness in their early warning training.
- Theatre staff completed the appropriate safety checks before, during, and after surgery using the World Health Organization (WHO) surgical safety checklist. Local checklists had been developed for tracheostomy, pleural drainage, intubation and insertion of central venous catheter (CVC).
- Consultants provided on site medical cover from Monday to Friday. On call and out of hours surgical cover was provided by a consultant of the week in general surgery and trauma and orthopaedics. The elective commitments of the team of the week were cancelled during the on the call period to ensure medical staff had the capacity to deal with emergencies.
- Nursing staff exceeded the 85% completion targets for 26 out of 27 mandatory training modules and medical staff exceeded the target for 20 out of 25 modules.
- During our last inspection, we found medicines related incidents were not always reported. On this inspection, we found the reporting of medicines related incidents had improved and all the staff we spoke with were aware of recent medicine incidents.

## Is the service effective?

**Good**  

Our rating of effective improved. We rated it as good because:

- Clinical guidelines and protocols were developed and reviewed in line with the recommendations of the National Institute for Health and Care Excellence (NICE), the Royal Colleges and other relevant public bodies. Policies and protocols were available for staff to access on the hospital intranet. Staff we spoke with told us that the intranet was accessible and easy to use.
- The service participated in a number of national clinical audits including bowel cancer, vascular surgery, oesophago-gastric cancer and emergency laparotomy. The results of these audits showed the majority of services were comparable with the England average.
- Where the service did not fully comply with national guidelines, the service carried out a risk assessment to mitigate any adverse effect on patient treatment which was adjusted, based on the audit results.
- We reviewed patient records and found regular assessments for nutrition and hydration.
- Multidisciplinary daily board rounds ensured staff focused on planning patients' discharge and resolved any blocks or hold ups in the process.
- The trust had link nurses to provide information, advice and training for nursing staff in areas such as continence, diabetes, tracheostomy care, tissue viability, stoma care, pain and sepsis. Nursing staff told us they could access support and specialist advice easily.

# Surgery

- The surgical service had recently appointed practice development nurses (PDN) on the wards who reviewed and updated nursing skills by providing staff training. Staff we spoke with provided examples of training they had received such as cannulation and prevention of pressure ulcers.
- A consultant led multi-disciplinary pain team assessed and treated patients with acute and chronic pain.
- The National Patient Reported Outcomes Measures (PROMS) survey results for the service were better than the England average for all four procedures surveyed (groin hernias, varicose veins, hip and knee replacements).
- Patients were provided with information leaflets in advance of their surgery based on national guidance. The leaflets were specific to the patient's condition, describing the benefits, risks and alternatives to surgery.
- The trust displayed posters providing a range of health promotion information for patients throughout the hospital such as smoking cessation. The trust's website had information on staying healthy during Ramadan and provided advice on when to seek medical attention.
- Staff were aware of the requirements of their responsibilities as set out in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

However, we also found:

- Although the service had introduced the enhanced recovery programme, this was limited to orthopaedic patients. The trust had re-established enhanced recovery in colorectal surgery three months prior to our inspection which meant it was not fully embedded during our inspection. Therefore, the full potential to improve patient care and length of stay was not being fully utilised as enhanced recovery was not embedded throughout all the surgical specialties during our inspection.
- Trust data for the 2017 National Hip Fracture Audit showed the proportion of patients having surgery on the day of or day after admission was 67.6%, against the national standard of 85%. The service was unable to give patients a new fracture clinic appointment within the recommended 72-hour time frame. The service acknowledged this represented a potential clinical risk for patients and had included it on the risk register.
- Although the service achieved 92% appraisal completion rate for medical staff, the trust did not provide a breakdown for non-medical staff.
- During our last inspection, we found the consent process for surgery was not completed in line with trust policies and best practice. On this inspection, we were informed that the trust was undertaking a trust wide review to understand what changes were required. The review report was due later in September 2018 and so was not available at the time of our inspection.
- On our last inspection we found the monthly Malnutrition Universal Screening Tool (MUST) audits did not consistently meet the trust target of 95%. On this inspection, we found that although some improvements had been made, further work was required to ensure all the surgical wards consistently met the target.

## Is the service caring?

Good   

Our rating of caring stayed the same. We rated it as good because:

- Most of the patients and relatives we spoke with told us all staff, whether permanent or temporary, were compassionate and caring.

# Surgery

- People using the trust's surgical services were treated with dignity and respect. For example, theatre staff ensured patients were covered up with a sheet or blanket during surgery to maintain patients' privacy and dignity.
- We observed staff provided emotional support before and after surgery. For example, theatre staff reassured patients as they waited for surgery and afterwards in the recovery area.
- Staff recognised the importance of providing good standards of care regardless of how busy they were.
- Clinical nurse specialists provided emotional and practical support for patients who might need help to adjust to changes in their lives; for example, following stoma-forming surgery or patients who required palliative care.
- Most patients we spoke with felt staff involved them and their carers in planning their treatment and care.

However, we also found:

- Between July 2017 and June 2018, the average Friends and Family (FFT) feedback for Whipps Cross Hospital was 20% against the England average of 25%. Staff told us the low response rates were due to the trust recently changing to an electronic method of collecting FFT data.
- Although most patients praised the nursing staff, there were some isolated incidents where patients felt staff were too busy to provide the support they needed and that communication around their care and discharge could be improved.

## Is the service responsive?

**Requires improvement**   

Our rating of responsive stayed the same. We rated it as requires improvement because:

- At our previous inspection, we told the trust that they should improve admitted referral to treatment time (RTT) performance and reporting. As the trust had only started reporting RTT data nationally in April 2018, there was no data available for inclusion in the evidence appendix. Although the trust provided data after the inspection which showed performance had slightly improved, the leadership team acknowledged further improvement was required to be compliant with national standards.
- The site level figures for the RTT admitted pathway, provided by the service showed varied performance between September 2017 and July 2018 in most specialties. For example, trauma and orthopaedics achieved 74.7% in July 2018 which had slightly reduced from 77.4% in April 2018. Although the service had maintained the improvement from 61% in May 2017, further improvement to meet the national standard was required.
- Trust data between March 2018 and August 2018 showed that 587 patient's surgery was cancelled on the day the operation was scheduled to take place. Of these, 383 were patient-initiated and 98 were hospital-initiated cancellations for non-clinical reasons which included: lack of time (22), lack of beds (37), another emergency priority (10), lack of staff (10) and equipment issues (10).
- Although the trust had improved their performance for delayed theatre lists, further improvement was still required to achieve the trust's target. Data for the period between April 2018 and August 2018 showed 13.4% of patients experienced a delay. Theatre utilisation rates between March 2018 and August 2018 across the 10 main theatres varied between 70% and 72% against the trust's target of 85%.
- On our previous inspection, we told the trust that they should improve the flow of patients across the hospital to reduce late and cancelled operations. On this inspection, we found there had been no significant improvement.

# Surgery

- Trust data for the number of patients discharged out of hours (between 8pm and 8am) had increased to 16% between January 2018 and August 2018 compared with 13% between April 2017 and December 2017.

However, we also found:

- During our last inspection, the practice for having patients cared for overnight in theatre recovery had reduced. On this inspection, although there had been three occasions in April and May 2018, the practice had stopped altogether with zero occasions between June and August 2018.
- During our last inspection, the trust did not consistently record the reasons for delayed surgery. On this inspection, we found this had improved as we found the reasons for delays were being recorded.
- The trust had suitable arrangements in place for people who needed translation and advocacy services.
- The service dealt with concerns and complaints appropriately and investigated them in the required time scale.

## Is the service well-led?

**Requires improvement**   

Our rating of well-led stayed the same. We rated it as requires improvement because:

- The service had made some improvements since our previous inspection in April 2018, but further work was needed to ensure the service was achieving the division's top objectives. This included plans for improvements to; referral to treatment times, nursing recruitment and retention and the surgical pathway.
- During our last inspection, the surgery risk register included the implementation of the electronic patient record system due to the variation in practice between clinical teams. On this inspection, managers told us this was still a risk but they were reinforcing the importance of accurate information in electronic records. Agency staff did not have access to electronic patient records and had to ask ward staff to access or update records.
- Although the service had made improvements to the culture within the service, on this inspection we found pockets of tension between staff groups such as registered nurses and health care assistants. We discussed this with the leadership team and they acknowledged there were issues which needed to be addressed.
- During our last inspection, staff on the wards and in theatres told us there were no or very few opportunities for staff development. On this inspection, we found staff still felt the same. Managers acknowledged staff development was limited and hoped to address this in future.
- The trust had recently introduced an electronic method to collect patient feedback which had resulted in very low response rates. Staff on some wards had developed their own feedback forms because the response rates were so low and were unsure what plans the trust had for addressing this.
- During our last inspection the service had recently appointed a staff member to lead on the enhanced recovery programme. On this inspection, we found that progress had been slow as the programme was limited to one surgical speciality and not fully embedded. Pressure on staffing levels meant ward staff were unable to implement the objectives of the programme.

However, we also found:

- The trust had recognised the need to complete a strategic review of services provided at Whipps Cross, including surgery. The review was in its early stages however managers from the hospital were involved in developing plans for services which more closely met the needs of the local population and for high quality, effective pathways.

# Surgery

- Governance within the service had recently improved with clinicians identified in each surgical specialty to engage with colleagues. The leadership team told us administrative support was being provided to facilitate meetings and audit completion.
- Staff told us they felt more supported following the recruitment to vacant posts in the senior leadership team. For example, theatre staff told us their managers were supportive, visible and approachable.
- The surgical service had recently appointed two practice development nurses to focus on improving the standards of care by working with ward managers to develop a training programme for staff.

## Outstanding practice

Staff within the pre-assessment unit had researched the needs of patients living with a learning disability to provide more tailored support when undergoing surgery. The team had developed a patient passport which informed the surgical team about any adjustments the patient might need during their treatment.

## Areas for improvement

**We found areas for improvement:**

**Actions the provider SHOULD take to improve:**

- The trust should improve the flow of patients across the hospital to reduce late and cancelled operations and discharges out of hours.
- The trust should continue working to improve theatre utilisation rates to meet the trust target.
- The trust should ensure the enhanced recovery programme is embedded and applicable to all surgical specialities to improve patient flow.
- The trust should review clinical decision making to ensure acutely ill patients receive timely reviews whilst plans for a surgical assessment unit are developed.
- The trust should ensure the facilities used by the pain service are fit for purpose.
- The trust should ensure there is an agreed replacement programme for theatre equipment.
- The trust should continue working on improving referral to treatment times performance and reporting.
- The trust should ensure that consent to procedures is obtained in line with trust policies and best practice.
- The trust should review the methods by which patient feedback is collected to ensure the feedback is more representative to the local population.
- The trust should continue addressing the high vacancy rates for nursing staff, focussing on recruitment and staff retention.



# Critical care

Good  

## Key facts and figures

The Critical Care Department at Whipps Cross Hospital consists of 17 beds; seven are funded for level 3 care, and 10 are funded for level 2 care.

The Intensive Care Society classifies patients' level of clinical need and dependency based on their acuity and the number of organs supported by clinical intervention. There are three levels of care; the high dependency unit (HDU) provides levels one and two and the Intensive Care Unit (ICU) provides level three care.

An ICU is a specially staffed and equipped, separate and self-contained area of a hospital dedicated to the management and monitoring of patients with life threatening conditions. The ICU provides both specialist and general critical care support for the local population.

The HDU was opened in January 2017 and increased the bed base from nine beds to the current 17. The department is led by the clinical lead and matron with support from the ward managers. The unit accepts both elective and emergency admissions on agreement with the critical care consultant in charge.

Between May 2017 and May 2018, staff cared for 962 patients with an occupancy rate between 86% and 94% which was higher (worse) than the national average. Of the total patient admissions, 80% were unplanned from either the emergency department or admitted from another ward which resulted in 20% of patients being planned cases.

During our last inspection in September 2016, we rated critical care as requires improvement overall with a rating of good in the caring domain and requires improvement in safe, effective, responsive and well led. We inspected Whipps Cross Hospital on an announced visit on 11 to 13 September 2018. We visited all critical care areas and attended handovers, ward rounds and meetings. We spoke with 33 members of staff representing a range of clinical and non-clinical roles. This included staff that provided care to patients in critical care but were not permanently based there such as physiotherapists, pharmacists and dietitians. We spoke with five patients and three relatives and reviewed the care records of 10 patients. We reviewed and used information provided by the organisation in making our decisions about the service. We spent time observing staff deliver care.

## Summary of this service

Our rating of this service improved. We rated it as good because:

- Following our last inspection in July 2016, we issued 16 actions the provider should take to improve. During this inspection, the service had dealt with or shown improvement for most of the previously reported concerns.
- Nursing staff exceeded the 85% completion target for all 27 mandatory training modules.
- At our last inspection, we found staff did not always have access to reliable equipment. During this inspection we found this had improved as the unit had procured a variety of medical equipment such as: six non-invasive breathing machines, one kidney machine, a number of epidural pumps, patient bedside chairs and a patient iPad.
- Staff on each shift documented checks on emergency equipment, including resuscitation and airway trolleys.
- During our last inspection, we found that doctors did not consistently wash their hands when entering the unit. On this inspection, we found all staff complied with hand hygiene practice consistently. We observed staff asking relatives and other staff to wash their hands on entering the unit.

# Critical care

- At our last inspection, we found staff did not always record actions taken or learning points for incidents and had inconsistent knowledge of incidents. On this inspection, we found learning from incidents and morbidity and mortality meetings had improved and processes were in place to provide more consistent communication and safer practice.
- During our last inspection, there was limited evidence of relevant audit activity and learning was not always shared with staff. During this inspection, we found this had improved as there was a dedicated audit team who worked with the senior staff to develop audits to benchmark care and treatment standards in line with national guidance. Staff acted on audits and implemented improved working practice as a result.
- At our last inspection, intensive care national audit and research centre (ICNARC) data suggested that between April 2015 to December 2015 the unit had higher than expected mortality levels (compared to similar units nationally). During this inspection, we found the expected mortality rates had improved at 1.2 which was slightly worse than the national average of 1.1.
- The team could demonstrate improved outcomes for patients such as; the reduction of higher risk patients being admitted to the unit and the number of patients experiencing sepsis along with the reduction of patients having unplanned readmissions to the unit. The instances of patients being transferred from the unit throughout the night had significantly reduced.
- Since the last inspection, the hospital had opened an HDU which increased the bed base from nine beds to the current 17. The matron and senior staff had successfully transitioned staff to an integrated ICU and HDU and reduced nurse vacancies simultaneously.
- During the last CQC inspection, there was no protocol for weaning (reducing patients level of respiration support) and rehabilitation for long term patients. On this inspection we found this had improved as staff had developed an approach with three possible options.
- During the last inspection, we found that due to bed pressures patients were sometimes transferred out of the unit for non-clinical reasons and many patients were transferred out overnight contrary to professional standards. During this inspection, trust data showed the unit was within expected range although bed pressures remained a challenge.
- Staff we spoke with demonstrated good knowledge and understanding of patient risk, particularly for people living with dementia or learning disability.
- The senior team demonstrated the high levels of experience and capability needed to deliver embedded system of leadership development and succession planning.
- During our last inspection, we found the acute response team (ART) was not able to provide a 24-hour, seven-day service and plans to provide this cover did not seem sustainable. On this inspection, we found ART staffing levels had increased and plans were in place to continue to increase these staffing levels and rotate staff from the unit in the future.
- During the last inspection, we found there was no documented long-term strategy for the division and staff had poor awareness of the leadership's plans for the department. On this inspection, we found the service had implemented a strategy which had been developed with staff involvement.
- We found a positive staff culture supported by clear career progression for all staff. The staff we met told us they felt cared for, respected and listened to by their peers and managers.
- During our last inspection we found the risk register did not fully document all risks identified across the unit and senior leaders had limited awareness of key challenges and risks. On this inspection we found some improvements as the risk register was more comprehensive and more actively managed.

# Critical care

However, we also found:

- During the last inspection, we found that due to bed pressures patients were sometimes transferred out of the unit for non-clinical reasons and many patients were transferred out overnight contrary to professional standards. During this inspection, trust data showed the unit was within expected range although bed pressures remained a challenge.
- At the last inspection, we found there were mixed-sex accommodation breaches due to the lack of bed capacity and service leads had not highlighted this as a risk. During this inspection, we found mixed sex accommodation remained a challenge for the unit but had been documented on the unit's risk register.
- During our last inspection, we found high bed occupancy levels and the service did not meet the professional standards for delayed discharges. On this inspection, we found that the unit had not successfully addressed this.
- At our last inspection, the unit was failing to comply with a number of the 'London quality standards' for adult critical care. For example, not all patients were seen and reviewed by the consultant in clinical charge of the unit at least twice a day, seven days a week. During this inspection, we found this was still the case but these figures were being reviewed due to lack of data as 20% of the data was missing.
- Although the senior team encouraged staff to be involved in audits and research to improve patient experience and outcomes, staff could not always rely on the data as the unit experienced data collection issues which resulted in some unreliable performance information.
- The trust did not provide mandatory training data for medical and dental staff as part of the provider information request and post inspection additional data request.

## Is the service safe?

**Good**  

Our rating of safe improved. We rated it as good because:

- At our last inspection, we found staff did not always have access to reliable equipment. During this inspection we found this had improved as the unit had procured a variety of medical equipment.
- At our last inspection, we found staff did not always record actions taken or learning points for incidents and had inconsistent knowledge of incidents. On this inspection, we found learning from incidents and morbidity and mortality meetings had improved and processes were in place to provide more consistent communication and safer practice.
- The ratio of nurses to patients met standards set by the Faculty of Intensive Care Medicine (FICM) and the Intensive Care Society (ICS).
- The most recent antibiotic audits indicated good standards of practice in line with trust standards, including a multidisciplinary approach to management and staff education. Monthly quality audits demonstrated consistently good practice in line with hospital policy.
- During our last inspection, we found that doctors did not consistently wash their hands when entering the unit. On this inspection, we found all staff complied with hand hygiene practice consistently. Hand hygiene audits indicated consistent practice in exceeding the trust target of 95% between April 2017 and April 2018.
- We observed staff wearing personal protective equipment (PPE), including aprons and gloves, when delivering personal care.

# Critical care

- The environment was clean, safe and had safe arrangements for the handling, storage and disposal of clinical waste, including sharps bins.
- All clinical staff had up to date training on sepsis testing, treatment and risk management, using of the national Sepsis 6 care pathway and the National Institute for Health and Care Excellence (NICE) guidance.
- Staff knowledge of safeguarding principles had improved since our last inspection and a safeguarding link nurse had prepared additional resources for staff to use in risk assessments. 100% of staff had up to date level 2 adults and children safeguarding children. This exceeded trust the target of 90%.
- Staff we spoke with demonstrated good knowledge and understanding of patient risk, particularly for people living with dementia or learning disability.
- Medication audits showed significant improvements in the management and storage of controlled drugs.
- There was a consistent standard of risk assessment and documented nurse and therapies observations. Staff completed daily progress notes for each patient and included a review of their care bundles, resuscitation status and communication with family members.

However, we also found:

- During out of hours on weekdays and at weekends the ratio of consultants to patients was 1:17. This was worse than the faculty of Intensive care medicine (FICM) guidance ratio of 1:15.
- The pilot of 'top up' medicines needs to be reviewed to ensure the best option for the supply of medicines is the correct one for the unit.
- Due to the lack of on site pharmacy provision at weekends and out of hours, the unit had at times experienced delays in obtaining medicines.
- Some consumable items procured were of poor quality. For example, staff were ordering over 20 pressure relief pillows per week as they were disintegrating quickly. Staff told us they had to use more than one poor quality pillow when making sure patients had sufficient pressure relieving care, instead of using one pillow of good quality. Paper cups used for patients needing sips of water whilst recovering on the unit, were difficult to procure. Staff paid for these out of their own money.

## Is the service effective?

**Good** ● ↑

Our rating of effective improved. We rated it as good because:

- During our last inspection there was limited evidence of relevant audit activity and learning was not always shared with staff. During this inspection, we found this had improved as there was a dedicated audit team who worked with the senior staff to develop audits to benchmark care and treatment standards in line with national guidance. Staff acted on audits and implemented improved working practice as a result.
- Clinical staff were encouraged to develop audits that would establish standards of care in the unit and drive improvements.
- At our last inspection, ICNARC data suggested that between April 2015 to December 2015 suggested the unit had higher than expected mortality levels (compared to similar units nationally). During this inspection, we found the expected mortality rates had improved at 1.2 compared with the national average of 1.1.

# Critical care

- During the last CQC inspection, there was no protocol for weaning and rehabilitation for long term patients. On this inspection, we found this had improved as staff had developed an approach with three possible options.
- Consultant cover was 24-hour, seven days a week and high-risk patients were reviewed within one hour of a consultant being called out.
- Opportunities for learning and clinical and professional development were seen as a priority. Two nurse educators were in post which ensured staff were supported throughout their probationary periods.
- The unit had recruited assistant practitioners who supported training for nursing staff and also provided a clear career progression pathway.
- Most multidisciplinary teams, including chest physiotherapy, speech and language therapy and microbiology, provided seven-day services through an on-call system.
- Data showed that unplanned readmissions within 48 hours of discharge were consistently low and better than the national average.
- Staff monitored patients for malnutrition and dehydration using evidence-based tools and audited effectiveness monthly.
- We saw that patients' pain assessments were carried out by staff correctly and patients told us they had access to pain control medication when required.
- Critical care staff operated a follow-up clinic in line with professional standards and guidance which included access to psychologist support.
- All doctors and 100% of nurses had an up to date appraisal.
- Staff we spoke with were aware of the Deprivation of Liberty Safeguards (DoLS) processes and gave good examples of what constituted a DoLS.

However, we also found:

- At our last inspection, the unit was failing to comply with a number of the 'London quality standards' for adult critical care. For example, not all patients were seen and reviewed by the consultant in clinical charge of the unit at least twice a day, seven days a week. During this inspection we found this was still the case but these figures were being reviewed due to lack of data as 20% of the data was missing.

## Is the service caring?

**Good** ● ➡ ➡

Our rating of caring stayed the same. We rated it as good because:

- During all our observations, staff treated patients and their visitors with kindness and compassion. Patients we spoke with told us they were extremely happy with their care and the response from nursing staff was timely.
- Staff demonstrated an understanding of the anxiety and challenges patients and their families experienced in critical care and provided support accordingly.
- We observed patients being handled with respect and dignity. For example staff used curtains to ensure patients' privacy and dignity was maintained.

# Critical care

- Patients had access to emotional support through the follow-up service which included time with a clinical psychologist and the use of patient diaries during and after discharge.
- Patient and family experience link nurses had acted on feedback received to improve the understanding and involvement of patients and their relatives. For example printed information was available to help understand the critical care processes, support available and what to expect after discharge.
- The unit had information leaflets for family and friends about a variety of conditions such as a guide for family and friends about delirium.
- Matrons acted on feedback from the internal patient and relative's survey that indicated opportunities for improvement, such as reducing noise levels at night.
- Two nurses acted as dedicated patient and family experience links and helped to ensure patients and their families were well-informed about the work of the unit and the services offered.

However, we also found:

- Carers did not always have access to the range of benefits and support available to them through the passport scheme.
- Although most relatives told us staff were in constant communication with their patients and relatives, some relatives said they had not been kept informed of treatment plans or involved in care planning by doctors.

## Is the service responsive?

**Requires improvement**   

Our rating of responsive stayed the same. We rated it as requires improvement because:

- During our last inspection in July 2016, bed occupancy levels for the ICU were consistently higher than the national average. On this inspection we found there was no change. Although the trust data showed a stable trend in monthly bed occupancy rates ranging from 86% to 94% between May 2017 and May 2018, this was generally higher (worse) than the England average.
- During the last inspection the unit did not meet several professional standards for patient care due bed capacity issues. Patients waited more than four hours for admission to the unit and sometimes were cared for outside the unit by staff without intensive care training. On this inspection we found that although no patients received care outside the unit by inappropriately trained staff, bed capacity remained a challenge due to the patient flow issues within the trust.
- At the last inspection the service was not meeting the professional standards for delayed discharges over four hours. During this inspection, we found this remained unchanged and had been noted on the units' risk register.
- During the last inspection we found that due to bed pressures patients were sometimes transferred out of the unit for non-clinical reasons and many patients were transferred out overnight contrary to professional standards. During this inspection, although the trust data was within expected range for the 451 admissions, the figure had increased from 1.9% in 2015/16 to 3.1% in 2016/17.
- At the last inspection we found there were mixed-sex accommodation breaches due to the lack of bed capacity and service leads had not highlighted this as a risk. During this inspection we found mixed sex accommodation remained a challenge for the unit but had been documented on the unit's risk register.

However, we also found:

# Critical care

- Since the last inspection in 2016, the unit had increased its bed capacity by eight beds and included increasing its nurse staffing levels and expanding nursing competencies to include caring for patients on an ICU and HDU. During our inspection we saw recruitment was in the final stages of completion.
- At our last inspection, we found there were no designated facilities for relatives to stay overnight. On this inspection, we found the unit had addressed this with appropriate provisions in place such as providing reclining chairs and fold up beds for relatives.
- Patients' individual needs were being met. For example a psychological nurse practitioner supported patients and their relatives and patients living with a learning disability who were flagged before admission. Patients had access to translations services and information leaflets in several languages were provided in the visitor's waiting rooms.
- The unit had low numbers of complaints which reflected the services' responsiveness and proactive approach to local resolution.

## Is the service well-led?

**Good**  

Our rating of well-led improved. We rated it as good because:

- The service had a coherent leadership structure and all of the staff we spoke with said they felt supported and respected.
- During the last inspection, we found there was no documented long-term strategy for the division and staff had poor awareness of the leadership's plans for the department. On this inspection, we found the service had implemented a strategy which had been developed with staff involvement. The strategy was developed with external partners with a focus on the frail elderly.
- Staff told us they valued working for the trust and that service leaders were supportive, visible and approachable. We found a positive staff culture supported by clear career progression for all staff. The staff we met told us they felt cared for and listened to by their peers and managers.
- Governance processes were more robust with staff taking responsibility for actions and shared learning.
- There were sufficient computers stations for staff to access information readily such as the trust intranet.
- The unit communicated with patients' GPs using an electronic discharge letter both at time of discharge and after any follow up appointments.
- Patient diaries were used to assist and engage patients to gain more of an insight to their care.
- Staff from other areas of the hospital were invited to attend the unit's teaching sessions on areas such as tracheostomy care
- The senior team encouraged staff to be involved in audits and research designed to improve patient experience and outcomes.
- The service participated in a number of clinical research studies which ensured nursing and medical practice was up to date and evidenced based.

However, we also found:



# Critical care

- During our last inspection, we found the risk register did not fully document all risks identified across the unit and senior divisional leaders had limited awareness of key challenges and risks on the critical care unit. On this inspection, we found some improvements as the risk register was more comprehensive.
- Although the senior team encouraged staff to be involved in audits and research, staff could not always rely on the data as the unit experienced data collection issues which resulted in some unreliable performance information.

## Outstanding practice

- The senior team should be commended for their positive and inclusive leadership skills resulting in the successful transition of staff to an integrated ICU and HDU with a reduction in nurse vacancies.
- The leadership team maintained focus and motivation of their staff through this transition: staff were positive about their new ways of working.

## Areas for improvement

### **We found areas for improvement:**

#### **Actions the provider SHOULD take to improve:**

- The trust should address issues of timely admission and transfer arrangements to reduce delayed discharges and mixed sex breaches.
- The trust should reinforce the use of a risk register to include more day to day issues.
- The trust should review the 'top up' medicines service to ensure the unit has the best option for medicines supply based on patient usage
- The trust should review the procurement of consumable items such as pressure pillows and paper cups to improve the quality of care and cost effectiveness.
- The trust should review how the unit collects performance data to ensure information is accurate and reliable.

# Outpatients

**Requires improvement** 

## Key facts and figures

From April 2017 to March 2018, Whipps Cross Hospital delivered 521,004 outpatient appointments across 86 clinical specialties and services. The hospital averaged 1057 clinics per month and the phlebotomy team contributed to the 96,172 procedures carried out across the trust.

In August 2018, the hospital took over operations of the outpatients services from the clinical support services (CSS) division. At the time of our inspection the service was fully based in Whipps Cross Hospital and an improvement board was working with staff to complete the transition. This meant governance processes were not yet embedded and there was disturbance to some processes, such as the implementation of standardised administration. The trust was not able to provide us with all of the data we needed and this is noted in our report.

The hospital's sexual health service was networked and had recently moved to the Sir Ludwig Guttman Health and Wellbeing Centre. We visited the service and spoke with the clinical lead for HIV and a consultant for HIV as part of our inspection.

We last inspected outpatients in May 2017 and rated the service requires improvement. We inspected the service with diagnostic imaging services, both of which contributed to our rating. At this inspection we inspected outpatients and diagnostic imaging separately.

In May 2017, we told the trust it must:

- Ensure governance systems are fit for purpose and embedded in practice.
- Improve its referral to treatment times towards the national standard of 92% in the 18-week target.
- Improve completion of mandatory training.
- Improve standards of infection prevention and control.
- Ensure there are functioning panic alarms across outpatients departments.

We told the trust it should:

- Ensure staff always have access to reliable equipment to minimise potential delays.
- Take action to address feedback from the staff survey.
- Ensure the physical environment is fit for purpose and maintained in a good state of repair.
- Update the business continuity plan to reflect systems failures.
- Improve practice around the use of interpreters.
- Ensure a consistent approach to sending reminders to patients about their appointments.

At this inspection (1 October 2018 to 3 October 2018), we found improvements in most of these areas, including some development in governance systems, an improved appointment booking system and more reliable medical notes systems. There were ongoing challenges in achieving national referral to treatment times and in maintaining the estate and highly variable use of interpreters.

During our inspection, we spoke with 37 members of staff from a variety of roles, specialties and levels of seniority. This included clinic and service managers representing 19 specialties. We also spoke with doctors, nurses and

# Outpatients

healthcare assistants, administration and reception staff, allied health professionals, medical records staff and the appointments service manager. We spoke with 17 patients and five relatives, looked at 10 sets of patient notes and inspected the clinical and patient environments of main outpatients, the Gillian Hanson Centre for Diabetes and Endocrinology, the eye treatment centre, children's outpatients and the chest clinic.

## Summary of this service

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings. We rated it as requires improvement because:

- The trust was not able to provide up to date monitoring data for mandatory training, staff vacancies, sickness and turnover rates and appraisal completion rates. This meant the senior teams responsible for outpatients and medical records did not have assurances around the performance of key issues affecting the service.
- Although governance systems and processes had generally improved since our last inspection, there were still gaps in risk and performance management and systems needed more time to be fully embedded.
- There was a lack of assurance around fire safety, including poor organisation we observed during an evacuation.
- Staff were not always able to manage local challenges relating to the estate and environment and this impacted the comfort of patients and the facilities available to them.
- There were significant gaps in assurance relating to the ability of staff to assess and respond to patient risks. For example, facilities and processes for treating patients with an active tuberculosis (TB) infection did not protect people from avoidable harm.
- There was a need for further improvement in the incident-reporting system, including in reporting and feedback.
- Auditing and benchmarking against national standards was limited and there was no overall assurance about the standards of care provided.
- There was limited use of IT and technology to drive improvements in access and capacity and this element of the outpatients transformation plan was not being consistently developed.
- The environment in most areas was not dementia-friendly and not all areas had safe or comfortable waiting space for patients who used a wheelchair.
- Achievement of the standard of 92% of patients being seen within 18 weeks referral to treatment time (RTT) had slowly increased for most specialities. However, only one speciality met the standard and managers told us further improvements were not possible without more doctors and/or more clinical space.
- Cancellation and did not attend rates were relatively high and rebooking and follow-up practices varied between specialties. From August 2017 to August 2018, 2079 appointments were cancelled due to consultant annual leave being arranged after an appointment was offered.

However, we also found:

- The trust performed better than national standards in access and treatment measures for patients diagnosed with cancer, including consistently high achievement of the 96% target of starting treatment within 31 days of diagnosis.
- The senior leadership team had expanded services based on local demand and by sharing recruitment of new staff with the rest of the trust. This included more availability of gastroenterology and ear, nose and throat (ENT) clinics and the development of a new community-based rheumatology service.

# Outpatients

- Strategies were in place in some areas to increase capacity. This included joint consultant-GP community clinics and ad-hoc out of hours clinics in a number of specialties.
- Patients rated the hospital consistently well in the annual patient-led assessment of the care environment (PLACE) for cleanliness, the environment and food quality.
- Diabetes and endocrinology performed better than the 92% referral to treatment time (RTT) target of 18 weeks, with 100% of patients being seen within this time.
- Some specialties had plans in place to expand capacity and reduce waiting times. This reflected localised good practice although there was limited evidence this was shared between teams.
- Significant work had been completed to improve information to patients under the Accessible Information Standard. This included the implementation of new patient-led quality assurance and readership groups and the provision of information in a wider range of formats including Braille.
- Patients provided consistently positive feedback about the standards of care they received. They referred to staff as kind and caring and in most cases said they felt listened to.
- Staff acknowledged previous issues with the working culture and most individuals we spoke with said this had improved.

We found breaches of Regulation 15 and Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to premises and good governance and we issued two requirement notices to the trust.

## Is the service safe?

### Requires improvement



We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings. We rated it as requires improvement because:

- The trust was not able to provide mandatory training compliance data for outpatients staff. This meant we were unable to establish completion of training against the trust's 95% target, including for safeguarding. Various governance meetings indicated overall compliance was around 93% but we were unable to confirm the trust had taken the action to improve training we told them they must do in May 2017.
- Completion rates of life support training were highly variable and the trust was not able to identify the level of training junior doctors completed.
- Monitoring of patients who experienced extended delays in accessing services was variable between specialties. Staff did not routinely contact patients to check on their condition when they were waiting for an appointment.
- Fire safety processes and training were not fully embedded. Staff did not demonstrate consistent knowledge of their responsibilities in a fire and an evacuation during our inspection was poorly managed and disorganised.
- The trust did not audit medical records and there were no systems in place to assess compliance with General Medical Council standards.
- During our last inspection in May 2017, we found a need for improvement in incident reporting, investigation and outcomes. At this inspection, staff told us they felt more confident in submitting incidents. However, there was a general lack of understanding of local incident trends and staff said they did not always or often receive feedback. Results from the staff survey indicated staff had a poor perception of incident investigation in the trust.

# Outpatients

- There was limited evidence the trust had sourced new or more reliable equipment to reduce clinic delays, which we highlighted as an area for improvement in May 2017.
- Although the hospital had an ambitious improvement plan in place for the estate and the environment, staff faced significant challenges in delivering the service as a result of aging physical infrastructure. We told the trust it should make improvements in the environment in May 2017 but there was limited evidence of substantive progress at this inspection.

However, we also found:

- The medical records team consistently exceeded the trust's standard of 98% availability of notes and used a robust system to ensure patients with safeguarding needs were protected when clinical information was shared between professionals.
- Although we were unable to identify completion rates for safeguarding training, staff demonstrated appropriate knowledge of trust policies and referral pathways for patients at risk.
- From January 2018 to June 2018, staff consistently exceeded the trust's 95% standard for hand hygiene compliance in monthly infection control audits. This reflected the improvements made in infection prevention and control standards since our last inspection in May 2017.
- The hospital scored highly in the cleanliness and nutrition elements of the annual patient-led assessment of the care environment (PLACE) audit, exceeding the national average in 2017 and 2018.
- Clinical specialties responded to specific risks, such as acting on Supply Disruption Alerts from the Department of Health and Social Care.
- The service demonstrated learning and improved standards following a never event in September 2018.
- Staff in all areas had means of seeking immediate help from security or colleagues in the event of an emergency, which was an improvement from our last inspection.

## Is the service effective?

**Not sufficient evidence to rate**



We do not currently rate effective in outpatients services. However, we found:

- There was no audit plan for outpatients, although individual specialties included outpatient services in some cases. This meant there was limited evidence of benchmarking practice against national standards.
- The tuberculosis (TB) service was not carried out in line with National Institute of Health and Care Excellence clinical standards. The trust provided evidence of improvements in this area after our inspection.
- There was limited evidence of effective communication pathways between specialist consultants and GPs. Therapists told us referrals to services was time-consuming as they needed to liaise with GPs even when the patient was being seen in the hospital.
- We were not assured all staff had access to regular appraisals or that they were fit for purpose and effective. The trust was unable to provide completion rates for appraisals and the most recent staff survey identified 28% of staff had not had an appraisal in the previous year.
- Nurses, healthcare support workers and allied health professionals had inconsistent access to training and development opportunities and this depended on their individual specialty.

# Outpatients

- Services were not commissioned on a seven-day basis although some clinics offered ad-hoc evening and weekend clinics to provide additional capacity.

However, we also found:

- The outpatients therapies team had developed a musculoskeletal referral pathway that enabled patients to access specialist services, including trauma and orthopaedics, more quickly.
- Nurses in the eye treatment centre were undertaking extended training to enable them to carry out more complex care and treatment procedures.
- Clinical nurse specialists worked with acute and medical colleagues across the hospital to provide ad-hoc and planned learning and education sessions. This included in response to incidents and changes in national standards.
- HIV support services were robust and a health advisor promoted opportunistic screening in some clinics. They also followed up patients who were 'lost' following an initial appointment to help promote better health outcomes through treatment.
- Health promotion activity was an on-going area of good practice in the hospital and specialist teams organised a range of events and activities in the hospital.
- There were some exceptions to the poor completion of appraisals, such as in the chest clinic, where 100% of staff were up to date with appraisals and supervisions.

## Is the service caring?

**Good** 

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings. We rated it as good because:

- Patients provided consistently positive feedback about the standards of care they received. Patients referred to staff as kind and caring and in most cases said they felt listened to.
- Staff demonstrated compassionate and friendly care during all of our observations.
- The faith centre and chaplaincy provided 24-hour, seven-day access to support patients and provide prayer space.
- Patients told us they felt involved in their care. Those who attended frequent appointments said it was normal practice for staff to ensure they always understood their care and treatment plan.
- The hospital had implemented continuing care standards in line with the Academy of Royal Colleges Guidance for Taking Responsibility: Accountable Clinicians and Informed Patients. This meant patients had more consistent involvement in care planning.

However, we also found:

- Privacy in some areas was challenging to maintain due to busy waiting areas and a lack of screens for procedures such as taking blood pressure.
- In the annual patient-led assessment of the care environment (PLACE), outpatients scored poorly in the measure for privacy, dignity and wellbeing, with a 77% result compared to the national average of 84%.

# Outpatients

## Is the service responsive?

### Requires improvement

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings. We rated it as requires improvement because:

- There were substantial waiting lists for clinic appointments and only one of the specialties met the national target of 18 weeks from referral to treatment (RTT). Most services had waiting times of 22 weeks and above and there were 4450 patients waiting in October 2018. Senior staff told us further improvements in access were not possible without more doctors and/or more clinical space. We told the trust in May 2017 that it must address this issue. At this inspection in October 2018 there were elements of improvement, including an overall reduction in waiting lists, however these were not sustained or embedded.
- Appointment booking systems and consultant rotas were not matched in advance, which led to cancellations when they could not be matched. Follow-up appointments were booked up to one year in advance and consultant rotas were confirmed six weeks in advance.
- Signposting in the eye treatment centre was not fit for purpose. There was no clear signage despite the centre including multiple reception desks for different areas and no easy-to-read or high visibility signage.
- There were no coherent, robust plans in place to improve access to specialist clinics. Additional capacity was provided sporadically based on the availability of individual consultants and their willingness to work additional hours.
- Outpatients environments were not dementia friendly and there was limited evidence of developments to improve this.
- Scores in the patient-led assessment of the care environment (PLACE) annual audit for dementia and disability had deteriorated significantly since 2016 and were worse than the national average.
- In specialties with more than 3000 patients annually, services cancelled an average of 19% of appointments with an average of 37 days to rebook the appointment.

However, we also found:

- Individual specialties scheduled ad-hoc clinics whenever clinician availability allowed this to reduce waiting lists. Ophthalmology offered a long-standing Saturday clinic to increase capacity and urology, respiratory, gastroenterology and rheumatology offered additional evening clinics each month.
- Although waiting lists remained significant, the ophthalmology service had reduced the waiting list by 1175 patients between October 2017 and October 2018.
- Sexual health and HIV services had moved off-site in May 2018 and had expanded to offer several new specialist clinics whilst retaining the ability provide care at the hospital through a lead consultant.
- A carer's policy and system was in place that enabled them to call ahead of an appointment for the nurse in charge of the clinic to make adjustments for the patient, such as to arrange a quiet waiting area.
- A learning disabilities nurse specialist supported patients to attend appointments, helped consultants to communicate effectively and provided adjustments to care plans to help patients maintained a better standard of health.



# Outpatients

- The administration team performed consistently well against trust targets for answering phone calls and the length of calls. This reflected a significant improvement from our last inspection in May 2017, after which we told the trust it should make improve performance in this area.

## Is the service well-led?

### Requires improvement



We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings. We rated it as requires improvement because:

- A temporary general manager was in post and reported to the deputy director for performance. A permanent general manager was due to take up the post in November 2018. There was a long-standing service manager vacancy and interviews were taking place shortly after our inspection. The deputy director of operations was acting as a general manager pending recruitment to that post. This reflected on-going instability in the senior teams, which had also been evident during our inspections in July 2016 and May 2017.
- The trust was not able to provide up to date monitoring data for mandatory training, staff vacancies, sickness and turnover rates and appraisal completion rates. This meant the senior teams responsible for outpatients and medical records did not have assurances around the performance of key issues affecting the service.
- Although staff generally spoke positively about hospital and service leadership, there were some high-level vacancies that impacted teams and delivery.
- Results from the latest staff survey indicated a need for significant improvement in the quality of management in some areas. For example, only 50% of staff said they were satisfied with support from their manager and 40% said managers could not be counted on to help.
- In the 2018 staff survey, 40% of respondents said they did not have shared team objectives in their usual area of work. In the same survey, only 53% of staff said they would recommend outpatients as a place to work.
- Although governance systems were more clearly embedded than during our last inspection in July 2017, further improvement was needed. This included improvements in the effectiveness of meetings to identify and respond to performance and safety data such as incidents and complaints.
- Use and knowledge of risk registers to track and mitigate service-level risks was highly variable and some managers were not aware of risks to their own services.
- There were significant lapses in information governance, including 18 incidents in which the private medical notes of more than one patient were found in a single file. This included instances in which patients accessed someone else's information. Trust incident records did not state if staff reported these as an information governance breach. We could not establish if the trust had reported these as breaches under the Data Protection Act (2018) or the General Data Protection Regulation (GDPR).
- Allied health professionals were not consistently represented at quality and safety board meetings due to the absence of a stable leadership post or team. Some therapies teams were significantly under-resourced, such as the speech and language therapy team, which was suspended if the sole active staff member was absent.

However, we also found:

- Although staff survey results highlighted a need for further work in the leadership team, most of the staff we spoke with said they were happy with support from their managers. Reception staff said their leadership team had significantly improved since our last inspection.

# Outpatients

- The trust had implemented an improvement board to oversee the transition of services into the hospital. The board was leading a transformation plan that would result in a range of improvements to the service. However, there was variable understanding of this amongst senior staff.
- The trust had acted on our findings from May 2017 and updated the business continuity plan to include systems failures.
- Most staff we spoke with described positive improvements in the working culture, including zero-tolerance of bullying and harassment. This resulted in part from the changes senior staff implemented in response to staff survey results. This reflected an improvement from our findings in May 2017.
- The outpatient quality and performance dashboard indicated consistent achievement of most key performance indicators from January 2018 to July 2018.
- Senior staff had developed and implemented a wide-ranging staff engagement programme following feedback from the most recent staff survey. This included well-being and health promotion events and increased opportunities for development and promotion.
- The hospital had completed significant work towards a better standard of information in line with the Accessible Information Standard and the Plain English Campaign Standards.

## Outstanding practice

- The hospital had introduced a walk-in clinic for survivors of female genital mutilation (FGM). This was a multidisciplinary service provided by a gynaecologist, a midwife and an FGM sample-taker. The team facilitated access to psychology services and provided interpreters.
- Allied health professionals were working with a gender identity clinic to deliver transgender support work, on an outpatient and community basis. This work was funded through a charity and reflected an innovative drive to extend therapies services to a community that lacked structured support.

## Areas for improvement

### **We found areas for improvement:**

#### **Actions the provider MUST take to improve:**

- The trust must ensure governance systems around risk management are coherent, fit for purpose and based on contemporaneously documented evidence. This must include effective use of risk registers (or equivalent) and processes to demonstrate how risk is minimised and safety improved. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17).
- The trust must ensure premises are fit for purpose and safe with hazards mitigated appropriately. This includes risks presented by damaged or defective premises fixtures and equipment and risks presented by failed or defective fire and emergency safety systems. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 15).
- The trust must ensure senior department staff (such as the nurse in charge or service manager) have the resources, capacity and ability to address failures in premises and equipment to reduce the impact on patients and staff. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 15).
- The trust must ensure premises are secure from unauthorised access, including unauthorised smoking. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 15).

# Outpatients

## **Actions the provider SHOULD take to improve:**

- The trust should ensure staffing levels in the therapies teams, including speech and language therapy, are sufficient to meet patient demand and to ensure existing staff can work effectively.
- The trust should ensure fire risk assessments are updated, with clear documentation of improvements.
- The trust should ensure services provided for patients diagnosed with tuberculosis (TB) in the chest clinic are managed safely and in line with national guidance.
- The trust should take action to reduce late-notice cancellations and ensure where they do occur that patients are rebooked within 28 days.
- The trust should ensure continuous action is taken to reduce waiting lists and to avoid 52-week breaches.
- The trust should ensure appointment booking staff and clinical specialty staff have the resources they need to offer responsive, timely appointments.

# Diagnostic imaging

Requires improvement



## Key facts and figures

The imaging service at Whipps Cross Hospital provides general and interventional radiology, magnetic resonance imaging (MRI) and computerised tomography (CT) scanning. It also provides ultrasound and breast screening and has a nuclear medicine department. There is a walk-in direct access service for GP referrals for x-ray. The department provides a service to an average of 150 patients a day from GPs and outpatients and performs in excess of 23,000 GP requested examinations per year.

There were 158,572 imaging tests undertaken across all modalities and neuro-imaging department between August 2017 and July 2018. We previously inspected diagnostic imaging jointly with outpatients, so we cannot compare our new ratings directly with previous ratings.

Our inspection was announced (staff knew we were coming) to ensure that everyone we needed to talk with was available and the inspection took place between 02 and 03 October 2018. We spoke with 33 members of staff including nurses, healthcare assistants, porters, service managers, administrative staff, radiographers and radiologists. We also spoke with 21 patients and relatives who were in the department at the time of the inspection and looked at eight sets of patient records. We reviewed and used information provided by the trust in making our decisions about the service.

## Summary of this service

We previously inspected diagnostic imaging jointly with outpatients so we cannot compare our new ratings directly with previous ratings. We rated it as requires improvement because:

- During our inspection, we found that hospital in-patients were frequently left unsupervised in handover areas. We raised this with the service lead who acknowledged there were such occasions and told us that various safety measures including the installation of closed circuit television had been considered but not materialised.
- During the inspection, radiographers in the emergency department x-ray department raised concerns about their personal safety at night time due to the location of an equipment.
- Some radiographers expressed concern about the night duty working conditions as there were times when more than one patient was brought down from the wards with one escort. This meant it was difficult to safely monitor all patients.
- The service had no schedule in place for quality assurance testing of the home computers. There was no assurance of Digital Imaging and Communications (DICOM) grey scale display function compliance.
- The service did not complete regular quality assurance checks on equipment including mobile scanners despite being advised to do so by the medical physics expert.
- We found there were long-standing concerns on the risk register about equipment and environment which were not addressed in a timely manner. Staff told us the service had a significant amount of aging equipment which was prone to breakdown. This resulted in clinic delays and early closure.
- We found the GP x-ray department was in the old part of the hospital and the environment was poor. For example, the waiting area was cramped and poorly ventilated and the toilets and the waiting area were not accessible for patients using wheelchairs.

# Diagnostic imaging

- We found radiofrequency coils on the floor behind the magnetic resonance imaging (MRI) machine. We raised this with the site lead who told us there was a problem with funding agreement for a suitable storage unit. After the inspection, the trust confirmed that an agreement had been reached and the coils were no longer stored on the floor.

However, we also found:

- Staff understood their role in identifying and reporting safeguarding concerns to keep patients safe. They understood how to protect patients from avoidable harm and abuse.
- All the imaging rooms and waiting areas we visited were visibly clean and there were hand sanitiser units throughout the department. There were adequate supplies of personal protective equipment (PPE) including gloves and apron dispensers available for use when required.
- Staff had good awareness of incident reporting and how to raise concerns. The division effectively shared learning from incidents and good practice with staff through e-mails, team safety huddles and team bulletins.
- Patients we spoke with provided positive feedback and told us staff treated them with kindness and were caring.
- Policies and protocols including the updated radiography protocols were available for staff to access on the hospital intranet.
- The imaging service sat within the clinical support services division (CSS) and was represented at board level by the CSS director of quality performance.

## Is the service safe?

We previously inspected diagnostic imaging jointly with outpatients so we cannot compare our new ratings directly with previous ratings. We rated it as requires improvement because:

- During our inspection, we found that hospital in-patients were frequently left unsupervised in handover areas. We raised this with the service lead who acknowledged there were such occasions and told us that various safety measures including the installation of closed circuit television had been considered but not materialised.
- Some radiographers expressed concern about the night duty working conditions as there were times when more than one patient was brought down from the wards with one escort. This meant it was difficult to safely monitor all patients.
- Radiographers in the emergency department (ED) x-ray department raised concerns about their personal safety at night-time as an item of equipment was in a room with no personal alarm system. Staff told us that if they experienced dangerous situations with aggressive patients, they had little back up support or way to raise an alarm. The service lead told us they were aware of this and an additional machine was acquired which could be located in or nearer to the ED but at the time of our inspection, the location had not been determined.
- The GP x-ray department was in the old part of the hospital and the environment was poor. For example, the waiting area was cramped and poorly ventilated and the toilets and the waiting area were not accessible for patients using wheelchairs.
- We found radiofrequency coils on the floor behind the magnetic resonance imaging (MRI) machine. We raised this with the site lead who told us there was a problem with funding agreement for a suitable storage unit. After the inspection, the trust confirmed that an agreement had been reached and the coils were no longer stored on the floor.
- The trust did not provide a breakdown of compliance rates for each mandatory training module but instead provided a collective performance figure by staff group. This meant it was not possible to determine which mandatory training modules had the lowest compliance.

# Diagnostic imaging

However, we also found:

- All the imaging rooms and waiting areas we visited were visibly clean and there were hand sanitiser units throughout the department. There were adequate supplies of personal protective equipment (PPE) including gloves and apron dispensers available for use when required.
- All imaging rooms were clearly signposted with “Do Not Enter” warning lights to ensure staff or patients did not enter rooms whilst imaging was taking place.
- We saw resuscitation equipment was regularly checked. Staff completed daily checks which were documented to evidence their completion.
- The medicines cupboards we inspected were locked and secure, all stock was within expiry date and there was evidence of stock rotation. Fridge temperatures were within the correct range and we saw that daily checks were logged.
- There was 100% compliance with the World Health Organisation Surgical Safety Checklist between July 2017 and July 2018.
- Staff had good awareness of incident reporting and how to raise concerns. The division effectively shared learning from incidents and good practice with staff through e-mails, team safety huddles and team bulletins.

## Is the service effective?

**Not sufficient evidence to rate**



We do not currently rate effective in diagnostic imaging. However, we found:

- Policies were regularly updated and based on National Institute for Clinical Excellence and best practice guidelines. For example, the radiography protocols were updated in June 2018. Staff we spoke with told us they could access policies easily on the trust intranet.
- The trust ensured patients had seven days a week emergency access to the imaging service.
- The appraisals rate for medical staff was 100%. However, the trust did not provide a core service breakdown for non-medical staff.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.
- Radiation protection supervisor refresher training was regularly provided.

However, we also found:

- Some staff told us there were few opportunities for continuing professional development.

## Is the service caring?

**Good**



We previously inspected diagnostic imaging jointly with outpatients so we cannot compare our new ratings directly with previous ratings. We rated it as good because:

# Diagnostic imaging

- Although the departments we visited were busy, staff were seen to be competent, caring and ready to undertake the relevant examinations as requested.
- Staff cared for patients with compassion. Patients we spoke with provided positive feedback and told us staff treated them with kindness and were caring.
- We observed staff give patients reassurance throughout their examinations. Patients told us staff were professional and supported them well to minimise their distress.
- Staff had good awareness of patients with complex needs and gave examples of how they would deal with individuals presenting as anxious.
- Staff gave emotional support to patients to minimise their distress. Staff showed awareness of the emotional impact a patient's care, treatment or condition would have on their well-being.
- Staff involved patients and those close to them in decisions about their care and treatment. Staff explained procedures in a way that patients could understand. For example, where patients were unable to communicate clearly, staff used communication aides to support patient interaction including pictorial aids and translation services.

However, we also found:

- Whilst we saw several examples of staff being caring and supportive to patients and their relatives, we found patient dignity was compromised in the GP x-ray department changing area.
- The service was not always able to provide a chaperone for patients and we observed that not all patients were asked if they required one.
- The trust was only able to provide limited feedback from patients and relatives between October 2017 and September 2018 due to a change in the data collection provider.

## Is the service responsive?

**Good** 

We previously inspected diagnostic imaging jointly with outpatients so we cannot compare our new ratings directly with previous ratings. We rated it as good because:

- The department offered a variety of services including at other trust hospital sites, which enabled patients to access investigations at their chosen hospital where possible.
- Patients received appointment letters, explaining the purpose of their diagnostic test, what they needed to bring and how they needed to prepare. Most patients we spoke with told us they received useful information to help them plan their visit.
- Staff in all departments told us a double slot was booked for patients with special needs, including those with learning difficulties. The extra slot was used to explain the process to the patient and help them get used to the environment.
- Patients did not have to wait longer than six weeks from time of referral for a diagnostic test or procedure in MRI, CT and ultrasound.
- Consultant radiologists managed a 'hot seat' and were available to advise staff and review any images which gave cause for concern.



# Diagnostic imaging

- The service dealt with concerns and complaints appropriately and investigated them in the required time frame. We saw examples of written response to complaints. The complaints were promptly responded to and included future actions and any learning for staff.

However, we also found:

- We found the GP x-ray department which was in the old part of the hospital and the environment was poor. For example, the waiting area was cramped and poorly ventilated and the toilets and the waiting area were not accessible for patients using wheelchairs.
- Staff told us the GP x-ray clinic frequently closed at 3:30pm in order to ensure that patients already waiting were seen by the end of the clinic 5:00pm.

## Is the service well-led?

### Requires improvement



We previously inspected diagnostic imaging jointly with outpatients so we cannot compare our new ratings directly with previous ratings. We rated it as requires improvement because:

- The service had no schedule in place for quality assurance testing of the home-based computers. There was no assurance of Digital Imaging and Communications (DICOM) grey scale display function compliance.
- We found there were long-standing concerns on the risk register about equipment and environment which were not addressed in a timely manner. Staff told us the service had a significant amount of aging equipment which was prone to breakdown. This resulted in clinic delays and early closure.
- The service did not complete regular quality assurance checks on equipment including mobile scanners, despite being advised to do so by the medical physics expert.
- The trust had not fully implemented the Ionising Radiation (Medical Exposure) Regulations 2017.
- Although senior staff had acknowledged concerns raised by staff regarding night working, we found there was no mitigation in place to address safety concerns in the interim.
- Senior members of staff told us they were not always able to attend the monthly cross-site governance meetings due to pressures of work. Staff were concerned that the Whipps Cross imaging department would be under-represented at divisional level.
- There was no protected time for superintendent radiographers to perform their junior management role in addition to their clinical responsibilities.
- Staff in all modalities told us they did not always have time to attend their team meetings.
- Although the imaging division had a three-year equipment and space strategy proposal, the service was waiting for final approval at the time of this inspection.

However, we also found:

- Diagnostics sat within the clinical support services division (CSS) and was represented at board level by the CSS director of quality performance.
- A local site leadership team was established in June 2018 which was expected to strengthen site governance.

# Diagnostic imaging

## Outstanding practice

See guidance note AL8 then replace this text with your report content (if required); otherwise, delete this section and its heading.

## Areas for improvement

### **We found areas for improvement:**

#### **Actions the provider MUST take to improve:**

- The trust must ensure quality assurance of equipment is routinely completed including mobiles so that patients are safe from risk. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12)
- The trust must monitor the quality assurance checks and address the medical physics expert's advice for equipment to mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17)

#### **Actions the provider SHOULD take to improve:**

- The trust should ensure the long-standing concerns about aging equipment and poor environment are addressed.
- The trust should ensure there are quality assurance checks of equipment used by radiologists in their own homes.
- The trust should ensure that hospital in-patients are not left unsupervised in handover areas.
- The trust should review the safety conditions for staff in some working environments.
- The trust should improve the GP x-ray department environment to ensure it is accessible to all patients and enhances patient dignity.
- The trust should improve the environment in the GP x-ray department to ensure patient dignity is not compromised.
- The trust should consider ways in which staff can access continuing professional development.
- The trust should provide chaperones for patients as and when required.
- The trust should ensure there is protected time for superintendent radiographers to fulfil their managerial responsibilities alongside their clinical roles.
- The trust should fully implement the Ionising Radiation (Medical Exposure) Regulations 2017.

# The Royal London Hospital

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## Key facts and figures

The Royal London Hospital is a large teaching hospital in Whitechapel, east London and is part of Barts Health NHS Trust, one of the largest NHS trust in the country, serving 2.5 million people across east London.

The Royal London Hospital provides district general hospital services for the City of London and the London Borough of Tower Hamlets. There are 675 beds, 110 wards and 26 operating theatres.

Specialist services include a large children's hospital and a paediatric accident and emergency department. There is a trauma and emergency care centre and hyper-acute stroke centre. The hospital's roof-top helipad is the London Air Ambulance's operating base.

The London Borough of Tower Hamlets has a population of 272,000 which includes a large Muslim population and an established British Bangladeshi business and residential community. The local authority for the City of London has a resident population of 9,400 but over 300,000 people commute to and work there daily.

A comprehensive inspection of the hospital took place in January 2015 and the report was published in May 2015. The trust was placed in to quality special measures. Another comprehensive inspection took place in July 2016. All core services apart from critical care (rated good) were rated as requires improvement and the hospital was rated requires improvement overall.

There have been significant changes to the leadership of the organisation since 2015, at both an executive and site based level. A new chief executive was appointed and soon after this time a site based leadership structure was introduced, giving hospital locations more oversight and accountability.

There is a leadership team at site level, led by a managing director and supported by a site management board which is comprised of a deputy managing director, director of nursing, medical director, head of quality and efficiency, head of finance, director of estates and director of operations. They report to the trust executive. They are responsible for operational management, clinical improvement, governance and budget management. Clinical divisions are led at site level and report to the site management board as well as to the clinical boards of cancer, cardiovascular, children's health, emergency, medical, surgery and women's health.

## Summary of services at The Royal London Hospital

**Requires improvement**   

Our rating of services stayed the same. We rated it them as requires improvement because:

# Summary of findings

We inspected six core services at this inspection. They were urgent and emergency services, surgery, medical care (including older people's care), services for children and young people, outpatients and dental services.

We rated dental services as good overall and outstanding in the effective, caring and well-led domains. We rated outpatients and medical care as requires improvement. All other core services inspected at this visit were rated as good. When aggregating the overall rating for the hospital, we also took into consideration the services we did not inspect, which were maternity, end of life care, diagnostic services and critical care.

At this inspection we found that:

- There were effective governance procedures in place to underpin the provision of services. A leadership structure supported the delivery of services. Leaders demonstrated that they understood challenges as well as being able to celebrate the successes.
- The incident reporting culture was well embedded and staff were encouraged to report incidents and learn from them. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- There was extensive evidence of well-structured, multidisciplinary engagement.
- Staff at all levels were confident and positive about the working environment and culture which recognised their contribution. This was a significant improvement from our last inspection in 2016 and staff offered numerous examples of how the work culture had improved.
- We observed nursing, medical, healthcare assistant and allied health staff provide compassionate and considerate care to patients. Patients and their relatives described staff as kind and friendly. Patients we spoke with told us that they felt staff included them in their care and that consultants explained things clearly.
- Staff we spoke with were aware of their duties and responsibilities in relation to patients who lacked capacity. The trust provided training on the Mental Capacity Act and Deprivation of Liberty Safeguards as part of their wider safeguarding training.
- The environment and areas we visited were generally visibly clean and tidy and staff followed the trust's infection control policy.
- The culture within children's services had improved since the last inspection. There was a positive, open culture which valued staff and was based on shared values. The service took account of the individual needs of children and young people.
- The recording of information within patient records included good completion of risk assessments and pain scores. However, the service was in the process of transitioning from paper to electronic records and there were some inconsistencies and gaps in records due to the use of both paper and electronic notes.

However, we also found:

- Referral to treatment times were below their intended targets. Information regarding referral to treatment times was difficult to access or fully understand how the hospital was working to improve this.
- Access to services and patient flow continued to be a challenge for the emergency department. Patients were often waiting for long periods before staff moved them to an appropriate ward or department once a decision to admit had been made.
- We identified ligature risks on one ward that had not been identified in risk assessments.
- Medicines were not always stored securely and managed appropriately.

# Summary of findings

- Mandatory training levels for medical staff remained low especially for basic life support training and level 3 children safeguarding training.
- There was still a lack of signage and signposting to children's wards, the neonatal unit and clinics. There were two public access lifts to the children's hospital and parents commented that they were sometimes late for appointments because of the queue for the lift. Parents and visitors also commented that they were not confident of the lift system and had experienced the lift stall or break down.
- Patients and families said that the Wi-Fi access rarely worked and children found it difficult to do schoolwork or access social media to keep in touch with friends and family.

# Urgent and emergency services

Good  

## Key facts and figures

The emergency department (ED) at the Royal London Hospital provides care for the local population 24 hours a day, seven days a week.

The ED is a designated Major Trauma Centre, providing a 24/7 specialist service to the north east and east London area alongside patients received via its role within the London Trauma Network. The department saw 164,710 patients in 2017/18 of which approximately a quarter were children. The department has approximately 300 WTE staff with a well-developed research facility and extended training opportunities for clinical staff.

Patients present by walking into the adult or children's reception areas or if arriving by ambulance via a separate entrance. If a patient arrives on foot, they are booked in by reception before being seen by an initial assessment nurse, who then streams them to an appropriate area. If the patient arrives by ambulance, they are assessed by an emergency medical consultant or senior registrar / ACP in the emergency assessment area before then being taken to the most appropriate area, e.g. the 16 bedded cubicle area, injuries, ambulatory care or urgent care to receive care and treatment. If the patient arrives via the designated red phone patch alert system (via air or road ambulance), they are taken straight into the department's eight bay resuscitation area.

The department also has a consultant-led psychiatric liaison team.

Children under 16 years of age are booked in at a separate Children's ED reception and triaged by a qualified children's emergency department nurse where they are then streamed to an appropriate area. It has its own high dependency area and new four bedded clinical decisions unit.

We visited the ED over three days during our announced inspection. We looked at all areas of the department and we observed care and treatment. We looked at 58 sets of patient records. We spoke with 71 members of staff, including nurses, doctors, allied health professionals, managers and support staff. We also spoke with 27 patients and 10 relatives who were using the service at the time of our inspection. We reviewed and used information provided by the organisation in making our decisions about the service.

## Summary of this service

Our rating of this service improved. We rated it as good because:

- Staff understood how to protect patients from abuse. Staff knew how to recognise and report abuse and they knew how to apply it.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- Staff monitored patients who were at risk of deteriorating appropriately. Early warning scores were in use in both adult and paediatric areas.
- There were good protocols in place for the recognition and management of sepsis.
- There was consistent recording of information within the patient records reviewed. This included good completion of risk assessments and pain scores. The recording of pain assessments had improved since the last inspection.
- The incident reporting culture was well embedded and staff were encouraged to report incidents and learn from them.

# Urgent and emergency services

- Multidisciplinary working was evident in all areas of the department.
- Staff were professional and care for patients in a caring and compassionate manner. Feedback from patients and relatives was positive.
- There was a positive culture within the department and staff generally felt supported by managers.
- The vision and strategy of the department was still one of striving for excellence which was demonstrated through a continuous programme of clinical and professional development.

However, we also found:

- The paediatric waiting room was still not in sight of the nursing station and checks were not consistently being carried out as we found in the last inspection. This posed a significant risk to children who deteriorate as there is a lack of clinical oversight of the waiting area.
- Some of the paediatric guidelines on the trust intranet were out of date and not reviewed.
- The department was still a negative outlier for the Trauma Audit and Research Network (TARN) mortality. However, the department was working with TARN on improving data collection methods.
- The department did not meet the target to admit, discharge, or transfer 95% of patients within four hours between in any of the 12 months preceding our inspection.
- Patients were still waiting for long periods before staff moved them to an appropriate ward or department once a decision to admit and been made. Access to services and patient flow continued to be a significant problem for the department and patients could experience long waits.

## Is the service safe?

**Good**  

Our rating of safe improved. We rated it as good because:

- Staff recognised incidents and knew how to report them. Managers investigated incidents quickly, and shared lessons learned and changes in practice with staff.
- Staff kept patients safe from harm and abuse. They understood and followed procedures to protect vulnerable adults or children.
- At the last inspection reception staff were responsible for the initial streaming of patients. This was no longer the case and patients were streamed by a triage nurse.
- At the last inspection we found pressure ulcer risk assessment tools were not used for patients at risk of developing pressure ulcers. We reviewed some records of patients at risk and found pressure ulcer assessments were completed appropriately.
- We saw patients at risk of deteriorating were suitable escalated and managed. Patients at a high risk of sepsis were reviewed and treated within recommended time frames.
- There were good medical and nursing staffing levels and skill mix which ensured the department was safe.
- At the last inspection we found hand hygiene audits were not always carried out and hand gel dispensers were empty. During this inspection this had improved. We found the department was clean and equipment well maintained. Staff followed infection control policies that managers monitored to improve practice.



# Urgent and emergency services

- Controlled drugs were stored securely and staff followed appropriate procedures.
- The psychiatric assessment room had been updated to ensure the doors opened both inward and outward. This meant staff could now access the room in the event of a barricade which kept patients safe.
- At the last inspection we found inconsistent recording of fridge temperatures. This had improved and fridge temperatures checks were consistently recorded.
- We previously found security guards were not willing to assist with violent patients. The department had increased security presence to improve this as part of the violence reduction plan.

However, we also found:

- The paediatric waiting room was still not in sight of the nursing station and checks were not consistently being carried out as we found in the last inspection. This posed a significant risk to children who deteriorate as there is a lack of clinical oversight of the waiting area.
- We found some sharps bins were open which would be a risk of patients put their hand into them.
- We found some mandatory training for medical staff had poor compliance. For example, infection, prevention and control, fire safety, medical gas safety and information governance.
- We found some poor compliance with medicines management. For example, in cubicles we found one medicines cupboard containing drugs had faulty key lock and was unlocked and a fridge in the resus area was also unlocked due to a faulty lock..

## Is the service effective?

**Good**   

Our rating of effective stayed the same. We rated it as good because:

- Staff provided care and treatment based on national guidance and evidence and used this to develop new policies and procedures.
- Staff displayed good knowledge of the treatment of patients presenting with sepsis. On two occasions during the inspection we saw staff appropriately following the sepsis six protocol.
- Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other preferences.
- Recording of pain scores had improved since the last inspection.
- Doctors said there was good access to training and support for professional development.
- We saw examples of good multidisciplinary working. Doctors, nurses and other healthcare professionals supported each other to provide care. The involvement of other teams such as the on-site psychiatric liaison helped to improve the patient experience.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.
- The department took place in a number of clinical audits throughout the year and showed evidence of learning and improvement following the audits.

# Urgent and emergency services

- Staff received their annual appraisals and the department was compliant with the trust target.

However, we also found:

- Similar to the last inspection, we found some paediatric guidelines were out of date or had not been reviewed.
- The mean rate of survival for trauma patients presenting to, or related to the department was a negative outlier. The department had worked with the Trauma network to understand why this was the case and had found errors in data submission. Whilst this had improved the score it was still a negative outlier at the time of the inspection
- The trust's unplanned re-attendance rate to accident and emergency within seven days was worse than the national standard of 5% and also consistently worse than the England average.

## Is the service caring?

**Good**   

Our rating of caring stayed the same. We rated it as good because:

- Patients, families and carers were positive about the care across the service and we observed compassionate and courteous interactions between staff and patients.
- Patients and relatives told us staff were respectful and helpful and gave them regular updates.
- Observations of care showed staff maintained patient privacy and dignity. Staff explained what they were doing at all times and allowed patient and relatives opportunities to ask questions.
- Staff provided emotional support to patients and relatives and could signpost them to services within the organisation as well as external organisations for additional support.

## Is the service responsive?

**Requires improvement**   

Our rating of responsive stayed the same. We rated it as requires improvement because:

- The department's performance against the Department of Health's target of 95% of patients admitted, transferred or discharged within four hours of arrival was poor. The department consistently failed to meet the standard, and performed worse than the England average.
- The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust did not meet this standard for five out of 12 months.
- From April 2017 to March 2018, the trust's monthly median total time in A&E for all patients was consistently worse than the England average.
- There were still issues with patient flow in the department. Patients were waiting for long periods of time in the department and experienced delays accessing beds within the hospital.

However, we also found:

- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

# Urgent and emergency services

- The trust planned and provided services in a way that met the needs of local people. They worked with commissioners, external providers and local authorities.

## Is the service well-led?

Good   

Our rating of well-led stayed the same. We rated it as good because:

- The service had a clear vision and strategy that all staff understood and put into practice.
- The department had governance, risk management and quality measures to improve patient care, safety and outcomes.
- Staff and managers were clear about the challenges the department faced. They explain the risks to the department and the plans to deal with them.
- The emergency department had a clear management structure at both divisional and departmental level. The managers knew about the quality issues, priorities and challenges. The department now had a matron in post.
- Staff described the culture within the service as open and transparent. Staff could raise concerns and felt listened to. They said leaders were visible and approachable.

However, we also found:

- Staff highlighted issues accessing computer terminals to record notes. Agency staff could not access computerised records.

## Outstanding practice

- The department ran an outstanding trauma service for patients and had undergone a health and wellbeing review for staff following difficult trauma cases and major incidents.
- The department had introduced virtual reality headsets in the paediatric emergency department which could be used to distract children during painful procedures.

## Areas for improvement

**We found areas for improvement:**

**Actions the provider MUST take to improve:**

- The trust must improve clinical oversight of the paediatric waiting room and ensure checks are completed and documented consistently. Children could deteriorate in the waiting room which posed a significant risk. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12)

**Actions the provider SHOULD take to improve:**

- The trust should ensure sharps bins lids are closed to prevent patient harm.
- The trust should continue to work towards improving flow and capacity within the ED to improve performance against the national target.

# Urgent and emergency services

- The trust should consider how to improve IT systems across the department to enable easier sharing and recording of information.
- Improve medical staff mandatory training compliance.

# Medical care (including older people's care)

Requires improvement   

## Key facts and figures

Medical care services at the Royal London Hospital (RLH) include acute, specialist and general medical services within two divisions. Specialist medicine division services are delivered across mixed and dedicated inpatient wards. There are five wards, including a 26 bedded renal ward, a 26 bedded cardiac and respiratory ward, a 22 bedded HIV, infectious diseases and respiratory ward, a 26 bedded ward specialising in diabetes, endocrine and metabolic diseases and a 26 bedded ward for gastroenterology and hepatology. Within the division is the endoscopy unit as well as HIV and sexual health services, dermatology and rheumatology services, provided on an outpatient basis.

The division of emergency care and trauma's medical services are provided across the four medical specialties of acute medicine (a 52 bedded acute medical admissions ward), stroke medicine (26 bedded ward, with 12 of these beds designated as hyper-acute stroke unit (HASU) monitored & funded beds), older peoples medicine (two 26 bedded wards) and urology medicine (this includes a large outpatient neurophysiology unit / sleep centre study centre and an outpatient specialist infusions unit).

For the medicine core service, the trust had 87,427 medical admissions from April 2017 to March 2018. Emergency admissions accounted for 42,691 (48.8%), 5,040 (5.7%) were elective, and the remaining 39,696 (45.4%) were day case.

Admissions for the top three medical specialties were:

- General medicine: 24,413
- Gastroenterology: 22,946
- Cardiology: 11,059

(Source: Hospital Episode Statistics)

We last inspected this service in July 2016 and rated the safe, caring and well-led domains as requires improvement, with a requires improvement rating overall. We told the trust they should:

- The trust should ensure nurse to patient ratios are managed in relation to the individual needs of patients, including whether they are bedbound and/or cared for in a side room.
- The trust should ensure staff who wish to undertake additional qualifications relevant to their role are supported to do so.
- The trust should ensure temporary staff, including agency nurses and volunteers, are suitably qualified and have the appropriate personal skills to adequately care for patients with understanding and kindness.
- The trust should ensure learning from infection prevention and control audits are implemented by all staff.
- The trust should ensure staff have the capability to safely manage documentation relating to patients, including observations, where areas use a dual system of paper-based and electronic records.
- The trust should ensure the variable staffing levels of nurses and medical staff, particularly at weekends, does not reduce the hospital's ability to provide safe care.

# Medical care (including older people's care)

We carried out our announced inspection at Royal London Hospital (RLH) medical and older people's wards from 11 to 13 September 2018. We found the trust had made progress in improving some of these areas, including significant improvements in the working culture and privacy and dignity of patients. However, we also found inconsistencies in the quality of recording, records audits and the identification of risks.

During our inspection we inspected a range of medical inpatient wards, the acute assessment unit (AAU), and the discharge lounge. We also met with trust wide senior staff from learning disability, safeguarding, and therapy services.

We spoke with over 40 members of staff across medical and older people's services across a range of roles and levels of seniority. This included agency and locum staff and staff providing services to patients and visitors through third party contractual arrangements. We also spoke with 11 patients and eight relatives and carers. We reviewed local and national audit data, trust policies and patient records.

## Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

Following our last inspection in July 2016, we issued six actions the provider should take to improve. During this inspection, the service had dealt with or shown improvement for some of the previously reported concerns. But we also found:

- We were not assured that all risks were identified and action plans in place to address identified risks. There was a divisional medicines risk register which fed into the corporate risk register. However, we identified ligature risks on ward 10E, but these were not identified on the divisional risk register. Senior staff on the ward were not aware of whether there was a ligature risk assessment in place.
- During our previous inspection we found that staff did not consistently record observations relating to an elevated NEWS score. During this inspection we found that staff on some wards were still inconsistent in their recording of NEWS scores.
- During our previous inspection we reported that we had found inconsistent recording of patient information in several areas. During this inspection we found the hospital had taken action in the form of regular audits to address shortfalls in record keeping. However, recording was still inconsistent on some wards.
- Staff on ward 10E were unaware of whether there was a ligature risk assessment for the ward. We requested the wards ligature risk assessment from the trust, but this was not received.
- Medical staff had not met the trust's 85% standard for six out of 24 subjects, this included rates of basic life support training at 59%. This meant there was a risk of medical staff not having up to date skills in resuscitation and basic life support.
- We found issues in regards to equipment being stored securely. We found the door to a medical room which stored medicines on ward 13E open.
- During our previous inspection we found there were significant gaps in understanding and practice in relation to the control of substances hazardous to health (COSHH). During this inspection we found there were still gaps in relation to the safe storage of COSHH.

# Medical care (including older people's care)

- Improvements were required in the management of medicines on some wards. We found: disorganisation within medicine cupboards, medicines not placed in their correct locations and not returned to pharmacy as appropriate, patients own drugs (POD), these are medicines bought in by patients from home, stored in a medicines trolley, overstocked controlled drugs (CD) cabinets and duplication in ordering, and fridge temperatures not being recorded accurately.
- Delayed transfers of care from April 2018 to August 2018 were stable, but the rates were high at between 28% in July 2018 and 35% in May 2018.
- Ward staff on 10E said they could not meet the psychological and emotional needs of patients diagnosed with personality disorders as these patients were not supported by the Mental Health Liaison Service.
- There were 3,298 patients moving wards at night across 13 wards within medicine at the hospital.

However, we also found:

- Staffing levels across most services had shown improvement.
- Staff delivered care and treatment in line with national guidance and standards and reviewed trust policies to ensure they were always up to date.
- There was extensive evidence of well-structured, multidisciplinary engagement and professional development that contributed to a better skilled workforce.
- There was a demonstrable focus on ensuring safeguarding was a key focus of every member of staff and of all care delivered in the hospital. This was evident from the highly visible, proactive work of the safeguarding team to increase training and discussions and to update the trust policy in a way that would be useful to staff.
- Patients and their relatives described staff that were kind, attentive and friendly. Patients told us staff included them in discussions about their care and that staff adapted communication styles to enable their understanding.
- Staff at all levels of responsibility were empowered and confident and were positive about a new working environment and culture that recognised their contribution. This was a significant improvement from our last inspection in 2016.

## Is the service safe?

**Requires improvement**   

Our rating of safe stayed the same. We rated it as requires improvement because:

- During our previous inspection we found that staff did not consistently record observations relating to an elevated NEWS score. During this inspection we found that staff on some wards were still inconsistent in their recording of NEWS scores.
- During our previous inspection we reported that we had found inconsistent recording of patient information in several areas. During this inspection we found the hospital had taken action in the form of regular audits to address shortfalls in record keeping. However, recording was still inconsistent on some wards.
- Staff on ward 10E were unaware of whether there was a ligature risk assessment for the ward. A site wide risk assessment was performed and acted upon in 2015 by the estates department. The hospital did not consider that the ward based teams needed to perform a further assessment of the area, or that an additional divisional risk was necessary. The hospital did not submit evidence of whether the 2015 risk assessment had been reviewed in accordance with the trust's policy.



# Medical care (including older people's care)

- Medical staff had not met the trust's 85% standard for six out of 24 subjects. This meant there was a risk of medical staff not having up to date skills in resuscitation and basic life support. Nursing staff met or exceeded the trust's 85% target for completion of all mandatory training subjects.
- During our previous inspection we found there were significant gaps in understanding and practice in relation to the control of substances hazardous to health (COSHH). During this inspection we found there were still gaps in relation to the safe storage of COSHH.
- The neurology planned investigations unit on Ward 11D identified a risk to patients with neurological conditions requiring intravenous immunoglobulin (IVIg). Patients requiring IVIg therapy were placed on inpatient waiting lists, with no plan in place in regard to a patient requiring IVIg in an emergency.
- Improvements were required in the management of medicines. There was disorganisation within the medicine cupboards on ward 13E. On ward 14E we found some medicines were not placed in their correct locations and not returned to pharmacy as appropriate. We found some examples of patient own drugs (POD), these are medicines bought in by patients from home, stored in the medicines trolley. We found that the controlled drugs (CD) cabinets were overstocked and some duplication in ordering had occurred. Fridge temperatures were recorded on a daily basis but were not recorded accurately.

However, we also found:

- All required staff exceeded the trust's minimum requirements for the completion of level 1 and level 2 safeguarding training. Although specialist medicine at 82% compliance was 3% below the trust's 85% standard for level 3 safeguarding training.
- There had been improvements in the standards of infection control, with most wards regularly achieving the trust's 98% standard.
- The trust nurse to patient ratios had improved since our previous inspection. A safer staffing tool was used to ensure staffing levels were based on the individual needs of patients, including whether they were bedbound and/or cared for in a side room.
- The hospital had introduced a unique rota system. The rotas ensured that urgent or un-planned medical admissions were seen and assessed by a relevant consultant within 12 hours of admission, or within 14 hours of the time of arrival, and ensured patients were assessed by a suitably qualified medical practitioner within 30 minutes.
- Data from the NHS Safety Thermometer indicated a trend of reductions in falls, hospital-acquired pressure ulcers and catheter acquired urinary tract infections.
- Medical wards investigated all incidents and used learning from investigations to improve the delivery of care. Incidents were reported on and discussed through the divisional governance structure, and from this actions were identified to minimise the risk of repeat occurrences. Staff also told us there was a culture at RLH where incident reporting was encouraged.

## Is the service effective?

Good  → ←

Our rating of effective stayed the same. We rated it as good because:

- Staff delivered care and treatment that adhered to national standards and guidance, including from the National Institute of Care and Excellence and royal colleges relating to individual specialties.

# Medical care (including older people's care)

- During our previous inspection staff told us the trust did not support staff wishing to complete qualifications relevant to their role. However, during this inspection staff told us there were opportunities for staff to complete further study.
- The hospital had implemented the Faculty of Pain Medicine's Core Standards for Pain Management (2015). Staff recorded pain scores routinely and consistently and these were up to date in 21 patient records we looked at.
- In the 2017 national lung cancer audit, the hospital performed significantly better than the national average in the proportion of patients with histologically confirmed non-small cell lung cancer (NSCLC) receiving surgery. The hospital had improved one aspirational standard and performed similarly to the national standard in three other measures.
- Staff spoke positively of the appraisal process and said they received structured, meaningful support from their line manager to progress.
- The trust had a team of practice development nurses (PDN) who were responsible for rolling out trustwide education. The hospital offered a range of training and continuous professional development (CPD) opportunities to staff.
- Multidisciplinary teams across specialties worked together to review patients regularly and ensure their care and treatment plan remained appropriate. Reviews were frequent, comprehensive, well-coordinated and included community and social care professionals.
- Consultant cover was provided in all specialist services seven days a week with varying levels of cover from other medical staff. Social workers, physiotherapists and occupational therapists were on site seven days per week. Junior medical staff had training competencies maintained and assured via the London Deanery Annual Review of Competence Progress (ARCP) outcomes process.
- Staff training, knowledge and practice of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS) was good and appropriate to their individual role and level of seniority.

However, we also found:

- Staff did not use a consistent process in managing nutrition and hydration, including in the use of the malnutrition universal scoring tool (MUST).
- Patients at the Royal London Hospital had a higher than expected risk of readmission for elective admissions and a higher than expected risk of readmission for non-elective admissions when compared to the England average
- There was variation in the number of patients screened for sepsis. The trend in patients' sepsis screening improved from August 2017 to May 2018. However, there was a decreasing trend in the percentage of patients screened from May to July.
- The amount of health promotion information available across the wards was variable from ward to ward.

## Is the service caring?

**Good**  

Our rating of caring improved. We rated it as good because:

- The Graham Hayton unit had a specific area for the support and treatment of patients with a diagnosis of human immunodeficiency virus (HIV), this ensured patients privacy and dignity was respected.
- Feedback from patients and their relatives was consistently good and they spoke positively about staff kindness and compassion.

# Medical care (including older people's care)

- The response rate to the NHS Friends and Family Test had been lower than the national average and individual teams had developed initiatives to address this.
- Counselling, bereavement and multi-faith chaplaincy services were readily available.

However, we also found:

- There was an inconsistent amount of printed information available across wards and departments.
- During our previous inspection we found some temporary staff, including agency nurses and volunteers lacked the appropriate personal skills to adequately care for patients with understanding and kindness. During this inspection we found interactions between agency nursing staff appropriate, the hospital had also reduced its reliance on agency staff.

## Is the service responsive?

**Requires improvement**  

Our rating of responsive went down. We rated it as requires improvement because:

- Delayed transfers of care from April 2018 to August 2018 were stable, but the rates were high at between 28% in July 2018 and 35% in May 2018.
- Ward staff on 10E said they could not meet the psychological and emotional needs of patients diagnosed with personality disorders as these patients were not subject to the Mental Health Act and therefore not supported by the Mental Health Liaison Service.
- Staff we spoke with recognised the risks associated with unnecessary patient bed moves. Staff told us patients were only moved when essential. However, from April 2017 to March 2018, there were 3,298 patients moving wards at night across 13 wards within medicine at the hospital.

However, we also found:

- There was evidence of service planning to meet the specific needs of the local population. This included staff in sexual health services working closely with local commissioners and non-profit organisations. The acute admissions unit (AAU) having a community liaison service that enabled GPs to speak directly to a consultant seven days a week.
- The hospital had a complex discharge team who could fast track complex discharges. This ensured patients with complex care needs who could be better cared for in the community had their care packages co-ordinated.
- To minimise the risk of outlying patients being missed off medical lists the medical team had created a patient list on the clinical records system (CRS) to enable medical staff in tracking their patients.

## Is the service well-led?

**Good**  

Our rating of well-led improved. We rated it as good because:

- Leadership at the trust had been devolved to the trust's hospital sites. Staff told us the move to a model of site based leadership had increased staff engagement at a local level.

# Medical care (including older people's care)

- During our previous staff reported extensive delays between recruiting staff and completing their pre-employment checks. However, during this inspection staff told us the trust's human resources (HR) had improved their pre-employment check processes and new staff received a starting date in a reasonable timescale.
- RLH had a range of specialist leads with responsibility for aligning services with the trust's vision and strategy. Divisional and specialist services teams had developed their own strategies based on the trust's overarching vision and strategy and transformation priorities. This enabled teams to drive forward the trust's goals whilst adapting these to their own service and patient's needs.
- During our previous inspection some staff told us there were pockets of bullying and harassment in the hospital. However, during this inspection staff without exception told us there had been a culture shift at RLH. Many staff told us they felt they were being listened to by the trust board. Staff across all services told us there had been improvements in staff morale across all areas of the hospital.
- A patient forum provided oversight of care standards and presented their experiences in board meetings. This was part of the trust's engagement strategy, which included several ways patients could be involved with the trust. Staff we spoke on medical wards stated there were opportunities for engagement with the trust and opportunities to speak with the trust's board and executive team.
- The trust had a range of networks to support staff, including a women's network which had a remit of encouraging women to apply for senior roles. There were also LGBTQ, black, Asian and minority ethnic (BME) networks, to support staff in minority groups and provide peer support. There had been a range of staff engagement activities to produce a 'diversity and inclusion positive action charter' for staff.
- The trust had developed a model of medical care that supported doctors.
- The research unit offered commercial clinical trials as well as portfolio trials. The trials offered novel, innovative treatments to some patients which would not normally be available on the NHS.

However, we also found:

- We were not assured that all risks were identified and action plans in place to address identified risks. There was a divisional medicines risk register which fed into the corporate risk register. However, we identified ligature risks on ward 10E, but these were not identified on the divisional risk register.
- Therapy staff said the trust's model for therapies had an impact on the ability of therapy managers to be involved in business planning. This meant some new business cases were developed without considering whether therapies had the capacity to meet the demands placed on them by new models of working.
- Staff told us the trust's IT systems had improved since our last inspection. However, most staff said there were still some issues with IT systems. Therapies staff told us there were insufficient numbers of computers on the wards for their staff to use.

## Outstanding practice

- The trust had developed a model of medical care which supported doctors. For example, doctors were initially employed in acute general medicine and encouraged and supported to develop skills in specialist medicine.
- The Grahame Hayton unit had launched a monthly clinic to support survivors of childhood abuse as a result of a research project which demonstrated that survivors of abuse preferred to access support from a hospital site. The unit had trained staff in interviewing survivors of abuse. Survivors could access counselling support at the clinic.

# Medical care (including older people's care)

- The renal ward had received £1 million from the Barts charity to develop a diabetic and kidney centre. The aims of the centre were to provide opportunities for clinical research and innovative treatments. The plan was for the centre to become commercially funded within five years.
- Older people's services had a frailty academy to promote research, education and training for staff working with older people.

## Areas for improvement

### **We found areas for improvement:**

#### **Actions the provider MUST take to improve:**

- The trust must ensure staff on all wards are consistent in their recording of national early warning score (NEWS) scores. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12).
- The trust must ensure that wards and departments are assessed for ligature risks. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17).

#### **Actions the provider SHOULD take to improve**

- The trust should ensure all staff have up to date skills in resuscitation and basic life support.
- The trust should ensure staff on all wards are consistent in their recording of patient information and that records audits are robust and address shortfalls in record keeping.
- All equipment should be stored securely including locked rooms where equipment is stored.
- Chemicals should be stored and handled in accordance with the control of substances hazardous to health (COSHH).
- The ward should ensure senior ward staff are aware of and familiar with ligature risk assessments on wards.
- The trust should ensure medicines are managed in accordance with best practice guidelines at all times.
- The trust should ensure there is a consistent process in managing patients' nutrition and hydration, including in the use of the malnutrition universal scoring tool (MUST).
- The trust should ensure there is consistency in the number of patients screened for sepsis.

# Surgery

Good  

## Key facts and figures

The Royal London Hospital provides a range of day case, elective and emergency surgical services to a population of patients from east London. More than 25,000 surgical procedures were carried out at the hospital last year, and the trust is in the top quartile for surgical activity nationally. Ten percent of activity was emergency work, including complex poly-trauma, 60% was day case activity and 30% elective inpatient activity.

Our inspection was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available. Our inspection team was overseen by an inspection manager and included a CQC inspector, a pharmacist inspector, three specialist professional advisors: two surgical nurses and a consultant surgeon, and an expert by experience. An expert by experience is a person with experience of using care services.

We inspected the perioperative care pathway from assessment, admission, operating theatre and recovery. We looked at provision for both inpatient and day care patients. We visited the main theatre and ambulatory care and diagnostic centre (ACAD) day care theatre departments. We also visited the pre-assessment clinic, and a sample of the nine inpatient wards where we inspected a range of surgical specialties: 3D, 3F, 10F, 12C, 12D, 13C, 13D.

We spoke with 41 members of staff including the surgery service leadership team, doctors, nurses, operating department practitioners, allied health professionals, pharmacists, health care support workers and administrators. We also spoke with 16 patients.

We reviewed 21 sets of individual patient records and 16 medicines administration records.

We attended a range of meetings including multi-disciplinary safety huddles, patient handovers, board rounds, and a trust bed capacity meeting.

Information we hold and gathered about the provider was also used to inform our inspection and the specific questions we asked.

## Summary of this service

Our rating of this service improved. We rated it as good because:

- The leadership team had sufficiently addressed the concerns identified at our previous inspection.
- There was a significant improvement in theatre utilisation, bed management, bed availability and a focus on improving patient access and flow.
- There were effective processes for incident reporting, investigation and evidence of improved shared learning from incidents.
- Staffing levels had improved in wards and the operating theatre department. There were low vacancy rates and less reliance on temporary staff to cover gaps.
- There was an improved supply and availability of surgical instruments with no recent cancellations of surgery attributed to lack of equipment.
- Surgical pathways were planned and delivered in line with referenced national clinical guidance. There was a clinical audit programme which informed service development.

# Surgery

- Staff had the required knowledge, skills and competencies to carry out their roles effectively. Managers appraised staff performance and provided developmental support.
- Patients gave consistently positive feedback about the quality of care they received.
- Staff felt the culture of the organisation had improved and described the leadership team as accessible and supportive. Equal opportunities for BAME staff had been addressed.
- The service promoted learning and development, and research and innovation. Staff were positive about the support they received to challenge existing practice and try out new ideas.

However, we also found:

- Compliance with mandatory training for medical and dental staff did not meet the trust target.
- There was a hybrid system of record keeping: part paper, part electronic which led to some delayed or missed information being available to clinicians.
- Medicines were not always stored securely and managed appropriately.
- Nursing documentation such as individual patient care plans was not always complete and did not always consider emotional and psychological needs.
- Clinical waste bags in the operating theatre department were not always disposed of correctly.
- Length of stay for surgical patients was higher than the national average.
- There was a higher than expected risk of readmission when compared to the England average.
- Referral to treatment times had not been reported between 2014 and 2018. As of September 2018, the surgical service was meeting 81% of the target times for referral to treatment for non- cancer referrals.
- Local audit of patients undergoing cranioplasty showed a high infection rate. A new protocol for peri-operative care has been instituted and the result of re-audit is awaited.

## Is the service safe?

Good  

Our rating of safe improved. We rated it as good because:

- There were improved processes for incident reporting, and an embedded culture of investigation, governance and improved shared learning from incidents.
- Recruitment processes and staffing levels had improved in wards and the operating theatre department. There were low vacancy rates and less reliance on temporary staff to cover gaps.
- There had been a reduction in never events in the surgery service.
- There were clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from avoidable harm and abuse. This included use of the five safer steps to surgery checks designed to prevent avoidable mistakes.
- There was a significant improvement in the availability of surgical instruments, and the decontamination service from an external provider.



# Surgery

- Emergency equipment was easily located and ready for use. Staff were trained to use it and fulfilled their responsibilities in checking and using it in line with national and local guidelines.
- Staff were trained and competent to monitor and act upon any deterioration in a patient's condition and used an early warning score to aid the process.
- Procedures to identify and respond to individual risks to patients were understood and carried out by staff.
- All of the patient areas we visited were visibly clean and there was good compliance with infection prevention and control processes.
- Medicines were generally stored and managed appropriately.
- Records were stored securely, and electronic records were accessed by a password. Information governance was part of mandatory training and understood by staff.
- There was a business continuity plan in the event of emergencies. Staff understood their individual responsibilities in managing this.

However, we also found:

- The ageing stock of anaesthetic machines had been identified as a risk because replacement parts for faulty equipment might not be available. These had not been replaced in accordance with national guidance.
- Compliance with mandatory training for doctors and dentists did not meet the trust target in all areas.
- Staff did not always label and dispose of clinical waste safely in the operating theatre department.
- There was a mixed system of record keeping which led to delayed or missed information being available to clinicians.
- Patient assessments and care plans were not always updated and individualised and did not consider the full range of people's needs.

## Is the service effective?

**Good** ● ➡ ➡

Our rating of effective stayed the same. We rated it as good because:

- Surgical pathways were planned and delivered in line with referenced national clinical guidance. The service engaged in local and national audit programmes which informed service development.
- Staff had the required knowledge, skills and competencies to carry out their roles effectively. Managers appraised staff performance and provided developmental support.
- Staff gave patients enough food and drink to meet their needs and improve their health.
- The service made adjustments for patients' religious, cultural and other preferences.
- Staff ensured that patients were given adequate pain relief and regularly assessed their needs.
- The multi-disciplinary team worked collaboratively to provide good care.
- Staff understood their roles and responsibilities under the Mental Capacity Act 2005.

However, we also found:

- Length of stay for surgical patients was higher than the national average.

# Surgery

- There was a higher than expected risk of readmission for elective and non-elective surgical patients when compared to the England average.
- Local audit of patients undergoing cranioplasty showed a high infection rate. A new protocol for peri-operative care has been instituted and the result of re-audit is awaited.

## Is the service caring?

**Good**  

Our rating of caring improved. We rated it as good because:

- Staff treated people with respect, compassion, and dignity at all times. Emotional support was provided for patients and relatives by people with the appropriate skills and experience. Information was given to aid understanding and involvement of patients and those close to them.
- Feedback from patients and those close to them was consistently positive. People felt supported emotionally and physically and that their social needs were understood from admission to discharge.
- Patients felt supported by having access to staff at a time to suit them in the walk-in assessment unit and by having telephone as well as face to face contact with specialist nurses.
- Patients felt involved in decisions about their care and encouraged to retain their independence whilst also being provided with necessary information.

## Is the service responsive?

**Requires improvement**  

Our rating of responsive improved. We rated it as requires improvement because:

- Referral to treatment times had not been reported between 2014 and 2018. As of September 2018, the surgical service was meeting 81% of the target times for referral to treatment for non- cancer referrals.
- The average length of stay for all elective patients at the trust was 4.9 days, which is high compared to the England average of 3.9 days.
- The average length of stay for all non-elective patients at the trust was 5.3 days, which is higher compared to the England average of 4.9 days.

However, we also found:

- The trust planned and delivered services to meet the needs and demands of local people. Senior leaders worked with the local clinical commissioning groups to improve patient care and access to services.
- There was a significant improvement in theatre utilisation, access and flow, bed management, bed availability and a focus on reducing referral to treatment backlogs.
- Priority was given to a daily review to plan and manage operating theatre activity and minimise delays and cancellations for patients requiring surgery. This set out clear lines of accountability and enabled services to remain flexible and be fully utilised.

# Surgery

- Where the bed capacity prevented inpatients being admitted to surgical wards they would be cared for in other wards within the hospital and supported by clinical nurse specialists.
- There were systems in place to aid the delivery of care to patients in need of additional support. For example, people living with dementia or a learning disability were identified and referred to specialist services within or outside of the trust where appropriate.

## Is the service well-led?

**Good**  

Our rating of well-led improved. We rated it as good because:

- The leadership team had sufficiently addressed the concerns identified at our previous inspection. For example, there were significant improvements in theatre utilisation, availability of surgical instruments, the decontamination service provided, staff recruitment processes, learning from incidents, reduced never events and enhanced recovery protocols.
- Staff praised the emotional and psychological support provided by the trust following the London Bridge terror attack in June 2017.
- Staff felt the culture of the organisation had improved and described the leadership team as accessible and supportive. Equal opportunities for BAME staff had been addressed.
- There were effective risk management and governance systems in place and risks identified by staff were aligned with what was on the risk register.
- The local leadership team was knowledgeable about the service's performance, priorities and the challenges they faced. Action was taken to address the challenges.
- Staff understood and applied the trust vision and values.
- Staff worked well together at clinical level and felt supported and valued by their clinical leaders. They felt proud to work at the trust and proud of the quality of care provided.
- Staff understood the principles of the duty of candour and felt confident in the related information and processes.
- There were defined career pathways in place from band two to eight in clinical practice, management, education and research in generalist and specialist roles, including clinical nurse specialists.

However, we also found:

- Insufficient measures had been taken to address safety of medicines and safe disposal of clinical waste in theatre following our previous inspection.

## Outstanding practice

- There had been significant improvements in availability of surgical instruments, decontamination services, staff recruitment processes, learning from incidents, reduced never events and enhanced recovery protocols.
- There was a significant improvement in theatre utilisation, access and flow, bed management, bed availability and a focus on reducing referral to treatment backlogs.

## Areas for improvement

### **We found areas for improvement:**

#### **Actions the provider SHOULD take to improve:**

- The trust should ensure the replacement of anaesthetic machines is implemented in accordance with national guidance.
- The trust should ensure compliance with mandatory training for doctors and dentists meets the trust target.
- The trust should ensure medicines fridges and cupboards are locked and medicines are stored in accordance with trust policy.
- The trust should ensure all staff label and dispose of clinical waste correctly.
- The trust should ensure patient assessments and care plans are updated, individualised and consider the full range of people's needs.
- The trust should take further steps towards a unified electronic system of record keeping.
- The trust should further develop enhanced recovery after surgery protocols.

# Services for children and young people

Good  

## Key facts and figures

The Royal London Children's Hospital provides secondary and tertiary specialist care to neonates, children and young people. The hospital provides care to children in the east of London and further afield. Based on the 6th, 7th and 8th floors, there are five paediatric outpatient clinics, five paediatric inpatient wards, a paediatric critical care unit, paediatric short stay assessment unit, day care unit and neonatal intensive care unit. There are 60 inpatient beds and 25 day case beds.

The hospital has a comprehensive portfolio of secondary and tertiary services including but not limited to, allergy, critical care, dermatology, endocrinology, respiratory, neurology, gastroenterology, haematology, oncology, urology and surgery. The surgical team deliver more operations as day care procedures than comparable providers. The hospital has 39 clinical specialists supporting children with long term and chronic conditions.

The 37 cot level three neonatal unit has a mortality rate 10% below the national average and hosts the neonatal transfer service for London facilitating the transfer of some of the sickest neonates to specialist providers.

Recent innovations in the service include the appointment of a specialist nurse for children and young people with a focus on the improvement of transition between paediatric and adult services. The hospital also has a rapid access clinic enabling general practitioners to obtain specialist paediatric advice and rapid review of patients without an A&E attendance.

We visited children and young people's services over three days during our announced inspection on the 11 -13 September 2018. We visited children's inpatient wards, outpatient clinics, day care unit, paediatric critical care unit, paediatric short stay assessment unit, children's discharge lounge and the neonatal unit.

We reviewed 12 patient care records and observed care provided. We spoke with four families, seven patients and 44 members of staff including nurses, matrons, play specialists, physiotherapists, consultants, healthcare assistants, housekeepers, teachers and administrative staff. We also reviewed the trust's performance data and looked at trust policies for paediatrics.

## Summary of this service

Our rating of this service improved. We rated it as good because:

- There was now a clear policy for children aged 16 – 18 on adult wards and children's services now had full oversight of all incidents involving these patients.
- At the last inspection we found the clinical audit process was not robust. Matrons now regularly reviewed outcome data such as hand hygiene and medicines management audits and shared these results at clinical governance meetings.
- In the previous inspection we found that there was no dedicated dietetic support in the neonatal unit. This had now improved and there was now a dedicated full-time dietitian on the neonatal unit.
- Children and young people's pain was managed effectively. The service used pain assessment tools including tools for children who were unable to communicate verbally.
- There was good multidisciplinary working within children's services and the neonatal unit. Records demonstrated input from a full clinical team of doctors as well as physiotherapists, play specialists and dietitians.

# Services for children and young people

- The service took account of the individual needs of children and young people. The service now had a clear learning disabilities pathway and the use of a learning disability hospital 'passport' was also encouraged.
- The service now focused on the improvement of transition from paediatric to adult services. There were now specialist nurses including a clinical nurse specialist for adolescents who supported young people transitioning for paediatric to adult services.
- The children's outpatient clinics were flexible with appointment times and offered clinics later in the day so older children did not need to miss a full school day.
- The hospital play team visited all children and had created daily schedules for children which were tailored to their individual needs.
- Although the new divisional leadership team had just been formed, they had a formalised, clear vision and strategy for the service. Staff were also aware of the vision of the service.
- Risks we raised at our last inspection which were not on the risk register had been addressed. The risk register also reflected the risks we identified during the inspection.
- Similar to our last inspection, there was good local leadership and managers were visible and approachable.
- The hospital engaged with young people in the design of services.
- The culture within children's services had improved since the last inspection. There was a positive, open and honest culture within the teams across paediatrics at the children's hospital which valued staff and was based on shared values.
- Staff knowledge of the duty of candour had improved since the last inspection.

However, we also found:

- Mandatory training levels for medical staff remained low especially for basic life support training and level 3 children safeguarding training.
- Some policies on the trust intranet were not in date such as information governance and the trust's safeguarding children policy.
- We were unable to find a deteriorating child policy on the trust intranet however paper paediatric early warning score charts contained instructions for the management and escalation of patients.
- There was a lack of overarching consultant oversight on the day care unit. Children were seen by multiple specialist consultants and the matron escalated clinical issues to an on-call consultant but there was no dedicated medical lead for the unit with oversight of acute medical problems.
- The service was in the process of transitioning from paper to electronic records. There were inconsistencies and gaps in records due to the use of both paper and electronic notes.
- There were two public access lifts to the children's hospital. Similar to the last inspection, parents commented that they were sometimes late for appointments because of the queue for the lift.
- Parents and visitors commented that they were not confident of the lift system and had experienced the lift stall or break down.
- Patients and families said that the Wi-Fi access rarely worked and children found it difficult to do schoolwork or access social media to keep in touch with friends and family.
- There was still a lack of signage and signposting to children's wards, neonatal unit and clinics.
- Staff knowledge of the trust 'We Care' values was variable.

# Services for children and young people

## Is the service safe?

**Requires improvement**   

Our rating of safe stayed the same. We rated it as requires improvement because:

- Mandatory training levels for medical staff remained low especially for basic life support training and level 3 children safeguarding training.
- There was no deteriorating child policy on the trust intranet; however, the trust had just appointed a deteriorating patient lead nurse and paper paediatric early warning score charts contained instructions for staff on the management and escalation of deteriorating patients.
- The trust's safeguarding children policy was not in date and was due for review.
- There was a lack of overarching consultant oversight on the day care unit. Children were seen by multiple specialist consultants and the matron escalated clinical issues to an on-call consultant but there was no dedicated medical lead for the unit with oversight of acute medical problems.
- Children's services were in the process of moving fully to the use of electronic records but at the time of the inspection were still in transition and using a mixture of paper and electronic notes. We found that on some wards it was difficult to ascertain whether a patient admission booklet had been fully completed due to some information being recorded by hand and some information being recorded on the electronic system. Agency staff were also unable to access the electronic records system.
- Parents and visitors commented that they were not confident of the lift system to the children's hospital and had experienced the lift stall or break down.

However, we also found:

- Staff knowledge of the duty of candour had improved since the last inspection.
- There was now a robust policy for children aged 16 – 18 on adult wards and children's services now had full oversight of all incidents involving these patients.
- In the previous inspection there was a high use of locum medical staff in the neonatal unit. The neonatal unit medical staff were now all substantive.
- Ligature risks we found on the last inspection had now been addressed.

## Is the service effective?

**Good**  

Our rating of effective improved. We rated it as good because:

- At our last inspection, we did not find a robust clinical audit process to monitor adherence to evidence based practice. At this inspection we found there was now a robust clinical audit process. Matrons regularly reviewed outcome data such as hand hygiene and medicines management audits and shared these results at clinical governance meetings.
- Staff knowledge of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) had improved since the last inspection.



# Services for children and young people

- At the previous inspection, discharge information was given verbally. We saw that discharge information was now given in written form as well as explained to the patient and carer by a nurse.
- The trust delivered care in line with national clinical guidance.
- The leadership team were aware of their national audit outcomes, recognised areas for improvement and had plans in place to address these.
- In the previous inspection we found that there was no dedicated dietetic support in the neonatal unit. This had now improved and there was now a dedicated full-time dietitian on the neonatal unit.
- Children and young people's pain was managed effectively. The service used pain assessment tools including tools for children who were unable to communicate verbally.
- Appraisal rates for nursing and medical staff had improved since the last inspection.
- There was now a structure in place which offered staff regular one to one clinical supervision. Compliance rates were also now being monitored.
- There was good multidisciplinary working within children's services and the neonatal unit. Records demonstrated input from a full clinical team of doctors as well as physiotherapists, play specialists and dietitians.
- Staff were engaged with different professionals to support the complex needs of their patients such as seeking mental health input for children with eating disorders and engaging with the local authority to support families. Consultants also provided teaching sessions in general practitioner (GP) practices in the community.
- The service supported patients by promoting healthier lifestyles.
- At our last inspection we found that staff did not use personal child health records (red books). Staff now actively encouraged parents to bring the book to their child's appointments.

However, we also found:

- Some policies on the trust intranet such as information governance were not in date.
- Records for young people now included nutrition and hydration assessments but audit results for the screening tool for the assessment of malnutrition in paediatrics showed that compliance remained low.

## Is the service caring?

**Good** ● ➡ ➡

Our rating of caring stayed the same. We rated it as good because:

- Staff were passionate about their work toward children and their families and focused on delivering patient centred care.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- There was a high level of emotional support provided by staff and the play team.
- Staff involved patients and those close to them in decisions about their care and treatment.

However, we also found:

# Services for children and young people

•We observed on two occasions where medical staff did not draw the curtains around patients during examinations to maintain their privacy.

## Is the service responsive?

**Good**  

Our rating of responsive improved. We rated it as good because:

- The trust planned and provided services in a way that met the needs of local people.
- The service took account of the individual needs of children and young people. The service now had a clear learning disabilities pathway and the use of a learning disability hospital 'passport' was also encouraged.
- The service now focused on the improvement of transition from paediatric to adult services. There were now specialist nurses including a clinical nurse specialist for adolescents who supported young people transitioning for paediatric to adult services.
- The trust now had a clear policy to ensure that mixed sex accommodation breaches did not occur. We saw that staff observed the policy and ensured that children over the age of 11 did not share bays with the opposite gender.
- There were appropriate translation and advocacy services to support patients with English as an additional language. Leaflets were also available in a variety of languages.
- Food menus were child friendly and snacks were also available for inpatients. Menus included options for dietary needs and specific cultures.
- The children's outpatient clinics were flexible with appointment times and offered clinics later in the day so older children did not need to miss a full school day.
- The hospital play team visited all children on inpatients wards and had created daily schedules for children which were tailored to their individual needs.

However, we also found:

- Patients and families said that the Wi-Fi access rarely worked and children found it difficult to do schoolwork or access social media to keep in touch with friends and family.
- There was still a lack of signage and signposting to children's wards and clinics.
- There were two public access lifts to the children's hospital. Similar to the last inspection, parents commented that they were sometimes late for appointments because of the queue for the lift.
- Staff told us children still stayed longer than 48 hours on the paediatric short stay assessment unit which was similar to what we found at the last inspection.

## Is the service well-led?

**Good**  

Our rating of well-led improved. We rated it as good because:

# Services for children and young people

- At our last inspection, plans to develop the directorate into a children's hospital had not been formalised. At this inspection, although the new divisional leadership team had just been formed, there was now a formalised, clear vision and strategy for the service.
- There were now effective governance arrangements and a focus on audit, review and oversight across the service which involved staff at all levels.
- Risks we raised at our last inspection which were not on the risk register such as ligature risks, risk of mixed sex breaches, and gaps in service for patients with learning disabilities had been addressed. The risk register now reflected the risks we identified during the inspection.
- At our last inspection, staff did not know who the executive team for the hospital site were. At this inspection staff we spoke with were able to identify site management and divisional leadership teams and also told us they were visible on the wards.
- Frontline staff were now aware of the long term vision of the service.
- The service had improved in their engagement with young people and their families in the design of services. For example, the service had developed child friendly feedback forms. Children and parents could also nominate staff members for 'going above and beyond'. The youth forum was well established in the hospital and gave young people the opportunity to influence decisions to make the hospital experience better for their peers.
- The trust had improved staff engagement and made use of 'greatix' for staff to report and share comments when their colleagues had demonstrated excellence in patient care. Staff were positive about the use of 'greatix'.
- There was a positive, open and honest culture within the teams across paediatrics at the children's hospital which valued staff and was based on shared values. At our last inspection staff reported instances of bullying and harassment. At this inspection, staff we spoke with consistently commented on a supportive and open culture.
- Similar to our last inspection, there was good local leadership and managers were visible and approachable.

However, we also found:

- Staff knowledge of the trust 'WeCare' values was variable.

## Outstanding practice

- There was outstanding practice in multidisciplinary team working throughout the children's hospital. There was a collaborative approach between clinical specialties, departments, allied health professionals, play team and the hospital school with inclusive discussions which considered the holistic needs of the child. Staff also demonstrated good multidisciplinary partnership working with external agencies and primary care providers.
- The play team provided tailored support to children in both inpatient and outpatient settings. We observed many positive interactions during clinical interventions between members of the play team and patients. The play team also provided a high level of emotional support to both patients and parents.

## Areas for improvement

**We found areas for improvement:**

**Actions the provider SHOULD take to improve:**

- The trust should improve compliance with mandatory training for medical staff especially basic life support and level 3 children safeguarding training.

# Services for children and young people

- The trust should ensure patient records are completed in full.
- The trust should ensure there is a deteriorating child policy available on the trust intranet.
- The trust should ensure all clinical guidelines and policies for children's services have been reviewed in line with trust timescales.
- The trust should improve Wi-Fi access for patients and families on the wards.
- The trust should improve signage to the children's services.

# Outpatients

Requires improvement   

## Key facts and figures

Outpatient services at Barts Health NHS Trust are provided at all hospital sites: Royal London Hospital, Whipps Cross Hospital, St Bartholomew's Hospital, Mile End Hospital and Newham University Hospital. Barts Health saw around 1.48 million outpatient attendances in 2017/18 with the Royal London Hospital seeing 118,114 first outpatient attendances and 473,697 follow-up attendances of these.

The trust took the decision to devolve the management of outpatient departments to each hospital. At the Royal London Hospital this took place in September 2018, shortly before our visit in October 2018. Previously core outpatients and central appointments were managed by a central directorate; clinical support services (CSS).

The outpatient services at the Royal London Hospital were contained within the specialist medicine division which was led by a divisional director, divisional manager and an associate director of nursing. The divisional leads reported to the hospital's managing director who in turn reported to the chief executive officer.

We inspected the service over three announced inspection days 01 to 03 October 2018.

During our inspection visit we visited seven departments we spoke with 13 members of staff including doctors, nurses, allied health professionals, administrative and other staff. We spoke with the 10 people who were part of the senior leadership team. We reviewed 10 patient records and spoke with 11 patients and relatives.

## Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- Outpatient services had transferred from a centralised management structure to site based leadership three weeks before our inspection. As a result, structures and processes were still embedding. The site based leadership team were aware of the challenges but had not yet had the time to address the challenges and make improvements.
- There were limited audit and performance measurement processes in place. The first outpatient's performance review under site based management was scheduled for two weeks after our visit.
- The trust had only recently returned to reporting on its referral to treatment (RTT) performance in recent months and there was limited information available. RTT improvement was not yet embedded within its governance processes. Performance was currently below the target of 92%.
- We were told that access to the appointment booking system was not restricted; this meant that departments could book onto the list which caused overbooking. Staff told us that it was unclear who had oversight of this within the trust.
- The trust was not adhering to its policy concerning ASI lists in that the trust stated in its 'Access and management' policy that ASIs should be resolved within a maximum of five working days for urgent patients and 10 working days for routine patients.
- Prior to the inspection data was requested through the Routine Provider Information Request (RPIR), some of this information was not provided by the trust although it was provided following the inspection.

However, we also found:

- Staff understood how to protect patients from abuse and were aware of their roles and responsibilities for escalating safeguarding concerns. Staff had received training on how to recognise and report abuse.

# Outpatients

- Outpatient departments were observed to be clean, furnishings and fittings were in a good state of repair, hand-free waste bins were clean with foot pedals, paper towels were available from enclosed dispensers, environments were free from visible damage (flaking paint or damage services) and work surfaces were free of clutter and visible cupboards were clean.
- Staff highlighted patients who were at risk before coming to the clinic during daily meetings; this enabled them to be prioritised. Stretcher patients were reviewed at the start of each clinic and were allocated a room which could accommodate a stretcher and hoist should this be needed. Patients living with learning difficulties, dementia or other mental health conditions were prioritised and reviewed as soon as possible.
- Evidence of risks were observed, Waterlow scale was documented on an admissions form, if there is an indication that the patient's pressure areas were at risk. We saw that clinics were flexed, this meant that patients were prioritised and those at higher risk were to be seen more urgently.
- Outpatient staff showed an understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff we spoke with were aware of their duties and responsibilities in relation to patients who lacked capacity. The trust provided training on the Mental Capacity Act and Deprivation of Liberty Safeguards as part of their wider safeguarding training.
- We observed nursing, medical, healthcare assistant and allied health staff provide compassionate and considerate care to patients. All staff we observed introduced themselves and attempted to build a good rapport with patients.
- Patients we spoke with told us that they felt staff included them in their care and that consultants explained things clearly. We observed a patient's appointment with a consultant and saw that the doctor took time to explain things to the patient and answer their question.
- The hospital was meeting its cancer referral targets between April 2017 to March 2018.
- Staff confirmed that the leadership support within the non-clinical teams and Clinical teams had improved and the structure was clear and confirmed that regular meeting were held and information is cascaded down to all the areas.

## Is the service safe?

Good   

Our rating of safe stayed the same. We rated it as good because:

- Training in key skills for staff within the outpatient department was above the trust targets in all but two areas, fire safety and infection prevention and control for non-clinical staff. The trust did not include data concerning its performance in the area of consent.
- Staff understood how to protect patients from abuse and were aware of their roles and responsibilities for escalating safeguarding concerns. Staff had received training on how to recognise and report abuse.
- Outpatient departments we visited during the inspection we observed floors to be clean, furnishings and fittings were clean and in a good state of repair, hand-free waste bins were clean with foot pedals, paper towels were available from enclosed dispensers, environments were free from visible damage (flaking paint or damage services) and work surfaces were free of clutter and visible cupboards were clean. Cleaning rotas were completed on departments and displayed continuity and evidence of staff cleaning the department.
- Resuscitation equipment was checked daily. These checks were found to be documented, with emergency medicines sealed and in date. Safety testing for portable appliances was carried out by the trust on an annual basis. All devices we checked during inspection were valid with the previous inspection date recorded on a sticker.

# Outpatients

- Outpatient staff identified patients who were potentially at risk before coming to the clinic during daily meetings. This enabled them to prioritise transport for patients so they were seen as early and as promptly as possible. Stretcher patients were reviewed at the start of each clinic and were allocated a room which could accommodate a stretcher and hoist should this be needed. We were told by nursing staff that patients living with learning difficulties, dementia or mental health conditions were prioritised and reviewed as soon as possible.
  - Evidence of risks were documented on admissions forms. Waterlow scores were also documented on an admissions forms if there was an indication that the patient's pressure areas were at risk. We saw that clinics were flexed, this meant that patients were prioritised and those at higher risk were to be seen more urgently.
  - We reviewed a sample of patient notes during the inspection and found that they were completed appropriately using the notes to identify patients with pre-existing mental health conditions, learning disability or dementia. Patients we spoke with told us that their notes followed them when they moved between different departments or saw different doctors. Patients told us that their notes were available for their appointments.
  - We saw that medicines were stored appropriately and recorded on patient notes. Controlled drugs (CDs) are medications requiring additional security. Staff we spoke with were aware of the appropriate safety measures required and knew how to access medication policies on the trust intranet. There were no drugs that were out of date in the clinical area and we found prescription sheets were stored securely when we checked.
  - Staff understood the process for reporting an incident and we heard that incidents were discussed at departmental meetings and huddles although this was rarely minuted, the matron confirmed that she had developed an outpatient's email group, in which they communicated continually to staff of any risks, learning from incidents and the trust bulletins. Incidents were reported electronically and investigated within the appropriate area, or escalated if necessary.
- However, we also found:
- The trust was unable to provide information in vacancy, turnover and sickness rates for nursing and medical staffing for outpatients at the Royal London Hospital prior to the inspection. This was later requested and the information provided was trust wide. The trust stated HR Data was reported monthly to the CSS Outpatients Performance Review by way of the Workforce Performance Review Pack. The Performance Review Process will in future be replicated in the RLH Specialist Medicine Outpatient Performance Review meetings. The first is scheduled for 18 October 2018 meaning that from this date specific data will be able to be produced. The trust later produced this information following the inspection.
  - We found signage to be mixed within the department with in some areas signage clearly indicated different areas such as dermatology, neurophysiology, X-ray, fracture and cardiac. Whilst in other areas this could be improved.

## Is the service effective?

**Not sufficient evidence to rate**



We do not rate this domain.

- Auditing of clinical activity and the identification and implementation of relevant National Institute for Health and Care Excellence (NICE) guidance was predominantly managed by individual specialties rather than overseen by the outpatient department as a whole. We were told that NICE guidance was disseminated by the trust governance team to the senior managers who distribute to matrons who would disseminate to staff via the meeting structure or via email. NICE guidelines were discussed at staff meetings and implemented if relevant.



# Outpatients

- Nursing staff told us that any patients experiencing chronic pain would be referred to the pain management team. Doctors seeing patients would usually prescribe any pain relief they required. Patients with sudden pain that may be in a deteriorating state were assessed using a scoring system.
- Staff were trained in areas outside of those considered mandatory, in such things as dementia awareness, blood transfusion and investigation of incidents. Newly qualified staff received an 18 month preceptorship, and a clinical development programme and the trust was considering implementing the Mary Seacole programme.
- Outpatient staff showed an understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff we spoke with were aware of their duties and responsibilities in relation to patients who lacked capacity. The trust provided training on the Mental Capacity Act and Deprivation of Liberty Safeguards as part of their wider safeguarding training.

However, we also found:

- The trust did not provide any appraisal data for staff within outpatient's services prior to the inspection. However, during interviews with the senior management team they indicated that an appraisal rate for the outpatients' department was 94%, although this was provided following the inspection.

## Is the service caring?

**Good** ● → ←

Our rating of caring stayed the same. We rated it as good because:

- Patients we spoke with consistently gave positive feedback about the care provided by nursing staff, who they described as kind and caring. Patients told us that the nursing staff were "excellent" and many patients commented that staff in general had "good communication skills".
- We observed nursing, medical, healthcare assistant and allied health staff provide compassionate and considerate care to patients. All staff we observed introduced themselves and attempted to build a good rapport with patients.
- Reception staff told us that some patients may arrive and there are no available details on the system. The technician will go through questions and assessments to check on patient needs and support they may require.
- Patients we spoke with told us that they felt staff included them in their care and that consultants explained things clearly. We observed a patient's appointment with a consultant and saw that the doctor took time to explain things to the patient and answer their question. One patient we spoke with told us 'my consultant explains things to me, is patient and answers any of questions'.

## Is the service responsive?

**Requires improvement** ● → ←

Our rating of responsive stayed the same. We rated it as requires improvement because:

- We were unable to obtain referral to treatment data (RTT) prior to the inspection from publicly available information as the trust had not publicly made available its RTT performance. We requested this data during the inspection; we were told that the trust had only begun to report on its RTT performance in recent months. The trust provided RTT

# Outpatients

information for the week 27 September 2018, this showed the trust had attained 89.2% which was below its target of 92%. Figures showed that for the months of June, July and August 2018 performance was 83.66%, 84.29% and 84.97% respectively against the trust's target of 92%. We saw in some areas such as Diabetic Medicine 100% that the trust was consistently achieving above its target whilst in others, ENT it was achieving 82.2%.

- We found that urgent, two-week referrals were prioritised and appointments would be given to these patients. However, patients considered to be non-urgent were allocated into a waiting list that the trust referred to as 'Appointment Slot Issues' (ASI) should capacity constraints exist. We were told that the ASI list was reviewed twice each day to determine its size for each speciality. This group of patients were found to be more difficult to allocate appointments to, due to availability. Patients could therefore remain on the ASI list awaiting an appointment for an unspecified time dependant on the capacity demands of the respective speciality.
- The data provided by the trust showed that numbers of patients awaiting appointments on the ASI list were 3087 in September 2018; however, the data shows an overall decrease from 5320 patients awaiting appointments in April 2018.
- We were told that access to the appointment booking system was not restricted; this meant that departments could book onto the list which caused overbooking. We were told that this could mean that people could be incorrectly classified as urgent in order to receive an earlier appointment; the central booking team had begun to identify GPs who may be incorrectly flagging patients as urgent. Staff told us that it was unclear who had oversight of this within the trust.
- The trust was not adhering to its policy concerning ASI lists in that the trust stated in its 'Access and management' policy that ASIs should be resolved within a maximum of five working days for urgent patients and 10 working days for routine patients.

However, we also found:

- The outpatients' department took account of people's needs. It offered a range of services for patients, this included audiology, ENT, dermatology, respiratory medicine, fracture clinics and gastroenterology.
- The hospital was meeting its cancer referral targets between April 2017 to March 2018. The trust was performing better than the 93% operational standard for people being seen within two weeks of an urgent GP referral. The trust was also performing better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat).
- The trust offered a service for adults with learning difficulties. The clinic had been running for 9 years was orthoptic and optometric led and delivered specialist assessment for patient with moderate to severe learning difficulties. It allowed patients to access eye health who were unable to attend their local opticians. It linked in with the dental team to coordinate assessments when a general anaesthetic is required to ensure the patients gets the most out of their visit. The clinic had won a national award and is considered the gold standard in eye care for patients with learning disability.

## Is the service well-led?

**Requires improvement**   

Our rating of well-led stayed the same. We rated it as requires improvement because:

- Outpatient services had transferred from a centralised management structure to site based leadership three weeks before our inspection. As a result, structures and processes were still embedding. The site based leadership team were aware of the challenges but had not yet had the time to address the challenges and make improvements.

# Outpatients

- There were limited audit and performance measurement processes in place. We were told that there were no performance review data packs available for the months preceding the inspection because the site based review process was not yet aligned to incorporate outpatient services. The first outpatient's performance review under site based management was scheduled for two weeks after our visit. Information that was submitted following the inspection was in many cases still trust wide, for example vacancy rates, turnover rates and sickness information.
- The trust had only recently returned to reporting on its referral to treatment (RTT) performance in recent months and there was limited information available. RTT improvement was not yet embedded within its governance processes. Performance was currently below the target of 92%.
- Patients remained on the appointment slot issues (ASI) list; awaiting an appointment for an unspecified time dependant on the capacity demands of the respective speciality. In September 2018, 756 patients had been awaiting an appointment for four weeks or more. We were not assured that governance processes were yet in place to manage the ASI list challenges.

However, we also found:

- The outpatient services were contained within the specialist medicine division. It was led by a divisional director, divisional manager and an associate director of nursing. The divisional leads reported to the managing director who in turn reported to the chief executive officer.
- Staff confirmed that the leadership support within the non clinical teams and clinical teams had improved and the structure was clear and confirmed that regular meeting were held and information is cascaded down to all the areas.
- Most staff we spoke with understood the 'WeCare' values whilst some staff were not aware of the trust strategy, but could verbalise the strategic direction of their own service.

## Areas for improvement

**We found areas for improvement:**

**Actions the provider SHOULD take to improve:**

- The trust should ensure that it develops systems and process which enable it to determine the quality and performance of its outpatients' department.
- The trust should ensure it complies with its procedures as detailed within its 'Access and management' policy with regard to appointment slot issue (ASI) patients.

# Dental Hospital

Good 

## Key facts and figures

The Royal London Dental Hospital provides clinical experience for undergraduates and dental care professionals and qualified dentists undertaking further training. It also provides specialist services in oral and maxillofacial surgery (OMF), oral medicine, orthodontics, paediatrics dentistry, restorative dentistry and an emergency dental service. In addition to these services there is a Behcets Centre of Excellence and a Specialist Sleep Apnoea Clinic.

The Dental Hospital is set out over five floors, including a dental school on the top floor. There are 111 dental treatment chairs. Various clinics run throughout the week which includes implants, prosthodontic and general restorative. The hospital sees approximately 110,000 patients every year.

Sedation and general anaesthetic are both provided at the hospital for patients who would benefit from these procedures.

We visited the hospital over three days during our announced inspection. We looked at all areas of the hospital visiting each department. We spoke with 27 members of staff including the divisional director, clinical director, consultants, lead nurses, general managers, general dental nurses and trainee dental staff. We also spoke with 10 patients and relatives of people who use the service. We reviewed and used information provided by the hospital to come to our judgements about the service.

## Summary of this service

This was the first inspection of the dental hospital so there were no previous ratings. We rated it as good because:

- Staff completed training in line with the trusts target for completion rates.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. We saw evidence of multi-agency working in relation to safeguarding.
- The hospital had processes in place for infection control. The environment and areas we visited was visibly clean and tidy and staff followed the trust's infection control policy. We saw staff used personal protective equipment and sterilised dental instruments in line with guidance.
- Health and safety risk assessments were completed periodically.
- The Radiation protection file was up to date and the hospital were complying with safety regulations relating to this.
- Medicines were stored, checked and managed safely.
- Staffing levels were appropriate to ensure the safety of patients and visitors to the hospital.
- Patient care was delivered in line with evidence-based guidance from the National Institute for Health and Care Excellence (NICE), the Royal Colleges and other relevant bodies. Policies we viewed were reviewed regularly, and new clinical guidelines were disseminated to staff appropriately.
- Patients' needs were monitored and planned for in an effective way.
- There was excellent multidisciplinary working at all levels within the dental hospital. They had developed innovative and efficient ways to deliver joint up care.

# Dental Hospital

- The hospital shared learning from incidents across the hospital internally and nationally across dental hospitals. Consultants from the hospital were representatives of National dental safety groups
- The hospital had undertaken audits looking at reducing antibiotic use nationally. This included all dental hospitals in the UK and Ireland.
- Lessons were learnt, analysed and investigated when things went wrong. The hospital took part in and lead on local and national safety programmes to share learning. They took the opportunity to learn and share their experiences of safety events with other dental hospitals and the wider dental community.
- Staff worked closely with General dental practitioners, GP's and community services.
- Staff were involved in promoting national priorities to improve the population's health and implemented initiatives to support this.
- People were given information relating to health promotion.
- Staff we spoke with demonstrated that they understood the legal requirements of the Mental Capacity Act 2005.
- Patients comments were consistently stating that they felt well supported and were given emotional support.
- There was a co-ordinated approach towards providing good quality care in a way that focussed on patients' needs.
- We saw that people were involved in the co-ordinating of their care in a meaningful way their feelings were considered and time was taken to ensure they were comfortable with procedures.
- Innovative techniques were used to provide emotional support to patients. For example, the sensory room for children and disabled people.
- The hospital worked extensively with other departments and organisations to ensure patients were involved and engaged with their care and treatment.
- The services provided reflected the needs of the local population
- The dental hospital responded to the needs of patients by providing flexibility with appointments and joint clinic appointments.
- The hospital was fully accessible. The entrance to the building was step-free and there were lifts to access each floor.
- The services were delivered and coordinated to consider people with complex needs.
- The hospital monitored complaints, responded to them and had processes to learn from them.
- The hospital has processes in place to manage people's information in a safe way.
- There was a holistic understanding of performance, which sufficiently covered and integrated people's views with information on quality.
- There were effective governance procedures in place to underpin the provision of services.
- Roles and responsibilities were clearly defined and there was a sufficient mix of skills and abilities across the staffing levels.
- There was a leadership structure that supported the smooth running and delivery of the service.
- The leaders who we spoke with demonstrated that they understood the challenges the hospital was facing as well as being aware of and able to celebrate the successes.

However, we also found:

# Dental Hospital

- Referral to treatment times were still below their intended targets in some departments. Oral surgery, which made up 60% of the patient tracking list was 73.1%.
- The service was experiencing issues with using technology to communicate with patients and ensuring it was appropriate for patients whose first language was not English.

## Is the service safe?

**Good** 

This is the first rated inspection of this service. We rated it as good because:

- The hospital shared learning from incidents across the hospital internally and nationally across dental hospitals. Consultants from the hospital were representatives of National dental safety groups.
- The hospital had undertaken audits looking at reducing antibiotic use nationally, in which all dental hospitals in the UK and Ireland were invited to take part
- Lessons were learnt, analysed and investigated when things went wrong. The hospital took part in and lead on local and national safety programmes to share learning. They took the opportunity to learn and share their experiences of safety events with other dental hospitals and the wider dental community.
- The service provided mandatory training in key skills to all staff and had systems in place to ensure all staff completed it.
- Staff completed training in line with the trusts target for completion rates.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- Staff we spoke with during the inspection had comprehensive knowledge of safeguarding and how to report concerns, including notification to the CQC. They understood their responsibilities and discussed safeguarding policies and procedures at various meetings and between teams
- The dental hospital had suitable arrangements for transporting, cleaning, checking, sterilising and storing instruments in line with HTM01-05. This process was carried out by the main hospital's sterilisation department.
- Health and safety risk assessments were completed periodically. The hospital had a named Radiation Protection Adviser (based at the main hospital) and Radiation Protection Supervisor ensuring that the service complied with legal obligations under The Ionising Radiations Regulations 2017 (IRR17) and The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2018 (IR[ME]R 2018).
- Patients were appropriately checked and assessed by staff for sedation procedures. There were appropriate arrangements in place for the treatment of medical emergencies.
- Medicines were managed in a safe way. Medicines were stored securely and logs were in place that recorded details such as expiry, checks, and use.
- Staffing levels were planned and reviewed so that people received safe care and treatment.

## Is the service effective?

**Outstanding** 

# Dental Hospital

This is the first rated inspection of this service. We rated it as outstanding because:

- We saw evidence that the dental hospital used relevant and current evidence-based guidance, standards, best practice and legislation to develop services and shape how care and treatment was delivered.
- Staff were leaders in their field of expertise and proactively involved in peer review research. They took opportunities to participate in benchmarking research. Several audits and projects had been published and peer-reviewed in journals and the work staff completed was nationally and internationally recognised.
- Quality and outcome information was used to inform improvements in the service. In several of the specialities the hospital achieved patient outcomes that were above the national average.
- The Behcets service was performing consistently high and achieving results above other Behcets services in the country in areas such as reducing and preventing blindness and reducing average diagnosis times for patients from 12-14 years to 6.5 years.
- Results of national audits demonstrated that some services were performing above national averages in relation to quality assurance, such as the orthodontics and Behcets services.
- Staff were skilled, competent and completed relevant training to keep themselves up to date with their Continuing Professional Development (CPD).
- Staff were involved in promoting national priorities to improve the population's health and implemented initiatives to support this.
- There was excellent multidisciplinary working at all levels within the dental hospital, the wider trust and with external organisations. They had developed innovative and efficient ways to deliver joint up care.
- There was a co-ordinated approach towards providing good quality care in a way that focussed on patients' needs.
- People were given information about nutrition and hydration. Information about healthy eating and how it related to good oral health was available to patients.
- People were given information relating to health promotion.
- There were oral health education nurses and trainee hygienists working in the hospital. They were available to give people advice about good oral health.
- Staff visited patients in other departments during quieter times at the dental hospital to give oral health advice, for example on dementia wards in the main hospital.
- Staff we spoke with demonstrated that they understood the legal requirements of the Mental Capacity Act 2005.

## Is the service caring?

**Outstanding** 

This is the first rated inspection of this service. We rated it as outstanding because:

- Patients and carers across all the dental services we spoke with told us that they had positive care and treatment experiences. Comments were consistently stating that they felt well supported and were given emotional support.
- We saw comments and feedback on the various success trees in each department saying, "staff go above what you would expect them to do."



# Dental Hospital

- We saw that people were involved in the co-ordinating of their care in a meaningful way, their feelings were considered and time was taken to ensure they were comfortable with procedures.
- Education days were run annually for patients with Behcets for them to provide feedback and also learn more about their disease.
- We observed details relating to information that was available to people if they required further emotional or practical support. Staff at all levels took responsibility for ensuring patients were aware of this information.
- We saw multiple examples of feedback from patients relating to how their care was managed in a caring way.
- Patients with complex conditions were treated with care and compassion with the co-ordination of their appointments and treatments.
- Innovative techniques were used to provide emotional support to patients. For example the sensory room for children and disabled people.
- The hospital worked extensively with other departments and organisations to ensure patients were involved and engaged with their care and treatment.

## Is the service responsive?

**Requires improvement** 

This is the first rated inspection of this service. We rated it as requires improvement because:

- Referral to treatment times were still below their intended targets in some departments. Paediatrics were at 89.3% and maxillofacial were at 97.1%. However, oral surgery, which made up 60% of the patient tracking list was 73.1%. Staff told us that improvements had been made with the referral to treatment times (RTT) over the past few months, but more needed to be done.
- The service was experiencing issues with using technology to communicate with patients and ensuring it was appropriate for patients whose first language was not English.

However, we also found:

- The services provided reflected the needs of the local population.
- The dental hospital responded to the needs of patients by providing flexibility with appointments and joint clinic appointments.
- The hospital was fully accessible. The entrance to the building was step-free and there were lifts to access each floor.
- We saw example of how the service was delivered and coordinated to consider people with complex needs.
- We saw that the service monitored complaints and had processes to learn from them.

## Is the service well-led?

**Outstanding** 

This is the first rated inspection of this service. We rated it as outstanding because:

# Dental Hospital

- The hospital had innovative ways to engage with patients. They had recently devised Success trees. There were areas throughout the hospital where patients and staff could make any comments they wanted relating to the service. The hospital responded to comments made.
- Staff were focussed on continually improving the quality of care. Staff told us they were given 'autonomy' to be innovative and they were always fully supported by senior managers.
- The hospital has processes in place to manage people's information in a safe way.
- We saw there was a holistic understanding of performance, which sufficiently covered and integrated people's views with information on quality.
- The dental hospital had effective governance procedures in place to underpin the provision of services.
- Multiple sets of meetings were held to facilitate the smooth running of the service. This included daily safety huddles in each department, weekly clinical leads, monthly governance meetings, monthly nurse manager meetings, monthly dental consultants meetings, bi-monthly service meetings, monthly audit meetings and monthly commissioners meetings. In addition they had ad-hoc senior team meetings and nursing leadership meetings.
- Staff across all staffing levels spoke positively about the service. They praised leaders and said, "They are transparent with us, managers operate an open door policy".
- Roles and responsibilities were clearly defined and there was a sufficient mix of skills and abilities across the staffing levels.
- There was a leadership structure that supported the smooth running and delivery of the service.
- The leaders who we spoke with demonstrated that they understood the challenges the hospital was facing as well as being aware of and able to celebrate the successes.
- Staff carried out 'walk arounds' on each floor of the dental hospital on a weekly basis. This included checks on all areas of the service including Infection control, health and safety and talking to staff or observing any staffing issue. This process was repeated once a month and they were accompanied by someone from the main hospital to audit the checks ensuring they had been completed correctly and to confirm or deny findings. The result were consistency throughout.

## Outstanding practice

- The hospital was performing above average in certain areas for patient outcomes such as Behcets and haematology, and was providing innovative services and treatments.
- The dental hospital has an international reputation in both research and training. The hospital has a National profile for the work they conduct with Behcets and Sleep Apnoea. They have a dedicated sleep apnoea clinic which is a nationally recognised centre.
- The hospital was leading many research projects looking at oral involvement of Behcets disease. They were part of a team developing a national standardised clinical data set for the disease.
- Staff working in the hospital had international profiles for their work and achievements. They were encouraged to use and develop their skills further in the service.
- There was excellent multidisciplinary working at all levels within the dental hospital, the wider trust and external organisations. They had developed innovative and efficient ways to deliver joint up care.
- We saw comments and feedback from patients relating to staff who had provided emotional support to them and enhanced their patient journey, often quoting that the staff had gone "above and beyond" expectations.

# Dental Hospital

- Staff were highly motivated and inspired to offer care to patients in a caring and dignified manner. We saw numerous examples of staff taking people's personal, cultural and social needs into account when providing care and treatment.

## Areas for improvement

**We found areas for improvement:**

**Actions the provider SHOULD take to improve:**

- The trust should continue to ensure referral to treatment times improve.
- The trust should ensure problems with technology that help patient communication is addressed.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

**Please note:** Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website [www.cqc.org.uk](http://www.cqc.org.uk))

**This guidance** (see [goo.gl/Y1dLhz](http://goo.gl/Y1dLhz)) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

#### Regulated activity

Diagnostic and screening procedures  
Maternity and midwifery services  
Nursing care  
Treatment of disease, disorder or injury

#### Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

#### Regulated activity

Diagnostic and screening procedures  
Treatment of disease, disorder or injury

#### Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

#### Regulated activity

Diagnostic and screening procedures  
Maternity and midwifery services  
Treatment of disease, disorder or injury

#### Regulation

Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

#### Regulated activity

Diagnostic and screening procedures  
Maternity and midwifery services  
Treatment of disease, disorder or injury

#### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

#### Regulated activity

Maternity and midwifery services

#### Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

## Enforcement actions

We took enforcement action because the quality of healthcare required significant improvement.

### Regulated activity

Maternity and midwifery services

Treatment of disease, disorder or injury

### Regulation

S29A Warning Notice: quality of healthcare

# Our inspection team

The team was led by Nicola Wise, CQC Head of Hospital Inspection and David Rogers, non-executive chairman of North Staffordshire Combined Healthcare NHS Trust, and the executive reviewer for this inspection.

Max Geraghty, was the lead CQC inspection manager for this inspection.

The team also included other CQC inspection managers, inspectors and specialist advisors.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ.