Barts Health NHS Trust

# Newham University Hospital

## Quality Report

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

## Ratings

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

# Summary of findings

## Letter from the Chief Inspector of Hospitals

Newham University Hospital is part of Barts Health NHS Trust and provides acute services to a population of approximately 308,000 people living in the London Borough of Newham.

Barts Health NHS Trust employs around 15,000 whole time equivalent members of staff with approximately 889 staff working at Newham University Hospital.

We carried out an announced inspection of Newham University Hospital between 20 and 23 January 2015. We also undertook unannounced visits to the hospital on 31 January, 2 and 4 February 2015.

Overall, this hospital is inadequate. We found that urgent and emergency care was good, but surgery, critical care, maternity and gynaecology services, services for children and young people and outpatients and diagnostic imaging all required improvement. We found that medical care and end of life care was inadequate and significant improvement is required in these core services.

Care at this hospital was good overall. However, the hospital requires improvement in order to provide an effective and responsive service in order to meet the needs of patients. The hospital was inadequate in being safe and well-led by the senior management.

Our key findings were as follows:

**Safe**

- Staff in the emergency department consistently completed paediatric early warning scores.
- Whilst inpatient wards were displaying safety thermometer information, not all were displaying in areas accessible to patients, their families and carers; planned and actual nurse and healthcare assistant staffing numbers and who was in charge for each shift, in line with NHS England guidance.
- Safeguarding arrangements were in place and were followed in most circumstances, although we identified some instances where this was not the case.
- Suitable arrangements existed for reporting and investigating incidents, and most staff were familiar with the reporting system.
- Medicines management was variable, but in the main was safe.
- Infection control principles were adhered to and monitored in most areas apart from hand hygiene auditing in some surgical theatres.

**Effective:**

- The emergency department had good processes in place to ensure that patients received evidence-based care and treatment.
- Pain relief was mostly well managed, but systems to ensure that children received adequate pain relief were not comprehensive.
- Multidisciplinary working was in place and appropriate, but seven-day working was not fully in place across all disciplines.
- Patient outcomes were at or better than the national average across most surgical specialties.
- The outcomes for women and their babies in maternity services were within expected limits.
- Trainee doctors were generally well supported in maternity services and had wide-ranging opportunities to put their learning into practice.
- Most staff were competent and had received the appropriate level of training.
- The nutrition and hydration needs of patients were being managed.

# Summary of findings

- Patients were largely given sufficient information about their treatments and had the opportunity to discuss any concerns.
- Processes were in place to assess and manage risk, which were promoted by close multidisciplinary working.

**Caring:**

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

**Responsive:**

- The emergency department consistently met the national four-hour waiting time target. This target was introduced by the Department of Health for NHS acute hospitals in England, and sets a target that at least 95% of patients attending emergency departments must be seen, treated, admitted or discharged in under four hours.
- All ambulances were able to hand over to staff in the emergency department within 30 minutes of arriving.
- Staff were familiar with the complaints process, and posters directed patients to contact the Patient Advice and Liaison Service to raise concerns. However, complaints were not always managed in a timely or appropriate manner.
- Patient flow was mostly well managed, although transfers between trust sites and the availability of some services that were no longer provided at Newham University Hospital caused some concern for patients and staff.
- Women were able to discuss the type and place of birth they wanted at antenatal appointments, and community care was responsive to their needs.
- There was open access for relatives visiting patients who were dying. Car parking rates for those spending long periods visiting were preferential.
- Bereavement services were well organised and responsive to people's needs.
- Plenty of information was available to patients in written form; however, this information was only provided in English, and not in the language of the predominant population served by the hospital.
- Translation services were available when required.

**Well-led:**

- There were examples of good local leadership at Newham University Hospital, and staff felt supported by their immediate line managers. However, the trust-wide senior managers did not support local managers well.
- Some visions and strategies were in place; however, they were not being realised.
- Governance and risk management was monitored in some instances, but improvements were not consistently made.
- Patient satisfaction among women using the maternity service had increased.

We saw an area of outstanding practice:

- The Gateway Surgical Centre's design, layout, forward planning, engaged staff and integrated care with members of the multidisciplinary team were outstanding.

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

**The trust must:**

- Ensure governance and risk management processes are robust and embedded throughout the hospital.
- Ensure, where appropriate, that intensive care and hospital risk registers reflect any risks in relation to the safety of patients and/or quality of care.
- Make sure that staff are aware of and adhere to local and national guidelines, to ensure patients receive safe care.

# Summary of findings

- Improve the leadership and direction of the end of life care service.
- Ensure that staffing establishments meet the acuity and dependency levels of areas such as the coronary care unit.
- Address the significant shortages of medical and midwifery staff which sometimes compromised the care and treatment delivered to women.
- Ensure nurse staffing levels and the skill mix on some surgical areas are always appropriate to meet the needs of patients, to ensure safe, effective, caring and responsive care is provided.
- Provide a minimum of 14 hours a day consultant cover in the emergency department, in line with the College of Emergency Medicine recommendation.
- Recruit band 5 nurses to the full establishment of the critical care unit, so that patient care is not adversely affected.
- Comply with The Misuse of Drugs Regulations 2001 in relation to the security of the keys for the controlled drugs cabinet on the medical wards and the condition of the controlled drugs record book on the surgical areas.
- Ensure arrangements are in place for the safe storage of intravenous fluids in line with best practice guidance.
- Ensure that nurses record the date and time they commence intravenous fluids for central venous lines and arterial lines.
- Make sure staff are aware of their responsibilities under the Mental Capacity Act and have suitable arrangements in place for obtaining and acting accordance with the consent of service users, or acting in accordance with the best interest principles of the Act.
- Ensure nursing records are completed fully and accurately to ensure patient safety.
- Ensure the do not attempt cardio-pulmonary resuscitation (DNA CPR) form and the new DNA CPR policy are clear and in keeping with any recent ruling or guidance.
- Make sure all nursing staff on the medical wards are competent to care for the patients they are caring for.
- Ensure that all relevant ward staff receive training specific to managing patients at the end of their lives.
- Improve processes/referrals for safeguarding children in the emergency department.
- Improve multidisciplinary working in the emergency department and paediatrics.
- Listen to staff concerns regarding bullying and harassment and take action to improve the culture of the organisation.
- Ensure national guidance for the care and treatment of surgical patients is always followed.
- Support staff must to obtain the necessary qualifications to meet the core standards for intensive care units.
- Make sure all staff have appraisals as required.
- Ensure reasonable adjustments are made for people with disabilities who access surgical services.
- Share the hospital's vision with all staff.
- Reduce patient waiting times in outpatient clinics.

**The trust should:**

- Use the modified early warning score consistently to assess patients whose health may be deteriorating and update the electronic patient record with modified early warning score and PEWS scores.
- Provide leaflets in other languages for the local population.
- Improve feedback on and learning from incidents, so that staff are aware of incidents that have occurred and so that appropriate recommendations are put in place to learn from them.
- Ensure cleanliness and infection control standards are adhered to consistently across the whole hospital.
- Keep up to date with equipment checks.
- Keep policies and procedures up to date.
- Consistently obtain feedback from patients and take action to improve the service based on this feedback.
- Meet the particular needs of vulnerable patients, particularly those living with dementia.
- Ensure complaints are responded to in a timely fashion and improvements are made following these complaints.
- Reduce the gap between recommended staffing levels in relation to the number of births and the current establishment in maternity. This relates both to midwives and obstetricians, and also to the availability of theatre staff to support obstetric surgery.

# Summary of findings

- Manage the risk to timely care and treatment of women in the maternity service that results from current staff deployment, particularly out of hours.
- Improve the environment for children in the operating department, as it is not child-friendly.
- Consider providing up-to-date training in children's resuscitation, as none of the staff in the operating theatre are trained in this.
- Review the level of resuscitation equipment for children undergoing surgery.
- Review pain relief for children, as the systems to ensure that children have adequate pain relief are not comprehensive.
- Review how the children's service is led, as the service is disjointed with no overall direction or strategy.
- Review its plans to move non-elective children's surgery to The Royal London Hospital, as some medical staff are not convinced that this move is the best option for the service.
- Provide patients with clear and up-to-date information on waiting times in outpatient clinics.
- Ensure the adequate availability of hand-gel sanitiser in outpatient clinics.
- Have a coordinated outpatient booking system.
- Monitor performance targets in the outpatient department and reduce the overbooking of clinics to avoid clinics overrunning, especially the West Wing clinic.
- Make sure administration staff are regularly supervised and thus better supported.
- Share performance data with staff to increase awareness and improve practice.
- Develop mechanisms to obtain feedback from patients and relatives about their experience on the unit and improving the unit.
- Continue to recruit nursing and medical staff on the critical care unit.
- Look for ways to improve the facilities for relatives and friends on the critical care unit.

**Professor Sir Mike Richards**
**Chief Inspector of Hospitals**

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Why have we given this rating? |
|---|---|---|
| **Urgent and emergency services** | Good  | There were arrangements in place for reporting and investigating incidents. Nursing staffing levels were well managed and a recruitment programme was in place. The paediatric area within the department was staffed predominantly with qualified paediatric nurses.<br>Suitable safeguarding arrangements were in place although there were a small number of examples where trust policy had not been followed and there were inconsistencies in referral of potential non-accidental injuries.<br>The department was meeting national targets and there were good patient flows through the department. Patients felt well cared for and staff told us they felt supported by their peers and management.<br>The governance structure worked well at a local level but some meetings lacked detail and routine agenda items were not consistently discussed at meetings.<br>Consultant cover was less than the College of Emergency Medicine recommendation of a minimum of 14 hours consultant cover a day. Some improvement was needed to ensure accurate records and the monitoring of early warning scores were maintained. |
| **Medical care** | Inadequate  | The hospital was not responsive to people's need. Patient transport provider was often late to collect patients being discharged. Out-of-hours ward transfers and overall bed moves were high. Considering the large population for who English was not their first language, there was a lack of information in languages other than English. Care of people living with dementia and learning disabilities were sometimes inappropriate and a low number of complaints were responded to within the required timescale.<br>The hospital was not well-led. Risk registers had not been appropriately reviewed and did not reflect the |

# Summary of findings

current situation. Most staff commented that they rarely, if ever, saw the senior trust leadership and none of the staff we spoke with were aware of the 'leading changing lives programme'.
Senior staff felt disempowered and other ward staff reported being bullied by the site managers. Some staff felt they could not raise issues, because they were worried about the consequences of doing so.
IT infrastructure and system was poor and slow and did help staff do their jobs effectively.
The safety of medical services was compromised in a number of ways, including low nurse staffing levels, poor record completion and poor awareness of learning from incidents.
Audits showed that patient outcome were mostly above average, and multidisciplinary team working was good, but we were not assured that national guidance was always followed or that staff were competent to care for patient's particular needs.
We observed variable and 'task-based' care with poor survey results to confirm our observations.

**Surgery** **Requires improvement**

We found that aspects of the hospital's surgical services were not adequately safe, effective, responsive or well-led. However, our findings about practice within the Gateway Surgical Centre were mostly positive.
We found inconsistencies in incident investigation throughout the service, and opportunities for learning were not shared with staff. While staffing levels and skill mix were appropriate in some areas, this was not the case on inpatient wards and theatres on the main hospital site. We identified many nursing vacancies, a poor skill mix and the use of large numbers of agency staff.
Patient flow within the service was poorly managed, which often led to operations being cancelled, delays in treatment, and patients being cared for in inappropriate clinical areas. Different staff collected operating data in a number of ways, including in handwritten lists, diary notes, theatres lists and via an electronic system.
Processes to coordinate this information meaningfully in order to monitor the impact of frequent cancellations or treatment delays on patients' clinical outcomes were ineffective.

# Summary of findings

Most patients spoke positively of the care they received within the hospital, although some patients individual needs were not always met. We identified concerns with how patients with complex needs were cared for.
The lack of meaningful and accurate data, and undeveloped governance systems within surgical services meant senior managers did not have control of the day-to-day running of the service.

**Critical care** **Requires improvement** 

The unit was grappling with a range of problems, including vacancies, staff attendance at mandatory training, and improving governance within the unit.
The key issues included nursing vacancies and poor uptake of mandatory training by nurses, which had resulted in the withdrawal of final-year nursing students and a temporary suspension (later lifted) on recruitment until staff were up to date with their training and able to support new staff. Insufficient nurses had completed the post-registration intensive care course, and the unit had experienced difficulties recruiting to the post of clinical educator.
Staff understanding of obtaining patients' consent and acting in their best interest in accordance with the Code of Practice of the Mental Capacity Act (2005) was not good.
There was 24-hour consultant cover seven days a week and a critical care outreach team. Consultants thought the on-call rota was demanding, and because of capacity issues and nursing vacancies, thought they spent a lot of time managing patient flow through the unit rather than caring for patients.
Nursing staff vacancies and a lack of beds affected patient flow and meant that some patients had their surgery cancelled and others had to be transferred to another unit.
Care was based on national guidance, but there was a lack of awareness of and adherence to guidelines by nursing staff. Outcomes for patients were reported and monitored, but other aspects of governance needed to be improved, including audits.

# Summary of findings

Multidisciplinary working was in place, the unit had a dedicated pharmacist, dietician and physiotherapist. Staff were positive about their working relationships, but formal meetings between different disciplines were limited.
Other aspects of patient care, such as their nutritional needs and pain relief, were managed well. We observed staff talking to patients in a kind and caring manner, but no mechanism was in place to obtain feedback from patients or their relatives.
Resources for relatives were limited, and visiting times were fixed; however, staff were flexible and relatives could visit outside set times.
The unit did not conform to modern building standards and had a shortage of space. The unit had started to address some of the issues, but progress was slow and some of the changes were reliant on the trust developing a clinical strategy.
Within the unit, progress was hampered by the lack of a joined-up approach to improving service and quality and potential further changes to the nursing leadership.

**Maternity and gynaecology** — **Requires improvement** 

Significant shortages of medical and midwifery staff at the time of our inspection sometimes compromised the care offered to women. Midwives were tired and overstretched, and shortages of midwifes in inpatient areas had been exacerbated by the decision to stop using agency midwives.
Consultant cover on wards was for less than half the recommended number of hours, which compromised care. Out-of-hours medical cover at all levels was overstretched, leading to delays in care.
Staff thought the senior leadership was remote and that leaders imposed decisions rather than listening to the concerns of staff and supporting their ideas for improvement. Despite evidence backed by external agencies that staffing in the maternity service was below widely expected standards, there was no plan to address this.
Staff at the hospital felt like the 'poor relations' to staff at The Royal London Hospital, even though Newham University Hospital had the larger maternity unit.

# Summary of findings

However, the inpatient environment was spacious and clean, women were involved in choices about their care, there were initiatives to encourage natural birth, and more midwives had recently been recruited to fill vacancies.
There was a focus on learning from serious incidents and from complaints. Staff of all professions and grades were conscious of the importance of reporting and learning from incidents. Improvements had been made in the way that complex complaints were dealt with, to ensure that people were kept fully informed about investigations. Serious incidents were investigated and actions identified. However, the response to incidents not categorised as serious was not consistent.
Processes were in place to assess and manage risk. These included the use of team briefings and the World Health Organization (WHO) surgical safety checklist in obstetric theatres.
There was an effective training programme for midwifery staff, although many midwives felt they did not have time to develop their skills outside the framework of mandatory training.
Trainee doctors were well supported and had opportunities to put their learning into practice.
Maternity and obstetric staff demonstrated a strong commitment to the women coming to the unit and showed a desire to improve services.
A values and behaviour programme had been launched in maternity services trust-wide to improve the way midwives interacted with women and with each other, and to improve the standard of care. Feedback from women using the service indicated that mothers' experiences had improved, and staff felt the training had been beneficial.
The termination of pregnancy service was well run and we had no significant concerns about the gynaecology service.

**Services for children and young people**

**Requires improvement**

Incident reporting was satisfactory, but opportunities for sharing lessons learned were limited. The environment on Rainbow Ward was in need of refurbishment, and single-sex accommodation did not exist.

# Summary of findings

There was a shortage of equipment and some was not fit for purpose. As no one in the clinical academic group (CAG) had overall responsibility for the children's service, there was the potential for fragmentation and ineffective management.
None of the nursing staff in the resuscitation area of the ED had a children's qualification. Low staffing levels resulted in staff not being able to undertake their mandatory training. However, staff were passionate about the care they delivered and reported positively about their immediate leaders.
Patient outcomes were mixed, but one audit showed that the median HbA1c of children and young people with diabetes using the hospital was worse than the national average.
Care and treatment was based on evidence. The service took part in local and national audits in order to keep its practice at safe levels.
Systems for regular education of staff on the neonatal unit were excellent. Most staff were competent to deliver effective care, and children were looked after in a caring and compassionate manner.
Some consideration had been given to meeting the needs of young people aged between 16 and 19 years and a draft policy had been developed. However adolescents were often placed on an adult ward.
Educational services had been removed from the hospital site, so a full-time teacher was not available.
Staff could access an interpreting service for families whose first language was not English via health advocates employed by the hospital.

**End of life care** — **Inadequate**

An end of life care strategy had only just been drafted and at the time of our inspection, and had not been ratified by the board. This draft strategy did not reference any published practice guidance and demonstrated no detailed planning of how the recommendations laid down in these guidance documents would be met through specific initiatives and service developments.
End of life care appeared to have been overlooked within the clinical academic group (CAG) structure and become a forgotten service. There was a lack of direction and a lack of leadership.

# Summary of findings

The do not attempt cardio-pulmonary resuscitation (DNA CPR) form was unclear, and we had concerns about the trust's new DNA CPR policy, which did not acknowledge a recent ruling or guidance.
New end of life care planning documentation and guidance to replace the Liverpool Care Pathway had been written but not yet implemented across the whole hospital. There had been no assessment of the current needs for service provision against major national documents.
Ward staff had not received any training in managing patients' end of life care needs or care plans for dying patients.
Clinical nurse specialists in the hospital palliative care team (HPCT) demonstrated an understanding of the safeguarding reporting process and of recognising vulnerable adults at risk of harm.
However, there was no policy or guideline on the consistent use of opioids, leaving scope for drug errors.
The limited number of nursing staff available to the HPCT and wards had a detrimental effect on the hospital's ability to meet patients' end of life care needs.
Conversations involving families and friends, in which they were updated on a patient's progress and about decisions such as preferred place of care, routinely took place. Relatives found staff very helpful, caring and compassionate.
Patients' individual needs were met by ward staff and HPCT staff. There was open access for relatives visiting patients who were dying and preferential car parking rates for those spending long periods visiting. Bereavement services were well organised and responsive to people's needs.

## Outpatients and diagnostic imaging

**Requires improvement**

Many patients complained about the waiting times in the outpatient clinics. They said they had very little information and staff were not always open with them about waiting times.
There was a lack of shared objectives and strategy to achieve an improved outpatient service. Local managers were not well supported by the trust-wide senior managers and there were no clear lines of accountability. Not all staff were aware of the electronic incident-reporting process.

# Summary of findings

Medicines were stored and administered safely. The department held its own training records, which were up to date and demonstrated that most staff had attended mandatory training.

All the patients we spoke with told us they had been treated with dignity and their privacy had been respected and protected. Patients found staff polite, supportive and caring. They spoke highly of the staff in the outpatients and diagnostic imaging department.

Patients were appropriately asked for their consent to procedures. Medical records were available on most occasions for patients' clinic appointments. Translation services were available for people who did not speak English.

Inadequate

# Newham University Hospital

## Detailed findings

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

## Contents

# Detailed findings

## Background to Newham University Hospital

Newham University Hospital is an acute general hospital and part of Barts Health NHS Trust. It has 344 beds. This Care Quality Commission (CQC) inspection was not part of an application for foundation trust status.

The hospital is in the London Borough of Newham and serves the population living in the East End of London. The 2011 census showed that 80% of Newham's population were from ethnic minority groups, the largest of which was Asian or Asian British, accounting for 43.5% of residents.

Newham ranks third out of 326 local authorities for deprivation. (The local authority that ranks first is the most deprived, and the one ranked 326th is the least deprived.) Life expectancy for both men and women is slightly lower (worse) than the England average. In Newham, rates of sexually transmitted infections, smoking-related deaths and hospital stays for alcohol-related harm are worse than the England average.

Newham University Hospital is one of six registered hospital locations of Barts Health NHS Trust. Other registered hospital locations of the trust include St Bartholomew's Hospital, Mile End Hospital, The Royal London Hospital and Whipps Cross University Hospital.

## Our inspection team

**Our inspection team was led by:**

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

**Head of Hospital Inspections:** Siobhan Jordan, CQC

The hospital was visited by a team of 72 people including CQC inspectors and analysts and a variety of specialists.

There were consultants in emergency medicine, medical care, surgery, gynaecology and obstetrics, palliative care medicine, an anaesthetist, a physician and a junior doctor. The team also included a midwife, nurses with backgrounds in surgery, medicine, paediatrics, critical care and palliative care, board-level experience, a student nurse and an expert by experience.

## How we carried out this inspection

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

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

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

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

Before our inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These organisations included the clinical commissioning group, NHS Trust Development Authority, Health Education England, General Medical Council, Nursing and Midwifery Council, Royal College of Nursing, NHS Litigation Authority and the local Healthwatch.

We observed how people were being cared for and talked with carers and/or family members and reviewed patients' personal care or treatment records. We held

focus groups with a range of staff in the hospital, including doctors, nurses, allied health professionals, and administration and other staff. We also interviewed senior members of staff at the hospital.

## Facts and data about Newham University Hospital

### Key facts about Newham University Hospital

Newham University Hospital is one of six registered hospital locations of Barts Health NHS Trust.

### Context

- Newham University Hospital is based in the heart of east London and serves one of Britain's most diverse, fastest growing and youngest populations.
- The hospital offers a range of local services including a 24 hour Emergency Department, an Urgent Care Centre, a modern purpose built outpatient facility and Care of the Elderly unit.
- The health of people in Newham is varied compared with the England average. Deprivation is higher than average amongst the worst in England and about 32.0% (22,700) children live in poverty. Life expectancy for men is lower than the England average. In Year 6, 27.3% (1,014) of children are classified as obese; worse than the average for England. Statutory homelessness, violent crime and long term unemployment are worse than the England average. Drug misuse, recorded diabetes, incidents of tuberculosis and acute sexually transmitted infections are worse than the England average.
- The hospital has a total of 344 beds - 270 general and acute beds, 41 paediatric and neonatal beds and 33 maternity beds.
- The hospital employs 889 staff members, 623 nursing and 266 other staff. The workforce was supported by 9% bank and agency staff against a national average of 6% in the last financial year (2013/14).

### Activity

- 299,283 outpatient appointments (Dec13 – Nov 14)
- 101,291 urgent and emergency care attendances (April-December 2014); 45,408 of which were seen and treated by the urgent care centre.
- 6,842 annual births (2013/14)
- 1,279 Deaths (2013/14 financial year) and 283 (Apr 14 – Nov 14)
- Around 3,700 inpatient surgical emergency admissions per annum
- Around 1,100 inpatient surgical elective admissions per annum
- Around 5,200 inpatient surgical day cases per annum

### Key intelligence indicators

#### Safety

- One Never Event in the last 12 months (wrong-site surgery)
- Strategic Executive Information System (STEIS): 168 serious untoward incidents
- Clostridium difficile: 10 cases overall
- MRSA: 1 case overall (target of 0)

#### Effective

- Hospital Standardised Mortality Ratio (HSMR) indicator: no evidence of risk
- Summary Hospital-level Mortality Indicator (SHMI): no evidence of risk

#### Caring

- NHS Friends and Family test (July 2014): the average score for urgent and emergency care was 18, which was worse than the national average of 53. The response rate was 17%, which was worse than the national average of 20.2%.
- The average Friends and Family score for inpatients was 65, which was worse than the national average of 73. The response rate was 33%, which was worse than the national average of 38%.
- The average Friends and Family score for maternity (antenatal) was 17, which was worse than the England average of 62. The average score for maternity (birth) was 62, which was worse than the England average of 77. The average score for maternity (postnatal) was 30, which was worse than the England average of 65.

# Detailed findings

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

**Responsive**

- ED, four-hour waiting time target: the trust met the 95% target over the previous 12 months.
- Referral-to-treatment times; The commissioners had agreed that the trust would stop providing this data beyond August 2014, so no reliable up-to-date data was available.

**Well-led**

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

**Inspection history**

Newham University Hospital was previously inspected in November 2013. The hospital was found to be in breach of Regulations 9 (care and welfare), 13 (medicines management) and 10 (assessing and monitoring the quality of services) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We followed up on the breaches of regulations from the inspection in November 2013. We found that the hospital still did not meet the regulations related to care and welfare, medicines management, and assessing and monitoring the quality of services.

# Detailed findings

## Our ratings for this hospital

Our ratings for this hospital are:

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Urgent and emergency services | Requires improvement | Good | Good | Good | Good | Good |
| Medical care | Inadequate | Requires improvement | Requires improvement | Requires improvement | Inadequate | Inadequate |
| Surgery | Requires improvement | Requires improvement | Good | Requires improvement | Inadequate | Requires improvement |
| Critical care | Requires improvement | Requires improvement | Good | Requires improvement | Requires improvement | Requires improvement |
| Maternity and gynaecology | Inadequate | Good | Good | Requires improvement | Requires improvement | Requires improvement |
| Services for children and young people | Requires improvement | Requires improvement | Good | Requires improvement | Inadequate | Requires improvement |
| End of life care | Requires improvement | Inadequate | Good | Good | Inadequate | Inadequate |
| Outpatients and diagnostic imaging | Good | N/A | Good | Requires improvement | Requires improvement | Requires improvement |
| Overall | Inadequate | Requires improvement | Good | Requires improvement | Inadequate | Inadequate |

**Notes**

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

# Urgent and emergency services

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

## Information about the service

The emergency department at Newham University Hospital provides a 24-hour, seven days a week service to the local population in and around the borough of Newham; the department is designated as a major incident centre. The majority of Newham's population are young ethnic minority groups with high numbers of Asian/British Asians accounting for approximately 43% of the population.

The emergency department saw approximately 125,000 patients from April 2013 to March 2014. In 2013/14, the department, including the paediatric area saw and treated approximately 78,000 patients and admitted 31% of the patients seen. The remaining 47,000 patients were treated within the urgent care setting. The trust anticipates an increase in attendances for 2014/15 of an additional 9,000 patients; information provided confirmed that the department had seen over a 100,000 patients from April 2014 to December 2014.

The department was built in 2012 and provides space to accommodate patient flows through the unit. The department is spacious, and the cubicles in the majors and resuscitation areas provide a good balance between giving patients privacy and allowing staff to observe patients easily.

The trust has a single point of access via reception staff for patients that walk into the department. Reception staff signpost patients to the urgent care centre, adult emergency department or paediatric area within the department. The urgent care service is provided by a neighbouring trust. The adult emergency department is divided into a triage, majors and resuscitation areas, with a separate paediatric area and a separate waiting area. Clinical staff in the emergency department triage patients, following signposting by the reception staff.

We visited the emergency department during both the announced and unannounced parts of the inspection. We observed care and treatment and looked at patients' records. We spoke with 41 members of staff, including nurses, consultants, doctors, receptionists, managers, support staff and ambulance crews. We also spoke with 26 patients who were using the service at the time of our inspection and their relatives. We received comments from our listening events and from people who contacted us to tell us about their experiences. We also used information provided by the trust and information we requested.

# Urgent and emergency services

## Summary of findings

There were arrangements in place for reporting and investigating incidents. Nursing staffing levels were well managed and a recruitment programme was in place. The paediatric area within the department was staffed predominantly with qualified paediatric nurses.

Suitable safeguarding arrangements were in place although there were a small number of examples where trust policy had not been followed and there were inconsistencies in referral of potential non-accidental injuries.

The department was meeting national targets and there were good patient flows through the department. Patients felt well cared for and staff told us they felt supported by their peers and management.

The governance structure worked well at a local level but some meetings lacked detail and routine agenda items were not consistently discussed at meetings.

Consultant cover was less than the College of Emergency Medicine recommendation of a minimum of 14 hours consultant cover a day. Some improvement was needed to ensure accurate records and the monitoring of early warning scores were maintained.

## Are urgent and emergency services safe?

**Requires improvement**

Safety arrangements for emergency services required improvement. We noted that risk assessments were not available for basic care, for example pressure area care, and nursing staff were relied on to complete such information within the free text area of the patient's notes or by completing a paper record. Also, no system was in place accurately to carry out early warning scores and monitor observations in the adult emergency department. Staff in the emergency department consistently completed paediatric early warning scores.

Equipment was available throughout the department, although some equipment had not been dated to show it had undergone a portable appliance test (PAT) or been serviced recently. The risk register identified that some additional monitoring equipment was required for the resuscitation area to monitor critically ill patients. Some gaps were noted in the checking of equipment within the resuscitation area.

Although safeguarding arrangements were in place and followed in most circumstances, we identified some instances where this was not the case.

Staffing arrangements were largely adequate for nursing staff, although some shifts were short staffed. Consultant cover was less than the College of Emergency Medicine recommendation of a minimum of 14 hours consultant cover a day. Out-of-hours, senior medical cover was provided at registrar and middle grade doctor level.

The department had arrangements in place for reporting and investigating incidents, and all staff were familiar with the reporting system. Staff received feedback on incidents. Two serious incidents had occurred in the preceding 12 months, and staff were aware of the incidents and/or changes made.

Suitable arrangements were in place for managing medicines; these were consistently followed, and staff checked controlled drugs daily, although two emergency transfer bags were found to contain out-of-date medication. The department was clean. Hand hygiene audits were completed on a monthly basis, although some gaps were noted.

# Urgent and emergency services

IT arrangements were good, and sufficient computers were available for staff to update the electronic patient records. This included mobile computer stations within the majors and resuscitation area. The IT systems in the urgent care centre (UCC) and the emergency department for registering patients at the main reception desk were not compatible, which meant that staff had to enter patient details twice on different systems.

Overall, staff mandatory and statutory training was completed, which included safeguarding at level 3 for all paediatric staff.Arrangements were in place for responding to external major incidents, although recommendations from the last table-top exercise had not been followed up.

## Incidents

- The paediatric and the adult emergency department had not reported any Never Events from April 2014 to the time of our inspection.
- Staff we spoke with told us they were aware of how to report incidents and they received an electronic acknowledgement after they had submitted a report.
- There had been 683 incidents reported from August 2013 to September 2014, with 56 being reported and investigated as serious incidents. Most incidents were recorded as grade 3 pressure ulcers that staff had noted on the patient's arrival to the emergency department. Staff told us these should be noted as community-acquired pressure ulcers as opposed to hospital-acquired pressure ulcers. The report provided did not differentiate between community-acquired pressure ulcers and hospital-acquired pressure ulcers.
- We reviewed two serious incident investigation reports and found that actions had been taken to prevent a similar recurrence. However, we found that regarding one of the incidents, a similar incident had occurred in 2013; actions taken did not mitigate the risk and resulted in the incident being repeated in June 2014. The investigation reviewed the root cause analysis, looked at both incidents and identified the same cause in June 2014 as in 2013.
- We spoke with 11 staff who were aware of the incidents in 2013 and June 2014 and the actions taken. Staff told us that information regarding changes to practice was discussed at the medical and nursing shift handover to ensure that learning was shared within the department. We saw evidence to show that staff had also been sent emails regarding the changes in practice. No further incidents had been reported, indicating that the risk had been minimised.
- During our inspection a serious incident occurred. We were made aware that a baby was transferred from the paediatric area within the department without a portable life support system. We saw that the incident was reported appropriately on the electronic system. The incident was discussed with senior staff within the department, and we were told that a full investigation would take place. The investigation was ongoing at the time of this inspection report, and therefore we were not able to report on the findings.
- The clinical academic group (CAG) held monthly mortality and morbidity meetings. We were told that specific cases were presented from each department, and minutes we saw confirmed this. We reviewed meeting minutes from April and June 2014 which did not outline any cases from the emergency department.

## Cleanliness, infection control and hygiene

- All areas and equipment within the emergency department were visibly clean. We were told that there was an established cleaning programme for the children's toys, and the minutes of staff meetings confirmed this.
- There were policies and procedures to reduce the risk of cross-infection. Staff confirmed that they could access the infection prevention and control (IPC) policy via the trust intranet.
- Staff were aware of the trust's aseptic non-touch technique guidance, which aimed to reduce the risk of infection.
- Hand-washing facilities and hand disinfectant gel were available throughout the department. We observed staff washing their hands and using hand gel between treating patients. Staff adhered to 'bare below the elbows' policies.
- Sharps bins were labelled, signed and dated correctly, and none were seen to be over-full, which reduced the risk of needle-stick injuries.
- Personal protective equipment such as disposable aprons and gloves was available and easily accessible to staff.
- IPC training was mandatory for all clinical and non-clinical staff. Training records confirmed that all the staff were up to date with IPC training.

- The emergency department had an IPC link nurse who attended the internal link practitioners' group meeting. We were told that the IPC link nurse was unable to attend the last study day because the department was very busy. The IPC link nurse was responsible for carrying out the IPC audit programme for the area, which included hand hygiene audits.
- Hand hygiene audits were undertaken monthly. Records showed compliance at 93% for August and 100% for October and November 2014, therefore no actions were outstanding, because improvement had been made. The link nurse for infection control told us that monthly audits had not been completed for December because of the workload within the emergency department and the high number of attendances.

### Environment and equipment

- The emergency department including the paediatric area was well equipped, and staff reported that they had access to the equipment they needed. We were told that repairs were carried out within the hospital, and usually within the same day.
- We noted that not all the equipment had an up-to-date service and portable appliance test (PAT) recorded. For example, in the resuscitation area a piece of equipment to warm patients (bair hugger) was serviced in June 2013 and PAT tested in March 2013, and a cardiac monitor (Lifpak20) was last PAT tested in 2006.
- All of the bays in resuscitation area were well equipped. Staff told us that they checked the bays on a daily basis and restocked each bay after use. However, we found gaps in the cheeking sheets we looked at. For example, daily sheets were missing for 7 February 2014 to 15 February 2014, and 13 June 2014 to 23 June 2014.
- The department had special ultrasound scanning equipment (FAST) to detect life-threatening abnormalities in patients with traumatic injuries.
- We found that two bags containing equipment to assist with transferring patients to other wards or hospitals contained some out-of-date drugs.
- The paediatric area had a high dependency treatment room which was equipped with resuscitation equipment in order for babies and children to be stabilised before being transferred to a ward or to a different hospital.
- The department had two blood-analysing machines to ensure that it could obtain blood results promptly and not delay patient care. The machines were checked daily and serviced annually.
- Staff told us that sufficient computer stations were available throughout the whole emergency department. This included mobile computers on wheels, which enabled staff to enter information directly into the patient record during the patient rapid assessment and treatment process. Staff reported that the computer system worked efficiently.
- Staff told us that they did not have the appropriate portable continuous positive airway pressure equipment to manage the transfer of neonatal babies from the paediatric area within department to either paediatric intensive care or high dependency if required. We discussed this with the paediatric nursing staff, and were told that the resuscitaire held was able to provide the support required. The resuscitaire did have oxygen and the appropriate ventilation bag (Ambu bag) in the drawer.
- The resuscitation area did not have a central monitoring system (telemetry) to enable staff to provide continuous monitoring of very unwell patients. This was listed as the second item on the emergency department's risk register, because staff told us that the impact could be failure to detect deterioration in patients. We were told the department mitigated the risk by providing, where possible, one-to-one care.
- The psychiatric team was provided by an external trust partly based in the emergency department. Staff reported and we witnessed the office environment to be cramped and not fit for purpose, which led to these staff feeling demoralised.

### Medicines

- Medicines including controlled drugs were stored correctly in locked cupboards that were in line with the relevant legal guidance.
- A record of all controlled drugs that were given was kept in a register. Two members of staff had signed each entry/administration. We noted that the pharmacy department had previously checked the quantities of controlled drugs held, and the date was recorded as 23 November 2014. The pharmacy department confirmed that these checks were undertaken quarterly.
- Staff told us that they could access the British National Formulary (BNF) via the internet if they needed to check

medication contraindications or doses. We saw that three paper copies of the BNF were also available in the resuscitation room for staff to refer to. However, two of these were dated March 2013; this was brought to the attention of a member of the emergency department team, and the copies removed.

- Staff told us that all drug errors were reported as an incident and escalated to senior medical staff. Controlled drug errors would be reported in the same way, and the accountable officer for the trust would be informed.
- The department held a stock of drugs to dispense to patients being discharged from the emergency department. This included analgesia and antibiotics.
- Prescriptions (FP10) were given for all other medication not held in the department. The FP10s were numbered, and details of the individual and the medication prescribed were logged against the serial number of the prescriptions. The FP10s were kept securely in a locked cupboard, and only the nurse in charge had key access. All FP10s issued had to be agreed by a consultant or registrar on duty to ensure the medication being prescribed was appropriate.
- The trust had implemented new drug charts. Staff told us that these included a separate drug chart that was clearly labelled for diabetic patients. We heard staff being reminded of the change at the medical and nursing handover, to ensure that all staff were aware of the change.
- The department held two transfer bags in an unlocked cupboard within the resuscitation area. We found that the bags contained drugs that were all out of date. For example, atropine was dated August 2014, and adrenaline June 2014. The bag also contained an anaesthetic drug which had been prepared and was dated 24 November 2014. This was brought to the attention of the staff, and action was taken to remove the drugs.

### Records

- Reception staff told us the hospital and the urgent care centre (UCC) did not use the same computer system. This meant that the records of patients needing to be seen initially in the UCC and then transferred to the emergency department could not be moved electronically; the information had to be re-entered onto the hospital system. Staff told us that this was time-consuming for patients and staff and created unnecessary delays at reception.
- An electronic patient record and some paper documentation were used within the paediatric and adult emergency department. Most information was entered directly onto the system; this included initial assessment, pain score, observations and treatment given.
- We reviewed 25 sets of adult and paediatric notes and confirmed there was evidence of clinical assessment, diagnosis and treatment plans clearly documented.
- The electronic patient record did not include an adult early warning score (the modified early warning score). The nursing lead for the clinical academic group (CAG) told us that a modified early warning score was due to be added, but some formatting problems needed to be resolved before installation.
- Staff told us that if the modified early warning score or Paediatric Early Warning System (PEWS) were required, they used the original paper documentation. However, we could find little evidence that modified early warning scores and risk assessments were being carried out on a regular basis, whereas within the paediatric area, PEWS scores were completed routinely and included as part of the electronic patient record.

### Safeguarding

- Staff had electronic access to the policies and procedures for safeguarding adults and children. The policies for both adults and children contained safeguarding flow charts which provided staff with details of how to report concerns, and the contact details of social services. Staff we spoke with were familiar with the reporting process and the safeguarding toolkit available. The safeguarding children policy dated 1 April 2012 was referenced, with some appropriate information; however, the policy did not reference the latest 2013 version of 'Working Together to Safeguard Children'.
- Records we reviewed showed that a recent safeguarding issue had been reported in the paediatric area with the emergency department. The incident occurred in June 2014 and was raised as a serious incident. The investigation highlighted a similar incident at another emergency department within the trust, and lessons

learned showed inconsistencies in safeguarding procedures across all emergency department sites. We have been provided with the action plan and recommendations to standardise the process for safeguarding children. However, the report was not completed until October 2014, and staff in the emergency department told us that they had not received the recommendations until December 2014; we saw that some recommendations were due to have been completed between October and December 2014. The delay in the emergency department receiving the report would have delayed the completion of the actions, and therefore did not safeguard against the risk of other incidents occurring.

- As part of the recommendations arising from the point above, the lead nurse in the paediatric area within the department was to complete level 3 safeguarding training. We were told that this had been completed.
- Child protection concerns and the number of attendances in the emergency department were flagged by staff on the IT system, and a child protection proforma was used to assess risk. We reviewed three patient records and confirmed that the proforma was in place and completed; this included body mapping of injuries; where appropriate, referrals were made to health visitors as well as to the safeguarding lead nurse.
- Some paediatric staff we spoke with were unsure how to access information relating to safeguarding children. Also, there did not appear to be a consistent method for recording information relating to social services by staff during the triage process on five of the records we reviewed. The department had links with a health visitor who reviewed all paediatric attendances.
- The trust did not have chaperone policy, and we did not see any posters in the department advising patients how to access a chaperone should they wish to do so. However, we did, on several occasions, hear medical staff from the emergency department team and specialist teams ask nursing staff to chaperone them when examining patients.
- We were told that training in safeguarding adults and children was mandatory for all staff. Training records showed that 94% of staff had attended adult safeguarding training. All the paediatric staff had completed level 2 and 90% of staff had completed level 3 safeguarding training.

### Mandatory training

- A training policy was in place which outlined the mandatory training staff were expected to complete. This included fire, health and safety, basic life support or intermediate life support, advanced life support and manual moving and handling. There was no specific mandatory training relating to the Mental Capacity Act (2005). Staff said this was touched on within safeguarding training.
- Training was delivered either via e-learning modules or face-to-face sessions. Staff told us that they were allocated time within the duty rota to ensure they were able to complete the required training modules.
- The department also had a professional development nurse responsible for ensuring that staff attended training and for maintaining a department training matrix.
- The training matrix showed that 90% of staff had completed their mandatory training.

### Assessing and responding to patient risk

- Patients who arrived by ambulance were taken directly to the majors treatment area. A process was in place to assess all patients arriving by ambulance within 15 minutes. We spoke to some paramedics who were in the department and who told us that this process generally worked well, but there could be delays if the department was busy.
- The department had not reported any delays of an hour or more in ambulances being able to hand over to emergency department staff. Evidence provided by the trust supported this.
- Staff told us that they operated a rapid assessment and treatment process. This was carried out by a senior doctor and senior nurse, and included all ambulance patients as well as patients that walked into the department. The staff allocated to rapid assessment and treatment 1 and 2 were identified at the beginning of the shifts, and this was recorded on the allocation board in the majors area.
- A clinical decision unit (CDU) formed part of the emergency department. The CDU accepted patients who met specific criteria and were expected to stay no longer than 12–24 hours.
- Paediatric patients shared the main reception and were directed through to a separate waiting area; patients were initially assessed by a children's nurse or a doctor.

- Staff did not consistently use the modified early warning score to manage deteriorating patients. An audit completed in January 2015 showed that only 22% of patients in the department had a modified early warning score risk assessment.
- Paediatric staff told us, and records confirmed, that all children seen in the department were risk assessed using the Paediatric Early Warning System (PEWS). Records showed that continuing observations were carried out in line with the allocated risk score.
- The department completed a confidential risk assessment in all cases of suspected domestic violence. Where the score was 14 or over and children were present in the home, a referral was made to the Safety Planning Panel (SPP) in Tower Hamlets to ensure that individuals and their families were protected.

### Nursing staffing

- We were told that 90% of the nursing vacancies had been filled; staff we spoke with confirmed that staffing levels had improved. The department was now able to allocate one nurse to four patients – a ratio in line with the safer staffing recommendations from the Royal College of Nursing. The allocation board and duty rotas confirmed this.
- Figures provided by the trust confirmed that from January to December 2014, 14 new staff had started work in the emergency department.
- It was noted through review of a sample of rotas that some shifts remained unfilled; evidence provided by the trust showed that from April to December 2014, 77 shifts remained unfilled by bank or agency staff across emergency department services.
- We saw during the inspection that three shifts were unfilled for the adult emergency department, paediatric area and clinical decision unit (CDU). Staff we spoke with told us although some shifts were short-staffed, this was manageable and that cover was always arranged wherever possible to maintain patient safety. The unfilled posts equated to one in each area, and staff told us that the impact was minor unless the department was very busy.
- Staffing levels were discussed at handover twice a day. We noted on one day that staffing shortages were discussed and arrangements made to ensure all areas were adequately staffed. Staff said they were able to cope with the patient flows, because the matron and practice development nurse provided additional support when required.
- We spoke with a newly appointed registered nurse who was part of the emergency department's three-site rotation. The nurse felt supported and had maintained a supernumerary status during orientation to the department, despite the shift vacancies.
- The matron had, within the last year, improved the staffing levels across nursing and, at the time of our visit, had a 10% vacancy rate with 14 new staff being recruited.

### Medical staffing

- Consultant cover was provided between the hours of 8am until 8pm Monday to Friday and 10am-6pm at week-ends; which is not in line with the College of Emergency Medicines recommendations (2010) which suggest a minimum of 14 hours consultant cover a day.
- Senior cover at night was provided by either registrar or middle grade locum doctors with support if required by telephone from the consultant team. Evidence provided by the trust showed that from April 2014-December 2014, 86 shifts remained unfilled (average of 9 shifts per month).
- The lead consultant told us that the daytime consultant stayed for an additional two hours to ensure the department was safe if required, however this was good will and not part of the consultant hours. Cover was always arranged wherever possible and that patient safety was always maintained and support for junior staff was provided. Although some junior doctors told us they did not feel as well supported at night due to the lack of consultant availability.
- At the time of inspection there were six point five consultants in post and two whole time equivalent vacancies. We were told by staff there had not been an increase in the consultant establishment levels over the last two years and therefore the department were unable to extend the consultant cover at night. The departments' attendances were increasing annually which staff felt may have a negative effect on the department's ability to continue to meet the four hour national targets.

- The clinical lead confirmed a current advertisement was in place to appoint an additional ED consultant specifically for NUH.
- We were told by staff locum cover was provided by medical staff who frequently worked in the department wherever possible. Locum medical staff were given an induction and supported by senior medical staff if they were new to the department.
- Two of the consultants had paediatric emergency qualifications and advanced paediatric life support and to provide expertise to care for sick children.

### Major incident awareness and training

- The trust had a major incident plan which was last updated in September 2014. The latest version included an update on lessons learned from previous exercises as well as changes resulting from the merger that created Barts Health NHS Trust. The plan set out roles and responsibilities, and included example scenarios.
- We were told that regular major incident training took place. Most staff we spoke with told us that they had attended major incident training. Some staff also talked confidently about what to do for certain major incidents and where to access equipment and clothing.
- A designated room was used to store equipment for major external incidents.
- The department had a decontamination tent for chemical incidents and a dedicated room to isolate any patients suspected of having contracted Ebola.
- The lead clinician told us that they had undertaken major incident training in April 2014; records we saw confirmed this. There was no evidence, however, that the recommendations had been put in place.

## Are urgent and emergency services effective?

(for example, treatment is effective)

Good

The emergency department was effective and had good processes in place to ensure that patients received evidence-based care and treatment. National guidance was incorporated into local policies and followed most of the time.

The staff we spoke with felt well supported by their peers and management and had good support from other departments as well as, for example, from the pharmacy and the specialist stroke team.

The emergency department completed a variety of audits at national and departmental level; however, evidence of completed action plans was not submitted to us.

Most of the staff we spoke with in the emergency department including the paediatric area, had a good understand of how to support and assess patients who lacked capacity.

### Evidence-based care and treatment

- Clinical pathways had been developed for a number of conditions; the pathways referred to national guidance as appropriate and were available on the intranet, which staff could access as required.
- The department's clinical care pathways were part of a 'how to' guide; the consultant team updated this guide, which staff could refer to for support when treating patients.
- The 'how to' guide referred to a combination of guidance from the National Institute for Health and Care Excellence (NICE), College of Emergency Medicine (CEM) and the royal colleges to support the treatment and care pathways developed.
- We looked at the care pathways for the treatment of headache, head injury, fractured hip and sepsis, and found these were up to date. For example, we discussed the headache care pathway with the clinical lead, who confirmed it had been reviewed in May 2014 and reflected the latest guidance.
- We reviewed a sample of patient notes for patients who had attended the emergency department. From the sample we reviewed, patients had received care in line with national guidance. For example, patients who had a suspected head injury received care in line with the relevant NICE guidance.

### Pain relief

- The emergency department had an electronic scoring tool to record patients' pain levels. Pain was scored from 0 to 10 (10 being the worse). Adult patients were asked (where possible) what their pain rating was and the

nurse documented this electronically. Within the paediatric area, we also noted a pain scoring tool for some younger children or for patients with a learning disability.

- A pain score was recorded in most of the paediatric notes we reviewed.
- The patients we spoke with told us that they had received pain relief if necessary, and the records we saw confirmed this. We did, however, receive information during our inspection about a patient who waited an hour for pain relief; this was brought to the attention of the matron following our inspection, for further investigation.

### Nutrition and hydration

- The majors area of the emergency department had healthcare assistants who were responsible for ensuring food and drinks were provided if required, such as for patients with diabetes.
- Staff told us that they were able to obtain sandwiches from the hospital kitchen if required.
- Some patients we spoke with were satisfied that their nutrition and hydration needs had been met. However, two patients were admitted to the clinical decision unit (CDU) at 10pm from the emergency department and not provided with food or drink until 8am the following day.
- Water dispensers were available throughout the department. However, we noted that the water dispenser in the majors waiting area was out of order during our inspection, and remained out of order 12 days later when we returned for our unannounced inspection.
- A vending machine containing snacks and a drinks machine were available in the main waiting area.

### Patient outcomes

- The department participated in national College of Emergency Medicine (CEM) audits in 2013/14 so that it could benchmark practice and performance against that of other emergency departments. The audits included sever sepsis and shock, asthma in children and paracetamol overdose
- The audit programme tracker for December 2014 to February 2015 identified the lead, type and stage of the audit undertaken. A programme of 14 audits – for example shoulder dislocation, mental health in the emergency department and head injuries – were allocated to junior doctors in the department. Most of these audits were not due to be completed until February 2015; although the tracker indicated that some audits had been completed, they were not provided to us. The audit tracker had not been fully completed, and therefore did not provide an overview of national audits that the department had carried out.
- The emergency department had completed a 'quality in the emergency department' analysis in May 2014, which looked at staff workload, configuration of services and safe and sustainable medical staffing. The plan submitted confirmed the progress the department had made, which included reviewing the weekly dashboard and the increases made in nursing and medical staffing.
- An audit relating to measuring the care of patients presenting with a possible pulmonary embolus (blood clot in the lungs) against the NICE guidelines for treatment (CG144) showed that the emergency departments across the trust demonstrated 93% adherence to the guidance. However, the audit was not dated and although recommendations were included, we were not provided with an action plan to improve compliance with NICE guidelines.
- The nursing team carried out a modified early warning score audit in January 2015. The audit showed that a modified early warning score was applied in 22% of records reviewed. The audit summary contained an action plan that included informing staff of the outcome of the audit, providing further training for staff and carrying out a further audit in April 2015. The actions had not been completed, therefore we cannot report on the outcome of the actions taken and whether they were effective.

### Competent staff

- The trust had systems in place to ensure that professional registration of permanent employees was maintained and up to date.
- The staff we spoke with told us that they had received an appraisal within the last year and had found this process helpful. We saw that most nursing staff had received an appraisal in 2014.
- We requested appraisal data for medical staff; however, the data provided was trust wide and not specific to the Newham University Hospital; therefore data could not be considered as part of this inspection.

- The junior and middle grade doctors we spoke with told us that they felt supported by the consultants and that they were available to discuss any issues or concerns.

### Multidisciplinary working

- We observed some multidisciplinary handovers and found these to be effective. Each patient in the department was discussed to ensure the next shift had up-to-date information regarding each patient's care plan.
- Admission protocols were in place enabling emergency department staff to admit patients to the clinical decision unit (CDU) or a ward under the specialist teams. Staff told us that the protocols worked well and communication and joint working with the specialist team was very good, which enabled them to meet the four-hour emergency department waiting time target. Minutes of meetings on 10 and 24 September 2014 confirmed that the emergency department and medical teams had reviewed the process for patients being admitted through the emergency department, to minimise the delay and the impact on patient care.
- The radiology department was adjacent to the majors emergency department area. Staff reported no significant delays for patients waiting for x-rays. We noted during our inspection no delays in patients receiving prescribed diagnostic tests.
- Emergency department staff told us that they had support from psychiatric liaison, self-harm and alcohol/substance misuse 24 hours a day, seven days a week, for adults and paediatric patients. The psychiatric team was provided by an external trust, and staff described the service as effective. The team had two dedicated rooms within the emergency department and were present on site from 9am to 5pm; access to the on-call psychiatry liaison team was available out of hours.
- Weekly multidisciplinary psychosocial meetings were attended by health visitors, a social worker, nursing staff and paediatricians to review paediatric attendances and ensure that all concerns were followed up by the appropriate community teams.
- Occupational therapy and physiotherapy services that staff could refer patients to if necessary were available from Monday to Friday, but not available out of hours.

### Seven-day services

- Pharmacy services were available during the day, and on-call arrangements were in place out of hours; the emergency department provided a range of medicines that was be taken home by patients.
- The emergency department had access to the radiology department, complete with x-ray machines and magnetic resonance imaging (MRI) and computerised tomography (CT) scanners. Staff did not report any significant delays to out-of-hours access to diagnostic tests.
- Blood and gas tests were carried out in-house, and therefore results were available promptly during and out of normal hours.
- The duty rotas confirmed that consultant staffing was adequate to provide senior medical cover during the days and evenings seven days a week.
- The duty rotas confirmed that there was adequate consultant staffing to provide senior medical cover between the hours of 8am-8pm Monday to Friday and 10am-6pm at the week-ends. Providing consultant cover at peak times a seven day a week.

### Access to information

- Staff had easy access to the computer system. Sufficient computers were available to staff.
- The computer system provided staff with information about the number of patients waiting to be seen and assessed, how long they had been in the department, and their plan of care. This information was colour coded to ensure staff could see it easily.
- The majors emergency department also had a computer linked to the London Ambulance Service; this provided information about patients that were en route to the department and approximate arrival times.
- The department did not display the results of the monthly Friends and Family test, although posters asked patients to participate in the survey.

### Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We talked to staff about the Mental Capacity Act 2005 (MCA), Deprivation of Liberty Safeguards (DoLS) and consent arrangements. Some of the staff we spoke with

had a reasonable understanding of the trust's policy as well as of legislation. Staff told us they would refer to a senior member of the team if they were unsure or needed advice.

- Paediatric staff were aware of Fraser guidelines (whether doctors should give contraceptive advice or treatment to under 16-year-olds without parental consent). However, staff used these guidelines verbally to assess patients and told us no formal tool was in place. This may affect the consistency of the management of pregnancy in children under the age of 16 years, because only some of the staff we spoke with were aware of the management procedure.
- There was no specific training provision for MCA or DoLS. We were informed that learning disability training included an element of mental capacity; however, this did not include an assessment of competency or capacity for children or for people who were incapacitated for other reasons, for example if they were unconscious or intoxicated.
- Through review of patient files, we saw examples of patients whose capacity had been assessed; the trust's processes had been adhered to and documented.
- The department had a nursing lead for domestic violence. All suspected cases of domestic violence were asked to provide signed consent to a risk assessment report, to enable further assistance to be provided and the report to be passed on to the domestic violence team.

## Are urgent and emergency services caring?

Good

The emergency department including the paediatric area provided good care for patients. Most of the patients and relatives we spoke with told us that they were satisfied with the care they received and felt staff listened to them and were compassionate; this was supported by our observations.

### Compassionate care

- Most of the patients we spoke with in the emergency department including the paediatric area told us that staff were kind and caring and that they felt well looked after. One patient who had waited in the department for a long time was dissatisfied with the level of communication from staff, because he was unsure what was happening with his tests and whether or when he would move to another department. However, most patients were complimentary. One patient told us, "The care here has been excellent. I was seen quickly and I cannot fault them."
- Parents told us that their children had been seen promptly and staff had explained their treatment and answered any questions. One parent told us their child had previously spent several weeks in hospital, and that the care, treatment and communication had been very good. The check-in process had been straightforward.
- The staff did not carry out 'comfort' rounds for patients to ensure their needs had been met – for example providing toileting assistance or to ensure patients were positioned comfortably. However, we observed staff supporting and treating patients in a caring and compassionate manner. We observed senior doctors carrying out 'rounds' at regular intervals within the majors area and updating patients on their care plans.
- The Friends and Family test is used to gauge patients' perceptions of the care they received and how likely they would be to recommend the service to their friends and family. Feedback from patients through the Friends and Family test for December 2014 showed 66% of people were extremely likely to recommend the department. However, we noted that for the two months we reviewed, the response rate was only 13%.
- Staff told us the trust had changed from using comment cards to collect Friends and Family data to obtaining information using a 'token' system. Staff thought this method was unreliable and did not enable qualitative data to be collected or patients' and relatives' comments to be acted on. The aim of using tokens was to increase the response rate; however, there was little evidence to show a sustained improvement in response rates.

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

- Most patients we spoke with were satisfied with the level of involvement of staff and communication from staff. One person, however, was dissatisfied with waiting times and communication from staff.

# Urgent and emergency services

- People who attended the listening event (a meeting held before the inspection to gain people's views) were mostly complimentary about their experience and the care they received from the emergency department.

### Emotional support

- A quiet, private room was provided within the emergency department for relatives who needed time to themselves or for staff to discuss bad news with them.
- Staff told us that they kept relatives informed during resuscitation attempts or if someone was critically ill. They told us that relatives and/or patients were able to access the chaplaincy team whenever necessary, and they were able to support people of all faiths.
- We observed staff providing emotional support to patients and their families.

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

Good

The emergency department including the paediatric area was responsive to patients' needs. The department consistently met the national four-hour waiting time target, and all ambulances were able to hand over to emergency department staff within a maximum 30-minute timescale. Flows within the department to either the clinical decision unit (CDU) or a ward were well managed. People's individual needs were met; we saw some use of translation services, and staff supported patients living with dementia or a learning disability. However, we noted that information leaflets were not available in languages other than English.

Staff were familiar with the complaints process, and posters directed patients to contact the Patient Advice and Liaison Service to raise concerns. The hospital did not have a Patient Advice and Liaison Service office on site, but people were provided with the contact details. Complaints were responded to in a timely manner, although no evidence was provided of change following complaints.

### Service planning and delivery to meet the needs of local people

- Staff in the emergency department had completed a course in 'How to achieve safe, sustainable care for our emergency department' in May 2014. Changes introduced included the use of volunteers to gain patients' views in the Friends and Family test, and increasing nurse staffing levels. The time allowed for completion 12 months, and therefore it was not due to be completed until May 2015.

### Meeting people's individual needs

- Patients in the department shared the main waiting area with patients waiting to be treated in the urgent care centre (UCC) until they were called through for triage assessment or to the majors areas. There was an additional majors waiting area where reception staff directed patients to wait. Reception staff also fast-tracked patients to majors if they presented, for example, with chest pain; this ensured that patients were seen and assessed promptly.
- A separate paediatric and associated waiting area was open 24 hours a day, seven days a week.
- Staff told us that people attending with learning disabilities or complex needs such as sickle cell anaemia held a passport of care and, where possible, were fast-tracked through the department.
- The trust had a dementia strategy in place, but staff we spoke with were not aware of the strategy. Staff had received dementia-awareness training, although the emergency department did not have a dedicated area to support people living with dementia.
- Support was provided for patients who attended the department with mental health problems. The emergency department had two rooms dedicated for reviewing patients with mental health issues.
- The department had an assortment of information available for patients, which was readily accessible within the majors treatment area. The information was displayed only in English. Patients in the emergency department included high numbers of Asian and Eastern European people, therefore the information may not meet the needs of the local population.

- Staff told us that they had access to Language Line if patients were unable to communicate effectively in English and staff needed to explain treatment or provide additional information.
- Waiting times for the emergency department were displayed on a television screen in the waiting area, although it was hard to determine whether the times reflected the waits for the emergency department or UCC. We observed reception staff informing patients verbally of approximate waiting times for the emergency department when they arrived.

### Access and flow

- The national target is for 95% of all patients attending the emergency department to be admitted, discharged or transferred within four hours. From January to December 2014, the hospital had, overall, achieved the target, with an average of 95.9%. For three months within the 11-month period, the department achieved just below the 95% target.
- The emergency department dashboard reported that the under-15- and under-30-minute handovers from ambulances were 67% and 98% for the year 2013/14, compared with national targets of 85% and 95%. The department reported that no ambulances waited longer than one hour to hand the patient over to emergency department staff.
- The data provided also indicated that 4.9% of patients left the department without being seen, which was marginally better than the national target of 5%.
- Ambulance crews confirmed that despite the department being very busy, they never had long waits to hand over patients.
- Staff we spoke with told us the department was frequently very busy, but they worked as a team to provide the best care. Staff we spoke with told us that patients were expected to have a plan of care in place within two hours to ensure they received appropriate care and were admitted within the four-hour waiting time target. Consultants and senior registrars checked to ensure this happened and specialist teams reviewed patients in a timely manner.
- Nursing and medical staff told us the clinical decision unit (CDU) played a vital part, along with bed vacancies, in ensuring that patients could be admitted when required. In 2013/14, 32% of the patients attending the emergency department were admitted; this shows that the admission process through the emergency department was responsive to the demands.
- The CDU forms part of emergency department; patients could be admitted to the CDU for up to 12–24 hours. The CDU accepted transfers from the emergency department for short-stay patients who required observation by the emergency department consultant team, as well as specialist and GP referrals. The lead clinician told us that one of the reasons the team achieved the admission target was that the CDU worked well and was able to maintain the flow from the emergency department.
- Staff told us that delays in paediatric admissions were frequent. We noted on one of the days of our inspections that five children had been waiting in the department for over four hours for admission. Staff told us that the paediatrician preferred to keep unwell children in the emergency department, where they could be closely monitored.

### Learning from complaints and concerns

- Posters and leaflets were available in the department and in the main hospital corridors, providing people with information regarding the Patient Advice and Liaison Service. The posters gave contact details; however, the Patient Advice and Liaison Service office was no longer on site at the hospital. Staff told us that the service had been centralised for the trust at The Royal London Hospital site.
- Patients we spoke with told us they felt able to raise concerns directly with staff, but would contact the Patient Advice and Liaison Service office if necessary.
- The department had received approximately 19 complaints from August to December 2014. All had been responded to within the trust's timescales, with one having been reopened following further correspondence from the complainant.
- Staff told us that, wherever possible, they tried to speak with people about their concerns and would raise an incident report if necessary. We also observed that during the handover between shifts, staff were updated on any incidents, complaints or changes to practice.

# Urgent and emergency services

- We reviewed the summaries of five complaints relating to staff attitude and medical/nursing care. We were not provided with examples of changes that the department had made as a direct result of complaints.
- The department held monthly governance meetings. Minutes confirmed senior medical and nursing staff regularly attended, and that complaints and incidents were discussed as standing items on the agenda.

## Are urgent and emergency services well-led?

Good

Local leadership worked well, and staff reported that they felt well supported by senior medical and nursing staff within the emergency department. Staff said there was an open and honest relationship between staff and management, and that the management were approachable. A governance structure was in place.

The emergency department did not have a written vision for developing its service, but the management team had a vision to improve care and provide a seamless service between the urgent care and the emergency department.

Leadership within the paediatric area within the department were not robust. Minutes of meetings of paediatricians did not provide details of joint working or of the governance structures in place. Staff expressed to us their concerns regarding proposed changes to paediatric surgical services.

Minutes were not provided for all meetings for which we requested them, and those that were provided did not always include detailed information, for example on the outcome of complaints. However, we observed changes in practice and incidents being discussed during the handover between shifts in the emergency department.

### Vision and strategy for this service

- The clinical lead told us that the department's vision was to recruit highly qualified staff and deliver excellent medical and nursing care. Although the vision was not documented, other staff we spoke with also expressed this.
- Some consultants in the emergency department were concerned about proposed changes to surgical emergency procedures and the long term effect these may have on services in the emergency department.

### Governance, risk management and quality measurement

- The director of nursing for the clinical academic group (CAG) told us about inconsistencies in the electronic patient record across the three emergency departments in the trust. We were told that the modified early warning score was fully integrated into the electronic patient record at one location and was working well. Newham University Hospital was one of two locations that did not have a modified early warning score as part of its electronic patient record.
- The paediatric area with the department used the Paediatric Early Warning System (PEWS), although it was only partially integrated into the electronic patient record. Staff told us the tool used was different to the ward-based PEWS system and therefore they could only use it electronically as an initial triage score.
- Following the inspection, we looked at minutes of staff and clinical governance meetings and noted that incidents, complaints and audits were discussed. We also observed that issues relating to incidents, changes in practice and complaints were discussed at handovers within the emergency department.
- There was no evidence of a clear governance framework between paediatrics and the emergency department; this may have been due to the structure of the paediatric team within the hospital, which was within more than one CAG.
- The emergency department disseminated to all staff a governance newsletter with a 'lesson of the month'. We reviewed three newsletters, each of which provided a case study with key learning points. For example, one case reminded staff that alcohol could mask serious medical problems.
- We reviewed minutes of the emergency care and acute medicine quality and safety committee meetings in November and December 2014 and found that key senior people were not present. The performance of the emergency department was discussed. However, no reference was made to the actions by paediatricians to resolve the delays in admissions.

# Urgent and emergency services

- The risk register was discussed at the department governance meeting and all the senior staff we spoke with were aware of the risk register and the items on it. For example the use of locum doctors within the department and the lack of central patient monitoring system within the resuscitation area. These items were fed into the risk register for CAG.
- The department risk register identified the actions taken to mitigate the risk as well as review date. For example the lack of a central monitoring system in the resuscitation area stated that a member of staff needed to be present at all times. We saw that the allocation of staff included assigning nursing and medical staff to cover the resuscitation area and we observed this was complied with during our inspection to ensure patient safety was maintained.

### Leadership of service

- There was a trust-wide directorate which was referred to as the clinical academic group (CAG). The emergency department at the hospital was part of the emergency care and acute medicine directorate, and was led by a clinical director, director of nursing and governance, and a general manager to the CAG operational director. The emergency department's leadership included a clinical consultant lead and a matron (nurse lead).
- The leadership within the adult emergency department between the nursing, medical staff and the specialties teams was positive. The consultants maintained an overview of the patients' care until patients were admitted to a ward or discharged.
- There did not seem to be the same emphasis on ensuring patients moved through the paediatric area as quickly as there was for adult patients. For example, during the inspection one patient had been in the department for 13 hours overnight.

### Culture within the service

- Staff told us that the culture within the department was open and honest, and we observed that the nursing and medical staff had harmonious and respectful working relationships. The aim of the staff we spoke with appeared to be to achieve and maintain good care within the agreed targets, and we saw this working within the emergency department.
- Nursing staff told us they felt able to voice opinions about care and would challenge decisions that they felt were not appropriate.
- There was a strong consultant presence during the day and early evening, but some junior doctors felt less supported out of hours without consultant support.

### Public and staff engagement

- We did, on occasion, see staff encouraging patients and relatives to take a 'token' and complete the Friends and Family test. Numerous notices asking patients and their relatives to complete the Friends and Family test were displayed throughout the department.
- We were not aware of any information being displayed in the department to inform patients of the results of the Friends and Family test and/or changes made as a result of patient feedback.

### Innovation, improvement and sustainability

- The nursing team had adapted the accident and emergency specialist training as an in-house course. The course was accredited and gave nursing staff easier access to the specialist skills they needed for the emergency department.
- The department had increased the number of healthcare assistants and expanded the role to incorporate, for example, phlebotomy.

# Medical care (including older people's care)

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

## Information about the service

Newham University Hospital has eight permanent medical wards and two day case units, with one surgical ward that can act as an overflow for medical patients. It admits 12,600 patients a year, most of which are emergency (non-elective) and day-case patients. Most patients are admitted as either gastroenterology or general medical patients.

We inspected all 10 wards/units, including the observation unit (which includes a clinical decision unit (CDU) and an acute medicine unit), general medical, care of the elderly, stroke, cardiology (as a coranary care unit), endocrinology, haematology, respiratory, gastroenterology, and chemotherapy day case.

We also inspected the winter pressure surge beds that were open on the stroke ward, visited the discharge lounge and attended a variety of meetings, such as bed meetings, handovers and multidisciplinary team meetings. We spoke with over 20 patients, over 70 members of staff, including doctors, nurses, allied health professionals (including therapists, pharmacists and technicians), administrative staff and site leads for the emergency care and medicine clinical academic group (CAG), which covers acute medicine, respiratory, stroke, gastroenterology, diabetes, endocrinology, neurology, GUM, HIV, rheumatology, renal and care of the elderly services. We checked over 50 records and over 40 pieces of equipment.

## Summary of findings

Medical care was not responsive to people's need. Patient transport provider was often late to collect patients being discharged. Out-of-hours ward transfers and those experiencing more than one bed move were high. Considering the large population for who English was not their first language, there was a lack of information in languages other than English. Care of people living with dementia and learning disabilities were sometimes inappropriate and a high number of complaints were not responded to within the required timescale.

The hospital was not well-led. Risk registers had not been appropriately reviewed and did not reflect the current situation. Most staff commented that they rarely, if ever, saw the senior trust leadership and none of the staff we spoke with were aware of the 'leading changing lives programme'.

Senior staff felt disempowered and other ward staff reported being bullied by the site managers. Some staff felt they could not raise issues, because they were worried about the consequences of doing so. IT infrastructure and system was poor and slow and did help staff do their jobs effectively.

The safety of medical services was compromised in a number of ways, including low nurse staffing levels, poor record completion and poor awareness of learning from incidents.

# Medical care (including older people's care)

Audits showed that patient outcome were mostly above average, and multidisciplinary team working was good, but we were not assured that national guidance was always followed or that staff were competent to care for patient's particular needs.

We observed variable and 'task-based' care with poor survey results to confirm our observations.

## Are medical care services safe?

Inadequate

We had multiple concerns with safety at the hospital. Incident reporting was haphazard, and learning from incidents either did not occur or was not appropriate. Cleanliness and infection control were variable, with some wards following guidelines and others not. Although the environment was mostly safe, we had concerns with equipment not being in place or up to date in some areas. Medicines management was variable, although drug charts were complete and up to date.

Patient record completion and storage was poor, with multiple omissions and errors found. Awareness of the safeguarding procedure and safeguarding team was appropriate. Numbers completing mandatory training were below the targets expected. Patients who deteriorated were not well managed or monitored. Nursing staffing levels were often below the established number, and even established levels were sometimes not appropriate. Medical staffing levels were much better, but there were still some vacancies and concerns.

### Incidents

- No Never Events were recorded for the medical wards at the hospital in the year 2013/14. Fifty-seven serious incidents were recorded 2013/14; 43 of which relating to pressure ulcers graded 3–4.
- We received a summary of the incidents reported on medical wards in the last six months. Most incidents had been closed and had some form of recommendation to prevent a future incident. However, the actions suggested were not always appropriate, because they asked staff to reflect or reminded them about policies and procedures, rather than suggesting additional training or reviewing of policies and procedures.
- Senior staff felt that the hospital had a good practice in the weekly review of serious incidents. However some staff, particularly student nurses and healthcare assistants were unaware of how to report an incident. Most nurses and doctors were aware of how to report incidents, but there were varied views on whether they

received individual feedback on incidents they reported and whether the learning from incidents across the hospital and trust was shared. Some staff told us that no actions were created as a result of reporting incidents.

- The serious incident investigation reports we reviewed showed that duty of candour was complied with, because an apology and a copy of the investigation were sent to the people affected. However, although contributing factors were identified, the root cause did not show why the contributing factors occurred. The investigations we reviewed included appropriate learning points and recommendations.
- We reviewed the minutes of mortality and morbidity meetings. In older people's services, the meetings only took into account the outcomes from patient deaths. In gastroenterology, the meetings reviewed the death, but no learning was stated.

### Safety thermometer

- The trust was above the national average for MRSA, Clostridium difficile (C. difficile) and methicillin-sensitive Staphylococcus aureus (MSSA), with two cases of MRSA and 10 of C. difficile at the hospital. However the rates of MRSA are within the national average and C difficile is below the national average for a similar hospital sites.
- There was a high pressure ulcer rate, with 43 pressure ulcers graded 3 and 4 (moderate to severe harm) and around two pressure ulcers recorded on each day of the safety thermometer, although the trust's pressure ulcer rate had declined by 11% in the last six months. Staff reported that there was only one tissue viability nurse available for the hospital and this was having an adverse effect on pressure ulcer care, particularly for those with skin integrity issues of the feet. Senior staff at the hospital agreed that more tissue viability support would be welcomed in order to further reduce the rate of pressure ulcers. There was also no vascular nurse on site, although we were told one was due to be recruited.
- On most wards, safety thermometer information was displayed and up to date. However, in the observation unit this was not the case, as no information was displayed. Nursing staff told us they had been too busy to update this information.
- Two wards had safety boards in place in the ward corridor to show which patients were at risk of falls or skin integrity issues, needed support for eating, had allergies, had the same names or needed soft diets. This was anonymised by patient initials and did not show patients' conditions to ensure confidentiality was maintained.
- Safety thermometer results we received were variable. The observation unit and the stroke unit recorded 100% harm-free care in the last 12 months, other than one venous thromboembolism (VTE) on the stroke unit. However, the results on the general medical wards and care of the elderly wards were poorer: on care of the elderly wards, up to a quarter of patients had pressure ulcers, up to one in 10 had a urinary tract infection, and up to one in 20 had a fall. These results partly matched what we saw on the wards, with multiple patients with pressure ulcers but very few with urinary tract infections and falls. Senior staff told us that most patients who had pressure ulcers had been admitted with them, but the pressure ulcers had not been recorded within the first 48 hours so the hospital had to declare them.
- Senior staff raised concerns about how accurately pressure ulcers were being recorded. They thought that agency staff did not grade pressure ulcers correctly.
- We observed variable practice to reduce patient harm. Patients at risk of pressure ulcers did not always have turning charts in place, and those charts that were in place were sometimes incomplete. Patients who were at risk of falls were sometimes in side rooms that were not near nurses' stations and did not always receive additional monitoring. However, we did observe that non-slip socks were available for patients in order to prevent falls.

### Cleanliness, infection control and hygiene

- The last Care Quality Commission (CQC) report on Newham University Hospital recognised its cleanliness and appropriate infection control. However, although we mostly observed clean areas, adherence to infection control policies and procedures was variable.
- Patients at the listening event reported that hand gel dispensers were broken in some areas. Although we did not witness this on any of the wards we visited, we did witness multiple members of staff on all the wards we visited not using hand gel, both when entering the ward and between caring for patients. There was a lack of infection control signage near hand gel dispensers, so staff and the public were not clearly reminded to wash their hands when entering/leaving wards or patient bays.

- We observed toilet brushes, which could become soiled, in use in parts of the hospital; these could become an infection risk. We were informed the hospital had two different cleaning contractors, so standards were different in different parts of the hospital.
- Staff wore personal protective equipment when entering the rooms of patients with an infection. Those patients who had infections were in side rooms with the doors closed and appropriate signage in place for visitors and staff. However, we observed multiple members of staff who were not 'bare below the elbows' in clinical areas, and other staff did not challenge this practice. The trust's policy required staff to be bare below the forearm only, despite this still being an infection risk.
- The percentage of staff completing training in infection control was low at 60%, despite the trust's target being 90%. This meant that staff were not always up to date with their training to ensure they followed appropriate infection control guidance.

### Environment and equipment

- Maintenance and checks of equipment were variable. We saw drip stands that had no clean stickers, or clean stickers that were over 24 hours old. Checks on resuscitation trolley were mostly completed, on three wards these checks were not up to date. The checks on some resuscitation trolleys did not go back further than two weeks. We saw two pressure pumps that were out of date.
- Nursing staff reported a lack of equipment; for example, an electrocardiogram machine had been broken for three months and had not been replaced. This meant that staff sometimes had to borrow equipment from other wards. Allied health professionals reported that often equipment broke down and could take up to three weeks to repair. However, they were positive about the estates department ensuring that the environment was properly maintained.
- In the coronary care unit, we observed that oxygen cylinders and a laryngoscope were not in place on the resuscitation trolley. Staff told us they had reported the equipment shortages but it sometimes took a few days for equipment to be replaced. We also found syringes that were out of date on resuscitation trolleys.
- Most of the portable appliance tests on equipment we reviewed were in date.
- Most of the sharps bins we saw, although appropriately placed, had their temporary lids open, which meant there was a risk the sharps could be accessed. Other types of waste bin were closed and not overflowing, apart from on one ward one morning, which was dealt with within the hour after we observed it.

### Medicines

- The last Care Quality Commission (CQC) inspection report raised concerns regarding storage of medicines. The trust said it would remedy this by bringing in swipe access or self-closing brackets on cabinets storing medicines. There would also be further staff awareness and an audit undertaken. Medicine incident reporting would be encouraged; the last performance indicator showed emergency care and acute medicine as the highest reporter, with 43 incidents. There would also be a review of the medicines storage risk assessment and a medicines management action plan. However, these actions had brought varied improvement.
- Most of the controlled drug cabinets we viewed were appropriately secure, with fixed cabinets on walls behind a locked door. However, there were instances of incorrect practice, with one cabinet fixed in an open area behind a nurses' station. Some of the medicine cabinets we observed were untidy, with medicines stocked in an unsystematic manner.
- Keys to the controlled drugs cabinets were not appropriately stored or used. One ward had the keys for its controlled drugs cabinet attached to other keys, and the keys were not identifiable as those for the controlled drugs cabinet. Staff other than the assigned person also had keys to the controlled drug cabinet. Keys were also stored in unlocked drawers. Pharmacists told us that controlled drugs were not always well managed.
- Most of the fridges we reviewed were at the appropriate temperature, and checks were being conducted daily to ensure the temperature was correct. However, one ward was only recording the actual temperature of the fridge rather than the highest and the lowest temperatures.
- Drug charts we observed showed that nursing staff largely signed for the medicines administered. Any allergies were clearly displayed on the drugs charts and reference was made to the diabetes chart for diabetics' medicines.
- Uptake of training on medicines among nursing staff was low, at 66%.

# Medical care (including older people's care)

- The safe and secure medicine audit showed that up to seven of 50 indicators were non-compliant in two wards; five indicators were non-compliant in two wards and four or less indicators were non-compliant in three wards.

### Records

- Records were a mixture of electronic and paper records; staff reported that these records did not always correlate. Most paper records we observed did not include the patient's records for their prior admissions, which meant there was a risk that staff were not fully aware of a patient's medical history. Record templates varied depending on the ward we visited, with some templates in place from when the hospital was run by a previous trust four years ago. We did not see complete nursing assessments for any patients, and it was not clear where to find each assessment in a patient's records, because there were no tabs or dividers.
- Record completion was inconsistent. All the patients' records we viewed had some form of missing information, whether it was a falls assessment, skin integrity, fluid charts or care plan. Some venous thromboembolism (VTE) assessments had not been completed, despite the patient being a high risk and audits showing these were normally up to date. Some patients with skin integrity and mobility issues had no turning charts. Some fluid balance charts had only the description of the intake, but neither the output or balance was recorded.
- A record completion audit was completed in October 2014 on two older people's wards and the stroke ward. This confirmed our findings that records were often incomplete, because on one ward the completion rate was 64%, whereas on the others it was 82% and 95%. However, the sample size was nine records on these three wards. We received no record completion audit figures for the coronary care unit, general medical, observation unit or respiratory wards.
- Most patients' notes were either left in trolleys in the middle of the ward or were on desks or tables, neither of which was secure. Many of the handwritten notes we read were not legible, and some had no date or time.
- One ward had a cupboard labelled 'bloods', but contained a variety of confidential paperwork including old discharge summaries from 2006 and complaints from 1999. The ward manager told us there had been more paperwork in this cupboard and they had been tasked to archive it because there was no housekeeper to do so.
- Uptake of information governance training among staff was low at 67%.

### Safeguarding

- Most staff we spoke with were aware of how to report a safeguarding concern and knew how to contact the safeguarding team.
- The percentage of staff completing safeguarding training in medicine at all levels was high at 96%.

### Mandatory training

- The overall mandatory training rate for staff within medicine was 74%, which was below the trust's target of 90%. However, staff we spoke with told us they were up to date with their training. Areas of concern where their was low uptake by staff included health and safety (80%), and moving and handling (72%).

### Assessing and responding to patient risk

- Although the modified early warning score system was in place, it was completed haphazardly. Observations for the score were mostly incomplete. Scores that totalled the risks from the observations were sometimes incorrect. Escalations and additional observations were not always completed when patients deteriorated. Some patients who were showing as below the correct body temperature and had complained of feeling cold had not been given anything extra to keep them warm, despite asking staff.
- Non-invasive ventilation patients were often cared for on the respiratory ward and this was managed properly.
- Staff reported that the crash team was quick to attend if a patient required immediate life support.
- The last modified early warning score audit showed that although 100% of patients who required escalation had been escalated, only 22% of modified early warning score records audited were complete.
- The pleural effusions audit showed that the hospital was better than average in two areas – for recorded nursing chest drain chart and length of stay– but worse than average in six areas, which were length of stay, complications during procedure, having a supervising doctor, recording whether a nurse was present during the procedure, use of ultrasound guidance in placing drain, recording of flushing the drain with saline, and

delayed complications. The hospital was around average in four areas, including the grade of doctor the patient saw, observations taken, record of consent, and review by a respiratory consultant.

- Staff told us that most pleural effusions were done 'blind' (without an ultrasound) at Newham University Hospital, and this resulted in a recorded pneumothorax rate of two out of nine cases (22%) compared with a national rate of 2%. Staff told us this was due to the lack of an ultrasound machine for the chest team. The lack of an ultrasound for the chest team had been on the risk register since 2013, and a business case had been submitted in April 2014 but not approved. In addition, the local area had a high rate of pleural disease. A further business case was submitted in October 2014, but the outcome had not been decided at the time of our inspection.
- Not all members of the site team were trained in airway management. There was no outreach service out of hours, and there were only enough medical staff to cover the intensive care unit. Therefore, we were concerned that patients in the coronary care unit and on the medical wards were at risk if they deteriorated and required ventilation.
- The coronary care unit was sometimes used to admit level 2 patients as well as non-invasive ventilation patients if the intensive care unit was full. This meant they could have to care for patients with arterial lines, inotropes and central venous catheters, despite staff not necessarily being trained to care for these patients. Staff told us they were always pressured to admit patients, because of the lack of capacity in the intensive care unit.

### Nursing staffing

- Safety thermometer displays on the wards showed multiple occasions when each ward was short of staff in January 2015; some wards were short of staff for over 75% of the time.
- One ward's rota showed some shifts with two qualified nurses when the establishment was to have four nurses for up to 26 patients and staff told us the empty shifts were not always covered.
- Nursing staff told us the staffing establishment did not meet the acuity and dependency of the patients they cared for, and even the establishment was not fully budgeted for. Often staff reported having to look after two patients, where both required one-to-one support. Newly qualified and agency nurses were often on a ward together with no experienced band 5 nurse.
- We observed and reviewed records which showed that levels of nursing staff in the observation unit were appropriate, with a 1:6 nurse to patient ratio. However, staffing levels elsewhere were a concern.
- Nursing staff reported concerns regarding staffing levels, with a high use of agency staff. Agency use was high in stroke (39.9%), cardiology (21.6%), care of the elderly (15.1%), respiratory (11.9%) and gastroenterology (10.6%) wards. Vacancies were also high at over 10% in most specialties, either for nurses or healthcare assistants. Staff told us vacancies were mostly being advertised, but recruitment was slow. Newly recruited staff agreed that the recruitment process was slow.
- Ward managers told us that agency staff had to be approved by the clinical academic group (CAG), which was often a long-winded process. Although staff shortages were raised as incidents, staff reported that this did not seem to have any impact.
- At the bed meeting, we observed that senior leads attempted to arrange staff for where shortages were most acute, but acknowledging they had a shortage. Staff were concerned they were not able to meet the needs of their patients.
- The coronary care unit, which cared for level 2 patients, was not staffed appropriately. The establishment was for seven qualified nurses and five healthcare assistants to cover 26 patients, of which 13 were acute patients and up to three could be level 2 patients (although this was often exceeded). The acuity of the patients meant the ward could never give a ratio of one nurse to two level 2 patients. This was contrary to national guidance for critical care units. Staff also told us this was further hampered by the trust removing the wards' dedicated phlebotomist, which meant that nurses also had to draw blood samples from patients when necessary.
- Nursing staff reported feeling exhausted due to the lack of staff, and this was compounded by having to do 12-hour shifts.
- We saw multiple examples of healthcare assistants' (HCAs) shifts being filled by student nurses although some of these may have been post qualification or

working as HCAs on the trust bank. This meant that student nurses had a caseload of patients to care for rather than being supernumerary and learning from qualified nurses as they were meant to.

- Senior staff acknowledged that the hospital had a high reliance on bank and agency staff, and that it was finding it difficult to recruit staff. Senior staff felt they needed support to recruit additional nurses and ancillary staff. The last Care Quality Commission inspection report recognised these issues in 2013. The trust's action plan was to reduce reliance on bank and agency staff by holding monthly recruitment days and having a recruitment/retention lead in emergency care and acute medicine. We were told that current staffing levels were 91% permanent, with 91% of non-permanent staff shifts filled, 75% of these by bank staff, although staffing levels were worse during the day than at night. Senior staff told us there was a lack of staff available on the bank, and that the situation had not improved in the last year.
- Band 6 and above nursing staff told us it was difficult for band 7 staff to remain supernumerary, because staffing levels meant they either had to take on a clinical workload or act in a band 6 role including supervising band 5 staff. Some band 7 posts were not filled, so some band 6 staff were 'acting up' into these positions. However, these staff told us they had no additional support or training.
- We were concerned by the quality of the handovers that took place between nursing staff shifts. Nurses were often not on time for their handover, with one handover starting 20 minutes late. Handovers took place in patient bays, but not with individual patients. Patients were therefore not aware of who was taking over their care. It also breached patient confidentiality, because patients' conditions and details were discussed within earshot of the other patients in the bay. There was no patient engagement during handovers.
- The last staffing review we were sent was for October 2013. This showed total nursing levels on each ward, but not how wards should be staffed by shift.

### Medical staffing

- No acute medical trained consultants were covering the observation unit. We were told there were also vacancies in medical cover for care of the elderly. Seven geriatricians covered the observation unit ward on a 'one-in-five' rota; and they were trained in general internal medicine which meets national guidance. Senior staff acknowledged that it needed support to recruit additional acute medical staff for the hospital.
- Medical staff at all levels told us that medical staffing levels were appropriate. However, there were some concerns with caring for outliers (patients cared for on wards that were not specific to their condition) and with the lack of a cardiologist on-call. There had been a vacancy for a part-time cardiologist since 2013; only one permanent cardiologist covered the hospital, with three others covering the trust's other sites. For stroke, there was a part-time neurologist plus geriatricians, with junior doctors and a registrar. There were four gastroenterology consultants. There were seven care of the elderly geriatric consultants, of which three were part-time. No specific doctor(s) covered the surge beds, particularly because there was a mix of patients including medical and surgical patients. Nursing staff told us they would bleep a doctor caring for an outlier, but that their calls were often not answered. At night, a junior doctor covered the wards along with a registrar.
- There were concerns with weekend cover for level 2 patients, because the coronary care unit did not have a dedicated consultant ward round at the weekend. The coronary care unit did not have dedicated anaesthetist or intensivist support. Patients only saw medical staff from the intensive care team if they were referred.
- The medical ward rounds we observed were appropriate. They were consultant-led with descriptions given of the patient's medical history, discharge plans and next treatment steps. These were all then communicated to the patient in a way the patient could understand. However, there was no nursing input and the consultants on call changed each day.
- The medical handovers we observed were mostly appropriate. Although the consultant was still reviewing patients at the time of the handover, it was led by a registrar; the handover was clear about what where patients were allocated and which medical specialty was taking them on. Any immediate issues were identified. Most doctors were on time, with only one specialty of doctors not in attendance for the first 10 minutes. No care of the elderly team was at the handover, but we were told this was not necessary because the consultant geriatrician who was still

reviewing patients would hand over to their team of doctors directly. Critical care outreach staff also attended to ensure that all acute patients had been identified.
- We requested the consultants' job plans, but we did not receive these.
- Locum use was low, with 5.9% of doctors as locums in diabetes, but no locums being used in cardiology or gastroenterology.

### Major incident awareness and training

- The hospital's escalation policy for opening wards in the event of increased admissions was out of date, because it required review in 2012. It also only focused on A&E admissions and not admissions from other areas.

## Are medical care services effective?

Requires improvement

Newham University Hospital medical services could not always assure themselves that they were delivering effective care and treatment. We were not provided with assurance that national guidance was being adhered to, and we found paper versions of policies and procedures that were out of date. Pain relief was mostly well managed. The completion rate for most national audits was better than the national average, although there were some areas of concern. Although we were satisfied by the training given to agency staff, there were multiple issues with the competency of permanent staff in some specialist areas. Multidisciplinary team working was in place and appropriate, but seven-day working was not fully in place. There was a lack of understanding and implementation of the Mental Capacity Act, and of consent in particular.

### Evidence-based care and treatment

- The last Care Quality Commission inspection report raised concerns that national guidance was not always adhered to. Over a third of clinical audits either suggested improvements or raised concerns about compliance with NICE guidance although this was trust wide, not specific to Newham University Hospital. Most of the issues raised were regarding dementia, epilepsy, psoriasis and delirium. In addition, only 47% of current National Institute for Health and Care Excellence (NICE) guidance had been audited, with large percentages not audited in diabetes, elderly care and emergency care (33% audited), hepatology (11%), gastroenterology (44%), neurosciences (47%), rheumatology (50%) and dermatology (56%). Doctors told us they received training in NICE guidance as part of their weekly teaching.
- Although most of the policies and procedures we reviewed on the intranet were up to date, we saw a number of out-of-date documents on the wards, some by over four years and referring o the previous trust.
- We saw an example of a patient with diabetes who had not had a blood test to determine whether they were having a hypoglycaemic or hyperglycaemic attack, but who was given a sugary drink. This was despite the diabetes chart having a blood glucose monitoring template for staff to complete.
- We were told there were no local audits of individual patients' notes regarding compliance with dementia standards.

### Pain relief

- A pain team was available 24 hours a day, seven days a week. Most patients thought that their pain relief was well managed. However, a couple of concerned patients told us their pain-management needs had not been met.

### Nutrition and hydration

- Patients on the observation unit told us they had no food or drink overnight, despite being admitted at 6pm; they had to wait until 8am the next day. We saw some patient records that showed that patients (who were not meant to be fasting) had not had breakfast by midday. One patient told us that the menus for food were completed while they were asleep; none were left for them to complete, so they did not get a choice of meal.
- Fluid balance charts were either not complete or not in place. We saw records of patients who were being over-hydrated despite being on fluid restrictions, whereas others had little fluid intake despite being a dehydration risk. We saw charts where the patient's incontinence was stated as the reason why staff were not able to measure the patient's fluid output.
- Multinutritional Universal Screening Test (MUST) charts were either not always completed or not always correctly followed. We saw examples of patients who were scored as a low risk for nutrition but were on

thickeners and nutritional supplements because they were losing weight. One MUST audit showed that seven out of 27 patient records did not have a complete MUST assessment.
- Some patients told us they were unhappy with the choice and quality of food available and had resorted to bringing in their own food.
- We observed food and drink being left out of the reach of patients.
- Although protected meal times were displayed, they were not adhered to. While lunch was being served, we observed nurses still treating patients, and we observed doctors undertaking ward rounds over 15 minutes into the displayed meal times.
- Red trays were in place for those patients who required support at mealtimes, although a few members of staff were unaware what the red tray system was for.
- The snacks provided in the afternoon were not nutritious, with a small amount of protein and high amount of sugar.

### Patient outcomes

- The hospital was around the national average for the overall Sentinel Stroke National Audit Programme (SSNAP) rating, with a grade C. However, a number of areas were better than the national average, with grade A and B ratings, such as for discharge processes, occupational therapy and physiotherapy. Senior staff thought that the grade C related to nursing issues.
- The heart failure audit showed that the hospital was better than the England average in all 11 indicators. In some areas of the audit, the hospital far exceeded the England average, such as in input from a cardiologist consultant, referral to cardiology for follow-up, referral to the heart failure liaison service, and prescribing of angiotensin converting enzyme inhibitors (ACEI) on discharge. Staff told us that the good heart failure audit result was due to the dedication and long hours of the consultant cardiologist. Staff were concerned that this performance was not sustainable, because the cardiologist was due to retire soon; they thought that it should not be expected of the consultant's replacement to put in the hours that the current consultant does.
- The Myocardial Ischaemia National Audit Project (MINAP) audit showed that the hospital was better than the England average in the main three indicators it provided data on. (The hospital did not provide thrombolysis.)
- The trust was better than the national average for the National Diabetes Inpatient Audit (NaDIA) in 15 of the 21 indicators. We were told this was partly due to work with local GPs to reduce admissions by improving GPs' skill in diabetes care.
- Senior staff told us that the hospital had a good mortality rate at 0.77, but we found mortality for both gastroenterology and hepatology was worse than the national average. We requested mortality figures by the other specialties, but the data received was insufficient to calculate their mortality rate.
- We requested the trust's action plans following the outcomes from the national audits, but it did not provide any.
- The trust performed worse than the national average in the dementia carers audit, and the hospital had only had one response in July to September 2014. We were told that the low response rate was probably due to 'questionnaire fatigue'. However, dementia champions were tasked to ensure that questionnaires were completed.
- The national learning disability audit showed that the hospital had variable performance, with 11 indicators above average, two indicators average and 15 indicators below average.

### Competent staff

- The last Care Quality Commission (CQC) inspection report acknowledged that junior doctors felt supported by consultants. This was still the theme on this inspection, with complimentary comments by junior doctors about the level of support and the time for which consultants gave them support. They were positive about the training opportunities they received and how they were mentored.
- Nursing staff in the coronary care unit had no electrocardiogram training, and only some had specific coronary care training. None of the coronary care nurses had non-invasive ventilation training, apart from the long term staff who had last been trained in 2007.
- Some staff reported being unsure of the appraisal process, with some thinking it was just linked to pay, whereas others were aware it was linked to personal development as well. Staff also reported not getting feedback on their appraisals. Some nursing staff reported they received good development opportunities. Some nursing staff told us that although the appraisal process was staff centred, they were

concerned it was too basic to ensure revalidation with the Nursing and Midwifery Council. Appraisals were 100% completed in cardiology, but 67% in the emergency care and acute medicine clinical academic group (CAG).

- Staff reported concerns regarding access to online training, because a pass was needed to log in, and not everyone had one. Some staff reported that these passes were shared around as a result, which they were not supposed to be.
- Healthcare assistants and student nurses reported not being able to keep up to date or access training because of a variety of reasons, including access to computers, staffing levels and lack of opportunities given by mentors. Allied health professionals also raised concerns that a lack of staff meant they were unable to attend the amount of training they needed to. However band 6 and above nursing staff commented that trainers were willing to come to the wards if staff could not be released for training.
- Nursing staff reported that they did not receive formal supervision after their preceptorship.
- Student nurses and healthcare assistants reported various experiences of mentors. Some reported being able easily to access their mentors and receiving good support. Others reported mentors not being on the same shift and therefore not providing the support they needed. One bank healthcare assistant we spoke with was unsure who was supervising, despite the healthcare assistant providing one-to-one support for a patient who required additional support.
- We spoke with nursing staff who told us they had no training to suction patients, but were being asked to do so.
- The corporate induction process was not appropriate, because it comprised two days' training, including for clinical staff, and this included training modules such as brief sessions on manual handling, fire and infection control.
- Staff that had been promoted from band 6 to band 7 positions told us they had no additional training for the extra responsibilities they had taken on. Senior staff agreed a lack of development opportunities were available.
- Agency staff were able to explain their induction process, which included appropriate key information such as fire training and the trust's policies and procedures. Each area was ticked off on an induction form to ensure the agency staff had covered all areas before they started on a ward. However, agency staff told us they received no feedback on their performance.

### Multidisciplinary working

- Staff reported mostly good multidisciplinary working, although no physiotherapist was dedicated to the coronary care unit . We observed an appropriate multidisciplinary team meeting, with both social and medical issues discussed for each patient.
- Patients at the listening event reported that physiotherapists had too many patients to see.
- Allied health professionals reported that turnover of their staff was high and senior staff were often replaced by newly qualified staff, which meant that experienced staff often had to supervise junior staff as well as conduct their normal duties. They reported that care of the elderly beds were often opened without increasing staffing numbers.
- Social workers were involved in multidisciplinary team meetings, but they were only involved once a referral had been made, not in deciding whether a referral was required. This meant there was a risk that inappropriate referrals would be made and some patients who required social care support would not receive it.

### Seven-day services

- The last Care Quality Commission inspection report raised concerns about a lack of consultant cover out of hours and at weekends. However, none of the doctors we spoke with had any concerns regarding medical out-of-hours staffing levels. The main concern was nursing staffing levels, because they were considered equally inappropriate at night and during the day.
- There was no speech and language therapy service out of hours.
- There was no pharmacy service available on site after 8pm during the week, after 2pm on Saturday and for the whole of Sunday. The hospital had to rely on the on-call team at The Royal London Hospital.

### Access to information

- The trust was not aware of an audit of the timeliness of GPs receiving discharge summaries. When we spoke with ward clerks, they told us it was a challenge to send the summaries on time.
- The hospital had well-established links with local GPs.

# Medical care (including older people's care)

### Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Most staff at all levels were unaware of their requirements under the Mental Capacity Act (MCA) and could not describe when a Deprivation of Liberty Safeguards (DoLS) application may be required. Nurses were not required to undertake separate MCA or DoLS training, and we were told this was covered as part of their safeguarding training.
- The acute admission proforma included no assessment of a person's capacity.
- We saw two completed deprivation of liberty safeguard applications. However, although these had been completed appropriately, they were not referred to in the nursing or medical notes.
- We witnessed, and records showed, that a patient who required a best interest assessment for their resuscitation status was unable to swallow food. Staff had attempted three times to fit a nasogastric tube, which the patient had refused each time. Staff had undertaken no mental capacity or best interest assessment for this procedure.
- We witnessed variable compliance with obtaining consent from patients. Some staff were clear in asking a patient for their consent, whereas others started treating and caring for a patient without asking or notifying the patient about the procedures they were going to undertake.

## Are medical care services caring?

Requires improvement

The hospital needed to improve how caring it was to people who used the medical services. Friends and Family test results were either average or below average, although these were against poor response rates. We observed variable care, with some being appropriate whereas others did not respect the privacy and dignity of patients. Although patient feedback was mostly positive, aspects suggested that a 'task-based' approach to care was undertaken. Emotional support was not always offered to patients.

### Compassionate care

- The trust was worse than average in terms of negative comments by patients on NHS Choices.
- Student nurses and healthcare assistants felt they received mainly positive feedback from patients. However, allied health professionals reported negative patient experiences, because their workload meant they could not see all the patients they needed to or for as long as required.
- Findings regarding the privacy and dignity of patients were mixed. Although most patients we spoke with were happy with the privacy and dignity afforded by staff, we observed a nursing handover where confidential patient information was openly discussed in patient bays and not next to the individual patient concerned.
- Most patients were happy with the care and treatment they received from all types of staff.
- Most of the care we observed did not put the patient at the centre of their care. Although we saw an occasional staff member ensure that a patient's preferences were met, such as what snack they would like, most interactions with patients were task-orientated with no attempt at friendly interactions.
- Intentional rounding (a the timed, planned intervention of healthcare staff in order to address common elements of nursing care, typically by means of a regular bedside ward round that proactively seeks to identify and meet patients' fundamental care needs and psychological safety) was in place and recorded on a two-hourly basis.
- The executive team told us that 94% of inpatients would recommend the services at the hospital, based on the hospital's inpatient survey.
- Patients told us that call bells were not always answered in a timely manner.
- We witnessed patients who were living with dementia being left in side rooms with the blinds closed during the day; it was therefore not clear to these patients whether it was night or day; nothing on the patients' records showed why this had been done. This had a risk of disorientating patients.

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

- Some patients and families told us they had not been fully involved in their care. One patient told us they had been left waiting, but had not been told why. Another family member told us they had not been kept updated about a patient's condition.
- Patients told us their named nurse changed each day and there was no continuity of care.

# Medical care (including older people's care)

- We observed music being played in an older people's ward. The music was modern pop, but we observed no interaction between staff and patients, and did not see that patients had agreed to the music being played.

### Emotional support

- Chaplains were available to patients who wanted them, in order to offer emotional support.
- One family member told us they had not been offered any additional support, despite being told their family member had a terminal disease. Although the family member was visited by the palliative team, they were not signposted to organisations or counselling.

## Are medical care services responsive?

Requires improvement

The hospital had a high readmission rate, particularly for general medicine, cardiology and care of the elderly. Discharge nurses were often not able to focus on discharge, as they had to assist on the wards due to a shortage of nurses. The contracted transport provider was often late to collect patients being discharged.

Out-of-hours ward transfers and patients experiencing two or more bed moves were high. Considering the large population for who English was not their first language, there was a lack of information in languages other than English.

Care of people living with dementia was sometimes inappropriate. 'Forget me not' documentation was not in place. There was limited use of hospital passports for patients with learning disabilities and no picture cards were in place to support patients who had difficulty communicating.

A high number of complaints were not responded to within the required timescale. Most of the complaints we reviewed had not been closed and none had an action plan.

Patient flow between the observation unit and the medical wards at the hospital apart from in the stroke unit was good.

### Access and flow

- Some staff told us that patient handover between wards could be timely, because it was done face to face.
- Bed occupancy across inpatient wards was 104.4% across the year. The coronary care unit was constantly over-occupied at between 140% and 170%, although we observed three empty beds on the days we inspected. The stroke unit varied between 80% and 160% occupancy. The general medical ward occupancy was between 75% and 100%. Care of the elderly varied between 70% and 190% occupancy. However, these figures did not take into account that the stroke unit had an additional 13 beds, and one of the care of the elderly wards had additional surge beds that increased its capacity beyond 100%. The trust planned to have occupancy at 93% despite evidence showing that care can become compromised at 85% occupancy.
- Senior staff told us that the hospital had a good patient flow and medical model. We observed a bed meeting, and this ensured that patients were appropriately allocated as far as possible. However, doctors did not attend this meeting so we could not be certain patients would always be allocated to the correct specialist ward.
- Although there were outliers each day we inspected, they were few, with up to five each day on the records we saw.
- Patient flow between the observation unit and the medical wards at the hospital apart from in the stroke unit was good. Although capacity was high at the time of our inspection, the hospital had the option of opening additional beds on one of their elderly care wards. The only time the hospital had recently been stretched was during December/early January as a result of winter bed pressures. In addition, only one patient told us they had been delayed receiving a bed which was during the stretched period. However, the stroke unit had opened an additional 13 beds in October 2014 and these were constantly full.
- Doctors at various grades working within the stroke unit were concerned that there were only 13 stroke rehabilitation beds after a reduction from 26. The previous 13 beds were not being used for extra capacity, but mainly for care of the elderly and for general medicine patients. Doctors thought that this was causing pressure on the stroke unit and could result in patients outlying on other medical wards. Many staff thought that the observation unit was too small to cope with increasing demand. However, during the factual accuracy checking process, we received information from the trust which stated 'The doctors were not

concerned over the reduction in beds to 13 – this is what is needed for acute and rehabilitation stroke because of improvements in length of stay due to the early supported discharge from stroke. The concern expressed by the stroke consultant was that having the surge beds open in winter could sometimes be problematic if the appropriate number of extra staff were not in place. There are never stroke outliers on medical wards'.

- The emergency care and acute medicine leads at the hospital felt there was a need for bigger observation unit.
- The trust could not provide us with any information on medical outliers, because this data was not being captured, although outliers were highlighted during bed meetings.
- Senior staff thought that the hospital had a better than average length of stay, but this was for emergency admissions overall. According to the Hospital Episode Statistics, it was worse than average for non-elective general medicine, elective cardiology and non-elective cardiology, but better than average for elective rehabilitation, elective general medicine and non-elective care of the elderly.
- The observation unit had a target length of stay of 24 hours. However, the average length of stay for those being transferred and admitted to another ward was above this at up to 1.4 days. For those discharged home, the average length of stay was 0.35 days. The unit staff acknowledged that some patients stayed for up to 30 hours.
- 'Length-of-stay' meetings took place. The ones staff told us about involved discharge coordinators, social services and nurses, but did not involve doctors. However the trust told us there was another type that did involve doctors.
- The hospital had a high readmission rate, particularly for general medicine, cardiology and care of the elderly, although senior staff thought that the readmission rate was average. We saw a patient who had been discharged then readmitted the next day but did not go back to ward they were discharged from. Staff told us that pressure to discharge patients was continuous. Estimated discharge dates (emergency department) were in place, but other than on one ward, most patients were still in hospital after these dates.
- There were some concerns with discharge medicines being delayed, particularly if they were in blister packs, but this was only a major concern after midday. If patients needed discharge medicines after this time, we were told they would normally wait until the following day to be discharged.
- Although there was a discharge team, they were often depleted because they had to help on the wards. Therefore discharge nurses were often not able to focus on discharge. Discharge coordinators often had to treat patients and help them get ready for discharge, which was supposed to be the duty of the ward nurses. We were told this situation was due to the constant lack of nursing staff. The Barts Health Way also required better utilisation of the discharge lounge, but we observed only two patients in the lounge on the Friday morning we visited, despite an emphasis on pre-midday discharges, and issues we identified regarding discharges at the weekend. There were no discharge guidelines for out of hours and there was not normally a discharge team at weekends. Staff estimated they had 20 patients a day delayed past their estimated date of charge. At the bed meeting, 14 patients were confirmed as having their discharge delayed.
- Staff raised concerns regarding transport not being on time for patients being discharged. For example, sometimes patients were waiting in the ward or in the discharge lounge when all their take home medicines had been given and the transport booked for when the medicines were ready, but transport would arrive up to two hours late.
- Out-of-hours ward transfers were high at 2,856 in the last nine months. Overall bed moves were 45% of patients experiencing at least one bed move, and 29% experiencing more than two. We spoke with a number of patients who had had multiple bed moves.
- An early discharge team was in place, from which patients could get multidisciplinary support in their own homes from staff such as physiotherapists, nurses and social workers.
- Staff expected an increase in admissions of 7% for January to March 2015 and planned to have a ceiling of 4% additional bed capacity across the trust. Because the hospital already had spare surge bed capacity, the trust planned to have step-down neurological rehabilitation unit at the hospital at the time of our inspection, but this had not yet occurred. There was also a plan to have an additional 19 beds available for winter demand.

- No angiogram service was available at the hospital, so patients had to be transferred to the London Chest Hospital for tests.

### Meeting people's individual needs

- Single-sex bays were in place, other than in the coronary care unit. However, some level 2 patients in the coronary care unit were not in single-sex bays, which complies with national guidance.
- Senior staff acknowledged it needed to review its translation services in the hospital. There was no list of staff members who could speak different languages. Staff told us they often asked families to interpret. Staff told us they did not get translators on site out of hours.
- The last Care Quality Commission inspection report showed that patients' needs were mostly responded to, but there was a lack of information on discharge and a lack of information in languages other than English. At this inspection, we still did not see leaflets in another language. When we asked staff for leaflets in another language, they only referred to providers of leaflets online, such as the Stroke Association. Some leaflets were also placed inappropriately, such as cancer leaflets on the stroke ward.
- Allied health professionals told us that the translation service was stretched, with three translators but nearly 300 languages spoken in the catchment area. Some patients were either seen without a translator or sometimes not treated at all, although we saw no evidence of this.
- There was a lack of volunteers to assist staff during busy periods such as mealtimes.
- We witnessed some inappropriate interactions between staff and patients living with dementia, and some inappropriate care. Only one ward had recorded a patient's dementia in their notes despite observing multiple patients who had signs of dementia and staff telling us they had more than one patient with dementia in multiple wards. We saw patients living with dementia being asked whether they needed their cardigan too quickly, so they did not comprehend the question. In the end, the staff did not wait for an answer and assumed the patient had consented to having the cardigan.
- No aids or support were provided for patients on the wards who were living with dementia. Although there was a remembrance room in the hospital, it was rarely used by inpatients, because it was far away from the wards although on the same wing. The environment on the wards was not dementia-friendly, because signage was not bold and colour coding and/or pictures were not in place for different parts of the ward.
- A liaison service was in place for care of the elderly patients that included those living with dementia. Staff from this service visited patients who were diagnosed or could potentially be diagnosed with dementia to ensure adequate support arrangements were in place both while the patient was in hospital and when they were discharged. However, when we spoke with ward nurses, they were not aware of this service. The notes for the liaison service were in the back of nursing notes and were hard to find, despite giving key information on how the patient's social needs should be accommodated.
- We were told that patients who had a potential or confirmed diagnosis of dementia were not screened for dementia until they were stable, and this was normally 24 hours before they were discharged, or they could be diagnosed based on their history. Although the dementia nurse told us they were able to assess all patients referred, we were aware there was only one dementia nurse, who had to cover all the sites at the trust. Not all doctors were aware of the dementia Commissioning for Quality and Innovation (CQUIN) payment framework.
- No 'forget me not' documentation was in place for patients living with dementia. We were told this was due to the lack of clinical nurse specialists in place. Dementia champions were supposed to be in place on the wards, but we were unable to identify many. Carers' surveys were taking place, but few were completed.
- Placing of patients was not always appropriate. On the observation unit, the most acute patients were placed near the nurses' station. However, on other wards, delirious patients and patients living with dementia were put in side bays, away from the nurses' station. These patients were often in cohorts, so one-to-one care was not provided when needed.
- There were no day rooms in which patients and their families could speak to staff privately. Visitors often had to use staff rooms or treatment rooms or the bays themselves.
- Some areas had limited space. We saw a sluice room with a macerator but little room to move or store any

other items. Storage areas were often full of items with little space to move. Items were often stored on wards or in bathrooms because there was no other space. Treatment rooms were used for storage.
- Visiting times were very restricted, at 2pm to 8pm. No patients or families we spoke with said that these times could be flexible.
- We observed only one ward using hospital passports for patients with learning disabilities. No picture cards were in place to support patients who had difficulty communicating.

### Learning from complaints and concerns

- Senior staff felt that the hospital dealt fully with complaints. However, only 65% of complaints regarding medical services were responded to within the required timescale in the last nine months. Senior staff told us the delays were partly due to complaints sometimes taking several days to reach the relevant clinical academic group (CAG). Most of the complaints we received summaries of had not been closed and none had an action plan. The trust identified the type of complaint, such as diagnosis or treatment, and where most complaints were being logged. However, no further work on trends had been done that we were informed about. Senior staff thought that 'communication' was the biggest trend, whereas the main trend on the complaints report related to treatment and diagnosis.
- Patients who were at the listening event and had received medical care at Newham University Hospital reported that the complaints procedure was hard to access, with a lack of a Patient Advice and Liaison Service (PALs) on site and displayed information on the procedure being out of date. Those who had made a formal complaint reported responses to complaints frequently being delayed. However on inspection, a PALs office was on site.
- We reviewed the responses to five complaints. Both the local resolution meetings and responses showed that although duty of candour was complied with when there was a serious incident (an apology and open investigation was carried out), there was no action plan to improve as a result of the investigation. Some of the wording of the responses was clinical and would not necessarily be easy for a lay person to understand. Appropriate appeal information was provided. Senior staff told us they were not always made aware of the final response and therefore could not necessarily have input into the actions, although they said trends in complaints were discussed at ward meetings.

## Are medical care services well-led?

Inadequate

The trust was at serious risk of failing to meet its vision of meeting a dementia CQUIN payment framework. Risk registers had not been appropriately reviewed, did not reflect the current situation and senior staff on the wards were not aware of what was on their risk registers.

Although staff reported that direct line management was supportive, most commented that they rarely, if ever, saw the senior trust leadership, apart from near the time of the CQC visit, and none of the staff we spoke with were aware of the 'leading changing lives programme'.

Senior staff felt disempowered and other ward staff reported being bullied by the site managers, particularly regarding getting patients discharged when staff felt patients were not ready. Many wards did not have a ward manager, so band 6 nurses were taking on these roles without receiving the necessary training or support to do so. IT infrastructure and system was poor and slow and did help staff do their jobs effectively.

Most staff had a negative view of the effect of the merger which created Barts Health, in particular, the structure arrangements of the clinical academic groups. Staff felt Newham University Hospital was not a priority for the trust and many were upset about nurses being downgraded, following a recent re-organisation.

Some staff felt they could not raise issues, because they were worried about the consequences of doing so. The medical services at the hospital had a high sickness rate and we were told that compassionate leave had been severely restricted.

The use of Skype for patients who were diabetic was considered to be an innovative service by senior staff.

### Vision and strategy for this service

- A vision and strategy were in place for the acute and general medicine and care of the elderly services at Newham University Hospital, with plans for a bigger

observation unit to help manage the flow of patients from A&E, particularly with expected increases in the number of inpatients. However, senior staff told us they had not been listened to by senior staff at trust level within their clinical academic group (CAG) in the development of the vision and strategy.

- A trust-wide dementia strategy was in place from 2013 to 2018; however, most of the actions had either not been started or were not yet complete, despite a number of them not needing two years to action. This vision included meeting a dementia Commissioning for Quality and Innovation (CQUIN) payment framework set by the clinical commissioning group, but the trust was at serious risk of failing to meet it, because the volume of completed dementia assessments had not met the required target for the last two months, with Newham University Hospital at 58%, 95% and 98% for each of the three indicators against an overall target of 90%. These percentages had dropped from 89%, 100% and 100% respectively; we were told this was due to not keeping on two healthcare assistants who used to chase doctors to ensure the assessment was done. The healthcare assistants cost £71,000 a year (both posts), and complying with the CQUIN would gain £405,000.

### Governance, risk management and quality measurement

- The last Care Quality Commission inspection report recognised that governance arrangements were not appropriate. The trust said it would review risk registers at the hospital management group and have quarterly peer reviews based on Sir Bruce Keogh's recommendations. However, risk registers had not been appropriately reviewed following the trust's action plan, considering risks were on the register that were three years old and did not reflect the current situation within medical care services.
- Risk registers included the age of pressure-relieving mattresses, lack of an area for rehabilitation, possible intruders on one of the care of the elderly wards, nurse staffing levels, damaged furniture, lack of budget to nurse patients who required it one to one, and pleural procedures. Mitigation was in place for each risk. However, some of these risks had been open since 2012. Some were also noted as closed but were still on the register. The staffing mitigation was not working in a lot of instances.
- The risk register for the hospital did not fully reflect the concerns we found at the hospital. No patient-orientated risks were on the register, such as the low Friends and Family Test scores and response rates. Some risks were over 18 months old, such as the lack of an ultrasound machine for the chest team.
- Senior staff on the wards were not aware of what was on their risk registers.
- The emergency care and acute medicine clinical academic group (CAG) did review performance at the hospital as part of its integrated monthly monitoring. This monitoring reviewed performance in the Friends and Family test, staff survey results, complaints, incidents, patient harm, safeguarding alerts, infection control, staffing levels, staff training and appraisals. However, we did not see any minutes to review what actions were being taken to improve or sustain performance.

### Leadership of service

- The trust's action plan following the last Care Quality Commission (CQC) visit included having the executive team on site at weekends and piloting a 'leading changing lives programme'. However, most staff commented that they rarely, if ever, saw the leadership on the floor, apart from near the time of the CQC visit, and none of the staff we spoke with were aware of the 'leading changing lives programme'.
- Staff reported that direct line management up to matron and lead consultant level was supportive. However, senior staff told us there had been 70 matrons across the trust and now there were 19, of which only three were at Newham.
- Allied health professionals reported that their line management was often not on their site, which meant they were unable to get the advice and support they needed. Some staff reported being bullied by the site managers, particularly regarding getting patients discharged when staff felt patients were not ready.
- Many wards did not have a ward manager, so band 6 nurses were taking on these roles without receiving the necessary training or support to do so.
- Ward clerks told us they had no management structure although we were told by the trust that they were managed by ward managers.
- Senior staff told us they had no budgetary powers, so could not recruit or invest in their services without going through the clinical academic group (CAG) structure.

- Multiple members of staff reported to us issues with the IT systems at the hospital. Doctors told us that mobile computers had been removed, and there were now queues to get onto a computer to fill in electronic notes and make order medicines. Most staff told us the IT system was "clunky and slow". They also told us that if the IT system failed, there were often long waits for repairs or support to be provided. One member of staff told us they had waited three and a half months for a new computer after the previous one had broken down. Senior staff acknowledged that the hospital had a poor IT infrastructure and felt they needed support with their IT systems.
- Staff were also concerned that there appeared to be three different systems across the trust sites. This meant it was often difficult to send pathology results between sites. Electronic records were also not integrated between sites.
- Staff reported that refurbishment work to the environment was taking longer than it had done before the merger with Barts Health, with some work not being completed. One ward told us that the heating had been broken for 10 months, but had been replaced the week before our inspection.
- Staff complained about a lack of staff room space, because they had to leave their belongings in the staff rooms. (There were no lockers).
- Administrative staff reported concerns that they were treated differently to colleagues at The Royal London Hospital. The Royal London Hospital had separate admissions and medical secretaries, whereas at Newham University Hospital medical secretaries had to fulfil both roles, which contributed to their high workload.
- There was a concern that human resources support had been removed from the hospital, which meant that managers were picking up these issues along with the rest of their duties.
- Staff also reported that there was no inter-site transport for staff. Those staff that worked across sites said this caused issues such as with the time spent travelling and the financial costs of transport.
- The haematology day unit had been closed, and there was no neurology medical cover at Newham University Hospital. In addition, the chemotherapy unit was only open on Thursday and Friday. This meant that patients were often transferred to The Royal London Hospital, either to be admitted or to return to Newham University Hospital after a transfusion. This reduced the number of staff on the ward, because the patient had to be accompanied on their transfer, and also caused lengths of stay to increase in these services. We were told these decisions were being reviewed but no business case had been drafted.

### Culture within the service

- Nearly all the members of staff we spoke with had a negative view of the effect of the merger between Newham University Hospital and Barts Health, in particular, structure arrangements of the clinical academic groups (CAGs). They told us they felt Newham University Hospital was not a priority for the trust. They were also upset about nurses being downgraded, following a recent re-organisation.
- Medical staff told us that any tests or reviews relating to rheumatology, dermatology, allergies, immunology and sexual health had to take place at The Royal London Hospital, and they were concerned that these had long waits. Senior staff were also concerned about a lack of beds being made available for certain specialties at The Royal London Hospital, such as neurosurgery, because it was difficult to transfer these patients from Newham University Hospital. Therefore Newham University Hospital had to transfer these patients to other trusts.
- Administrative support staff told us they did not feel the trust celebrated the work of the hospital. Allied health professionals told us there was constant pressure to meet targets. However, they noted that meeting one target often meant not meeting a target elsewhere, due to stretched resources, and this was not being recognised. Nursing staff at band 6 and above reported that social days had been arranged to help bring staff together.
- Although we received a couple of accusations of bullying and harassment, administrative staff told us the trust had tried to tackle bullying and harassment. Some staff felt they could not raise issues, because they were worried about the consequences of doing so. The trust acknowledged that staff morale was low and there was still a perception of a culture in which there was bullying and harassment.
- Staff reported there was a good teamwork ethic and that all staff cared about the work they provided at the

hospital. Staff told us they felt supported by other colleagues (including doctors, nurses and ancillary staff) within the hospital, but not by the CAGs or the trust management team.

- Staff were unhappy that although they were employed by Barts Health, working at Newham University Hospital meant they received outer London weighting, whereas employees at The Royal London Hospital received inner London weighting (which was more money). In addition, nursing staff at band 6 and above told us there was a disparity in the bands between sites, with similar jobs being in different bands depending on whether a person worked at Newham University Hospital or The Royal London Hospital.
- The medical services at the hospital had a high sickness rate, with nurses' sickness rates being: the stroke service, 5.8%; cardiology, 5.1%; and care of the elderly, 8.2%. The hospital rate was 3.6%.
- Some staff told us that compassionate leave had been severely restricted, such as to one day's leave when a close family member died.
- Staff turnover was 12%. Some wards thought that this turnover was high. Turnover was particularly high for allied health professionals in therapies (30.6%) and cardiology nurses (14.0%).
- One ward reported a sickness rate of 31%, and others said sickness had increased recently. However, although sickness rates were sometimes high (in gastroenterology: 5.4% for nurses, 10% for doctors), other specialties had low sickness rates (in respiratory medicine: 3.13% for nurses, 0.36% for doctors).
- Patients and Care Quality Commission staff could not always distinguish staff by their grade or profession, because staff wore several uniforms. Ward managers and band 6 staff, particularly, had different-coloured uniforms on different wards. The uniform policy made no reference to the type or colour of uniform that staff of each grade or profession wore. Nurses did not always have name badges.

### Public and staff engagement

- Senior staff felt that the hospital had good links with, and received good support from, commissioners and stakeholders.
- In response to the last Care Quality Commission report, the trust said it would increase the response rate to the Friends and Family test reporting to 20% and support those areas not achieving this. However, staff on the wards told us there was a constant struggle to obtain responses to the Friends and Family test.
- Almost all the staff we spoke with thought that information from senior staff from the clinical academic groups (CAGs) did not reach frontline staff. Some staff felt the CAGs had too wide a spread of control to give effective support.
- Nursing staff at band 6 and above reported that meetings were held with middle management at short notice. They also reported that changes to services were not always well communicated. However, they thought that communication from the CAGs had improved.

### Innovation, improvement and sustainability

- Senior staff thought that the hospital had an innovative service, with the use of Skype for patients who were diabetic.
- The stroke service was conducting trials and research, such as into the effect of new drugs and other types of treatment.
- Senior members of staff told us they did not think the hospital was sustainable in its current form with the current trust strategy.
- The trust told us about its three-year older people's strategy, which started in 2014. The strategy included providing study days and courses for staff in older people's services, as well as providing ongoing support programmes for staff, such as staff forums, dementia training and action plans for improvement. This improvement was to be evidenced by education and training records for staff involved in older people's services, such as for those nurses with a degree, and those who had completed an older people's course. Staff told us that activities had, so far, involved ward teams spending a day away to help reduce falls, pressure ulcers and complaints and improve the patient experience. However, this had had no impact on the wards we visited.
- The hospital had a consultant cardiologist, who was due to retire soon. We were told that the position would not be advertised until the consultant had left, rather than preparing for the vacancy in advance.

# Surgery

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

## Information about the service

The hospital provides a range of elective and emergency surgical services to the local population, including orthopaedics, general surgery, vascular surgery, colorectal surgery and breast surgery. In 2013/14, 52% were day-case procedures, 11% elective surgery and 37% emergency surgery. Of the specialties, 49% of operations were general surgery, 25% trauma and orthopaedics, and 20% urology. In the 12 months before the inspection, approximately 10,000 operations were carried out.

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

The surgery service is part of the surgery and cancer clinical academic group (CAG) that operates across the trust. The CAG was created in July 2014. At the time of our inspection, there were approximately 43 surgical beds in the designated surgical wards. We visited Clove Ward (12-bed, elective assessment) and Maple Ward (18-bed, elective surgery, inpatient), which are based at the Gateway Surgical Centre on the hospital site, and East Ham Ward (25-bed, non-elective inpatient surgery, with a further six-bed bay for winter pressures) and West Ham Ward (18-bed, day-case surgery). Surgical wards in the main hospital were relocated from Beckton and Tayberry Wards to East Ham and West Ham Wards in October 2014.

During our inspection, we were also guided by concerns that patients and staff had raised with the Care Quality Commission (CQC) before the inspection. These concerns related to low staffing levels. We spoke with 22 patients, observed care and treatment and looked at 21 care records. We also spoke with 36 staff members at different grades, including allied healthcare professionals, nurses, doctors, consultants, ward managers, matrons and members of the senior management team. We received comments from our listening event and from people who contacted us to tell us about their experiences. In addition, we reviewed performance information about the trust and undertook an unannounced inspection of surgical areas on the evening of Wednesday 4 February 2015.

# Surgery

## Summary of findings

We found that aspects of the hospital's surgical services were not adequately safe, effective, responsive or well-led. However, our findings about practice within the Gateway Surgical Centre were mostly positive.

We found inconsistencies in incident investigation throughout the service, and opportunities for learning were not shared with staff. While staffing levels and skill mix were appropriate in some areas, this was not the case on inpatient wards and theatres on the main hospital site. We identified many nursing vacancies, a poor skill mix and the use of large numbers of agency staff.

Patient flow within the service was poorly managed, which often led to operations being cancelled, delays in treatment, and patients being cared for in inappropriate clinical areas. Different staff collected operating data in a number of ways, including in handwritten lists, diary notes, theatres lists and via an electronic system.

Processes to coordinate this information meaningfully in order to monitor the impact of frequent cancellations or treatment delays on patients' clinical outcomes were ineffective.

Most patients spoke positively of the care they received within the hospital, although some patients individual needs were not always met. We identified concerns with how patients with complex needs were cared for.

The lack of meaningful and accurate data, and undeveloped governance systems within surgical services meant senior managers did not have control of the day-to-day running of the service.

## Are surgery services safe?

**Requires improvement**

We found inconsistencies in incident investigation throughout the service, and opportunities for learning were not shared with staff. Serious incidents were not always investigated appropriately. Shortages of staff on some inpatient wards were often reported, although evidence of action taken to adequately address staff concerns was limited. Staff rarely received feedback from the incidents they reported to senior staff. Daily consultant-led care worked well in elective orthopaedic surgery but was not embedded throughout the hospital.

We identified inadequate staffing levels and a poor skill mix on East Ham Ward, which had a significant effect on patients' safety within the service. We also identified some concerns relating to a lack of consistency in the mechanisms for reporting clinical incidents and providing feedback. Although nurses were being recruited, it was acknowledged that this was not having an impact on the skill mix on some wards. Acuity tools were not used consistently to plan staffing levels.Daily consultant-led care was not embedded, which was not in line with national or best practice guidance. Infection control was monitored in most areas, although we noted that compliance hand hygiene procedures for some theatres were not routinely audited.

### Incidents

- In data we received before our inspection, the trust indicated that one Never Event had been reported by Newham University Hospital in the year leading up to the inspection. (Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.) The incident involved wrong-site surgery. We spoke with senior nursing, medical and managerial staff to identify actions taken following the investigation into this Never Event. The staff members we spoke with gave conflicting information about the number of Never Events that had occurred on site. No senior staff were aware of the specific actions that had been taken following the investigation. Therefore we could not be assured that processes for investigation and learning from Never Events were embedded.

- Incident investigations where moderate or serious harm or death resulted were undertaken. However, we found a lack of evidence of subsequent actions and insufficient assurance of learning, communication or change in practice to mitigate or prevent similar events. Senior managers told us that two serious incidents and two moderate incidents had been reported and investigated in the preceding year. We reviewed the investigations for these four incidents. One of the four incidents had no investigation report and we were told that it would be reviewed at a morbidity and mortality meeting, but there was no evidence for this. For the second investigation report, there was no evidence that an action to review local management of beds was undertaken, despite being identified as an issue. In the third investigation report, concerns were identified about a lack of senior support for junior surgical staff and inadequate documentation, although evidence of reflection and learning within the report was limited.
- Of all incidents reported, staffing issues accounted for 16 (22%) of these incidents and was the highest reported category. Staff we spoke with told us of the impact of staffing shortages but were not aware that these reports accounted for most of the reported safety incidents, nor were they aware of any the learning that had been implemented in response.
- Incidents were reported through an electronic system that enabled incident reports to be submitted from wards and departments. Most staff we spoke within surgical services at Newham University Hospital were aware of the requirement to report any incidents and knew how to use the system. However, some staff told us that they did not always have sufficient time to report incidents that had occurred, because of staffing shortages. Some staff told us they had received limited or no feedback after they had reported incidents.
- We could see no evidence that agency nurses reported incidents, although senior staff told us all staff had access to the reporting system and were encouraged to report incidents.
- Senior staff told us that ward managers investigated incidents and communicated any learning from these incidents through ward meetings. We asked senior staff to provide examples of this dissemination; the agendas of meetings showed that matrons and senior staff were encouraged to attend meetings to discuss incidents and learning. However, the hospital could not demonstrate whether this happened in practice. Some senior staff were concerned that the dissemination of information was only cascaded by email.
- The post of ward manager for East Ham and West Ham Wards had been vacant since the end of November 2014, and staff told us they had not discussed incidents and learning for some months. Conversely, the ward manager for Maple and Clove Wards at the Gateway Surgical Centre told us how they provided feedback on investigated incidents and learning from Never Events in other hospitals within the trust. These had been discussed to disseminate learning across the trust as a whole. Staff on Maple Ward confirmed that this happened in practice in weekly meetings.
- Surgical specialties were encouraged to hold service-specific morbidity and mortality meetings. Some senior doctors and nurses told us these occurred monthly and that learning was shared among surgeons, although they highlighted that the meetings were informal within the specialties and no attendance records were kept. There were no terms of reference or meeting agendas and there was no evidence of action plans following discussion of incidents. Other staff we spoke with were not aware that these meetings took place. We asked for evidence of what was reviewed during these meetings, and managers told us this evidence was not routinely collected and that learning points were not identified and shared across specialties. Dedicated time was available for these meetings. In August 2014, the trust-wide mortality group identified that these meetings were not approached uniformly, nor were minutes taken to clarify how learning had been disseminated across the teams.

### Safety thermometer

- Newham University Hospital participated in the NHS Safety Thermometer scheme. Data was collected on a single day each month to indicate performance in key safety areas. The surgical areas we visited were not able to demonstrate how routine data was collected for the safety thermometer. Senior managers told us that safety thermometer information was available, but senior nurses relied on informal conversations with ward sisters to gather ward-level performance information.
- We saw that some of the information routinely submitted for the measures of the NHS Safety Thermometer was displayed and updated by ward staff.

Safety cross boards were used to note staff shortages, if patients had fallen or incidences of pressure ulcers. Between July 2013 and July 2014, surgical services at the hospital reported 53 pressure ulcers graded 1–4, 18 falls, and seven catheter-acquired urinary tract infections. All indicators were lower than the average reported within the trust.

- At our unannounced inspection, we noted that the safety cross boards were not completed for 1–4 February.
- The trust failed to provide us with data to show the rate of venous thromboembolism (VTE). We noted that blood tests could not be ordered electronically if the VTE proforma risk assessment had not been filled in, although this was not being reflected in trust-wide data. The local commissioners reported that VTE screening had fallen below the trust's 95% target. Due to a change from a paper-based to an electronic recording system, VTE screening activity was not being recorded and nothing was being done to rectify this.

### Cleanliness, infection control and hygiene

- We observed that ward and theatre environments were visibly clean and maintained. Patients told us they were satisfied with the standards of cleanliness. At the Gateway Surgical Centre, one patient told us, "It is absolutely spotless here."
- We were told that audits of cleaning were carried out by the infection control team, although we did not see the results of these audits displayed in ward areas.
- Hand hygiene results were reported to be routinely 90% or above for all surgical wards. However, recent results for theatres had not been shared with the theatre manager.
- An infection control nurse practitioner was allocated to review surgical patients throughout the hospital. Staff on Maple Ward told us they received information about the quarterly infection control audits from the ward manager, as shared by the infection control nurse practitioner.
- Throughout our inspections of the surgical wards, we witnessed that the isolation rooms had clear precaution signage, which was followed by staff to prevent the spread of infection.
- Each surgical ward had a ward-based cleaning team, and we saw that daily cleaning audits were displayed in wards. One patient we spoke with told us that the ward had undertaken more cleaning than usual for our inspection. Although theatres appeared clean, we noted that cleaning rotas were not used in theatres; staff, when questioned, said that they did clean the equipment and area, but were not required to document this anywhere.
- Hand-wash basins and hand sanitising gels were available within ward and theatre areas, although no facilities for hand washing were provided at the entrance corridor to East Ham or West Ham Wards or in recovery.
- We saw that equipment was regularly cleaned and labelled to identify that it was ready for use.
- An infection prevention and control dashboard was sent to ward managers and senior nurses weekly to provide information.
- Surgical-site infections were not counted or reported. In theatres, a surgical-site-infection audit was undertaken monthly. However, the results were not shared widely.
- The hospital and trust benchmark for people testing positive for the presence of MRSA bacteraemia in their blood was zero. One case had been reported between April 2014 and December 2014 within the surgery service, and an investigation had been completed.
- Three cases of Clostridium difficile diarrhoeal illness had been reported since April 2014. This exceeded the target of one for the whole year.
- We noted that although mandatory infection control training had been provided to all staff, no specific infection control training had been offered to staff on surgical wards.
- A campaign to raise the profile of sepsis was in place among staff ('STOP – Sepsis Treatment Optimising Patients'). However, some staff we spoke with were not aware of the initiative.
- The trust's MRSA screening policy required inpatients be screened within 24 hours of admission. Compliance was audited by reviewing 10 patients each month on each surgical ward. Results showed poor compliance, and variability, with East Ham Ward screening only eight of the 10 audited patients on average; in some months only five audited patients were screened.
- We saw two junior doctors who were not 'bare below the elbows' on Maple Ward.
- An external company was contracted to provide a monthly audit of waste and sharps management for all theatres. Results were fed back to senior managers to action. We saw evidence that this occurred in practice.

# Surgery

## Environment and equipment

- The Gateway Surgical Centre was a purpose-built facility for elective surgery, with predominantly single en-suite rooms, with pre-assessment, theatres and a physiotherapy gym within the building. Theatres had laminar flow ventilation, and surgeons we spoke with told us they were well-equipped.
- We were told that the hospital operated a central equipment library. Almost all high risk items of medical equipment had had planned maintenance within the 12 months before our inspection.
- We saw that all portable electronic equipment had portable appliance test (PAT) labels attached, indicating that it had been safety-tested in the previous year.
- Labels confirmed whether equipment had been serviced in line with the manufacturer's recommendations. All equipment we checked had been serviced as required by these recommendations.
- We saw resuscitation equipment readily available in each clinical area. Systems were in place to check equipment daily to ensure it was ready for use. We saw from records that staff complied with these systems.
- In theatres, the contract with the company that was responsible for maintaining and checking equipment had been stopped in mid-2014. Although this was identified as a risk on the risk register, measures were not yet in place to address this, and it was unclear whether high risk equipment was being serviced.
- Theatre ventilation was monitored, and there was a mechanism for alerting theatre staff when ventilation had failed so this could be immediately addressed.

## Medicines

- We were told that medicines were administered by appropriately trained staff whose competency had been checked, and that agency staff were not expected to administer medicines. However, when we asked for evidence that staff had the competencies to perform their roles in relation to administering medicines, the trust failed to supply it. Senior nurses told us that only staff who had self-confirmed that they had completed the required training were assigned to this role.
- There was a ward-based pharmacy service. We observed that a pharmacist checked patients' prescriptions to ensure their medicines treatments were safe, effective and met current guidance. We saw pharmacists' annotations on prescription charts, demonstrating such review. Clinical staff could access a pharmacist for advice, and patients and their families could also access medicines advice.
- We observed nurses administering medicines in ward areas, and found that, overall, nurses adhered to Nursing and Midwifery Council standards for medicines management.
- We found that medicines were stored securely in locked cupboards and trolleys. We saw that keys to drug areas were stored in a key cupboard, accessible only by a separate lock.
- Audits of the medicines management were in place. We found that medicines, including controlled drugs and stock balances, were correct. Managers showed us audits of controlled drugs and fridge temperatures had been completed. However, we found that the record book used to record the balances of controlled drugs in theatres was torn and contained loose pages from 2014 records. This meant that the accuracy of recording of controlled drug stock could be compromised.
- The hospital provided us with results from an audit on the quality of medicines reconciliation (a process for identifying a patient's current medication regime) performed by nurses in the pre-assessment clinic for elective surgery, which was completed in 2012. Actions stated had not been completed, and this included specific training on medicines reconciliation required for nurses in the pre-assessment clinics.

## Records

- Patients' records in surgical services were kept in two separate folders: the 'medical notes' contained notes from the multidisciplinary team, with overall summaries from nursing staff, and the 'nursing notes' contained care plans and nurse-led risk assessments, such as of pressure area care and nutrition and hydration. This meant that some information recorded specifically by nurses could not be seen by all professionals involved in a patient's care. Other diagnostic information was held on an electronic record-keeping database.

## Safeguarding

- Training in safeguarding children and adults formed part of the mandatory training programme. Of all surgical staff, 86% had completed some training in

safeguarding adults, and 87% in safeguarding children. This did not meet the required target of 90%. The trust did not provide us with specific details regarding completion rates for East Ham and West Ham Wards.
- Details of safeguarding referrals were maintained on the ward in a safeguarding folder. Staff we spoke with knew how and to whom to report concerns about abuse, domestic violence and neglect. We reviewed recent cases that staff had identified and appropriately referred to senior nurses and the safeguarding team for adults.

### Mandatory training

- Training records were provided by the trust, with most areas in the surgery clinical academic group (CAG) reported to achieve an over-70% training compliance rate. However, when we spoke to ward and theatre staff, it was difficult to identify whether the training provided was effective. This was because almost all mandatory training had been provided through a training booklet covering safeguarding, infection control, moving and handling, health and safety, and medicines and information governance. Ward managers had to ask staff whether they had completed the booklet. During the inspection, when we asked for evidence of these completed booklets for permanent and agency staff, we were not provided with it. Staff told us that they undertook their training, and most could recall specific details regarding safeguarding, health and safety, or infection control outlined in the training manual. Staff received face-to-face training for basic life support.
- While staff in most theatres and Gateway Surgical Centre staff on Maple and Clove Ward were reported to have completed this training, compliance on East Ham and West Ham surgical wards was neither provided locally nor by the trust.
- General health and safety formed part of the mandatory training programme, which staff completed by reading the training booklet. Of surgical services staff, 80% had completed health and safety training. This did not meet the required target of 90%. The trust provided a breakdown by staffing groups, which showed that 90% of nursing and administrative staff in the Gateway Surgical Centre and in theatres had completed the training. No breakdown was provided for the medical and surgical staff groups. We asked senior staff whether these figures included agency and bank nursing staff, and they could not confirm whether this was the case.

### Assessing and responding to patient risk

- The surgical wards used the modified early warning score to assess the severity of cute illness via observations of vital signs including pulse and temperature. We found clear directions for escalation, and staff were aware of the appropriate action to take if patients scored higher than expected.
- Trust staff told us that wards were expected to have started to use the national early warning score, to enable a standardised approach for escalating the deterioration in a patient's condition.
- Observations of patients' vital signs were also monitored electronically, automatically, which aided nurses in identifying signs of deterioration accurately and routinely. Nursing staff on East Ham Ward told us they were confident in using this system.
- We looked at an example where the modified early warning score had indicated a risk of deterioration, and saw that appropriate actions in line with the trust's protocol had been instigated. Completed charts demonstrated that staff had escalated correctly and that repeat observations were taken within necessary timeframes.
- Staff reported no concerns about accessing medical input when required, and noted that outreach services were available 24 hours a day, seven days a week.
- We saw that patients were risk assessed in key safety areas using national validated tools. For example, we saw that the risk of falls was assessed, and the risk of pressure damage was assessed using the Waterlow score. We noted that when risks were identified, relevant care plans that included control measures were generated. We checked a sample of these control measures and found them to be in place. We saw that risk assessments were reviewed and repeated within appropriate and recommended timescales.
- During surgical preassessment in the Gateway Surgical Centre, preoperative assessments were undertaken and recorded prior to and during consultations before the day of the procedure. Staff told us the assessment was valid for a maximum of three months, in case procedures were delayed or cancelled.
- From records we reviewed, hourly nurse 'rounding' (whereby nurses proactively check fundamental care, such as whether a patient is in pain or discomfort, is hydrated, and their general feelings) was in place. However, some patients we spoke with told us that although nurses came to their bedside regularly, they

did not always ask them these general questions about their care on an hourly basis during the day or evening. Some staff told us that they felt pressured to document that they had undertaken hourly nurse rounding even if this did not occur in practice. As a result of staffing shortages, the hospital had to reduce the frequency of rounding from every hour to every two or three hours.

### Nursing staffing

- Across the trust, there had been a review of the nursing staffing establishment, and a number of posts had been removed from each level of staffing grade, including healthcare assistants. Some staff posts had been downgraded. Overall, there had been a small decrease in the number of substantive nursing staff following a recent consultation. Staff told us this did not have a significant impact on nurse staffing levels and morale on surgical wards and theatres at Newham University Hospital.
- On Maple Ward, we found that staffing levels were planned in accordance with planned elective surgery at least two weeks in advance. The ward manager told us staffing levels were maintained, and we saw that this correlated with information publicised on the safety cross board that showed the ward had maintained its full establishment up to 21 January 2015.
- The trust expects ward managers to use a staffing acuity tool developed by The Association of UK University Hospitals, but senior nurses told us they did not use this because they found it did not accurately predict patients' needs. The trust's senior managers told us they intended to maintain staffing above the minimum levels recommended by the National Institute for Health and Care Excellence (NICE), at a ratio of 1:7 (staff to patients). However, we saw that wards were routinely not staffed at this level, and neither could we be assured that this ratio was appropriate for the case and skills mix on each surgical ward on any given shift.
- The staffing tool used in theatres was the Association for Perioperative Practice guidelines. We reviewed off-duty rotas, and lists identified that the skills mix was planned in order to adhere to these guidelines.
- On East Ham Ward we found there were regular gaps in staffing establishment. The post of ward manager had not been filled for over two months. There were four nurse vacancies on the ward.
- We saw that fill rates for healthcare assistants and nursing staff were not maintained for 13 of 21 days up to 21 January 2015 on East Ham Ward. Staff told us this occurred regularly, because arrangements to fill shifts were sometimes not made far enough in advance, and it was difficult to get approval from senior nurses. This meant that on six of 13 days up to 21 January 2015 the nurse to patient ratio was 1:12. On our unannounced visit, we found that this had occurred on four further occasions between 22 January and 4 February 2015.
- We were also made aware of 19 band 5 scrub nurse vacancies in theatre and three anaesthetic nurse vacancies. Staff spoke of an ongoing recruitment programme, but said there were difficulties in recruitment. Senior managers we spoke with were unable to provide us with accurate percentage fill rates for nursing shifts.
- During our inspection, we noted that staff shortages were recorded on all wards on the safety cross boards; notably, in January 2014, for 13 of 21 days for East Ham Ward, 6 of 21 days on West Ham Ward, and 1 of 21 days at Maple Ward at the Gateway Surgical Centre. Senior nurses we spoke with were aware that staff had reported these issues, and were asking staff to manage on a day-by-day basis.
- Use of agency staff in theatres was high because of the number of vacancies, but the allocation of staff showed good evidence of ensuring a safe skill mix of staff; staff we spoke with also stated this.
- The post of practice educator had been vacant for over three months following since the previous post holder had retired. The post had then been removed. The theatre matron was expected to manage training and development.
- We were provided with information from the trust that suggested sickness rates were over 25% for some areas, including general surgery nursing. However, although managers told us these rates were inaccurate, they were unable to confirm the sickness levels or assure us that they were being monitored.
- We observed that handovers occurred twice a day on inpatient wards. Nursing staff teams met and discussed patient safety briefings, where risks including patients with or at risk of developing pressure ulcers, nutrition and hydration status and signs of deterioration in their condition. Staff told us this worked well.
- On Maple Ward, staff meetings were held weekly. On East Ham and West Ham Wards and in theatres, ward team meetings were not being held, because of insufficient time.

# Surgery

## Surgical staffing

- We found that the consultant group provided cover between 8am and 5pm five days a week, as well as an on-call service at weekends. Some staff told us that consultants were available but were not always on site during these hours. The same named consultant covered weekends, but from Monday to Friday a different consultant provided cover each day.
- Senior managers told us that elective surgery was not cancelled when consultants were on call.
- Senior managers told us that the 'consultant of the week' model operated across most surgical specialties. Despite this, during the inspection we found that staff coordinating theatres were unaware of who the surgeon of the week was. This was not in line with recommendations for safe handover and consultant-led care for surgical staffing, as stated in the British Medical Association publication 'Safe handover: safe patients. Guidance on clinical handover for clinicians and managers' (2004).
- We observed that newly admitted patients received a timely review by a consultant. Daily morning and evening ward rounds took place, undertaken separately by each specialist team.
- Within the clinical academic group (CAG) for surgery at Newham University Hospital, the vacancy rate for surgical staff groups varied between 14% (orthopaedics) and 34.52% (general surgery) across all grades of surgeons in 2014. The use of locum surgeon staff was highest in orthopaedics, representing between 15% and 28% in the period March to November 2014.
- Across the trust, consultants represented 31% of the workforce in surgical services against the England average of 40%. Registrars represented 57% against an England average of 37%. Junior doctors represented 8% against an England average of 13%. This meant there were fewer consultants and junior doctors but more registrars in surgical care services than the England average.
- Overall, junior doctors we spoke with told us they were well supported, had good clinical leadership and were engaged. Surgical night cover consisted of an on-call consultant, a registrar and a junior doctor. Junior doctors told us that patients were often transferred from the emergency department to wards out of hours rather than being seen by an appropriate surgical specialist.
- There was an orthopaedic medical liaison service for patients on Maple Ward and East Ham Ward, and the trust employed two consultant orthogeriatricians.
- Staff spoke of difficulties admitting vascular patients out of hours because there was no on-site vascular team at the hospital.

## Five Steps to Safer Surgery

- The theatre staff completed safety checks before, during and after surgery, as required by the 'five steps to safer surgery' procedures – the NHS Patient Safety First campaign adaptation of the World Health Organization (WHO) surgical safety checklist. Theatre staff also demonstrated an understanding of the procedures. However, staff told us no 'observational' audits were undertaken to verify that staff were adhering to the 'five steps to safer surgery' procedures. Theatre staff carried out a surgical safety checklist audit against paper records and audited six cases per month. Over 10,000 operations were carried out in 12 months. Ten audits were conducted per month, which meant only than 1.2% of operations were audited.
- We were told that the results were reported to the theatre managers' monthly meeting. Concerns identified with teams not completing the surgical safety checklist would be escalated to a senior clinician. We were also told that staff could tell the theatre's matron if they were concerned about failure to complete the surgical safety checklist. Staff we spoke with were unaware of the audit results or identified learning. We were told that an action plan had started to be implemented in September 2014, although the trust failed to provide us with this. We could see that the audit results highlighted issues with the debrief and sign-out stages, although no improvements had been made in response. Audit results were not reported to any other committee or group. Therefore, the hospital failed to use the audit results for shared learning across the division.
- Overall, the risk of unsafe surgery was not mitigated. The trust was, therefore, provided with false assurances for surgical safety.

## Major incident awareness and training

- Major incident plans for Newham University Hospital had been finalised in January 2015.

# Surgery

- Protocols for deferring elective surgery to prioritise unscheduled emergency procedures were in place. Staff we spoke with were not aware of the plans and did not describe the appropriate action they would take.
- On East Ham Ward, a separately staffed bay with six dedicated beds was available at short notice for winter pressures.

## Are surgery services effective?

**Requires improvement**

The effectiveness of surgical services required improvement. Evidence of improvements to services following participation in national audits was limited. Although we found some evidence that services were aware of the requirements of the National Institute for Health and Care Excellence (NICE) national guidance, there was no consistent programme of delivery and learning from local audits. Generally, patient outcomes were the same as or better than the national average across most surgical specialties.

### Evidence-based care and treatment

- National Institute for Health and Care Excellence (NICE)guidelines were managed corporately, with a clinical lead assigned to each guideline, whereas national and local audits were managed by the clinical academic groups (CAGs). Senior staff told us they identified that the clinical leads were not consistently updating progress with meeting NICE guidelines or other published guideline recommendations.
- We asked the staff about clinical guidelines. We were shown examples of local guidelines used in anaesthetics, and we saw these had recently been reviewed. We were told that all other surgical specialties used national guidelines which were available on the staff intranet, but that these were not always easy to find.
- When we asked staff about their involvement in local audits, most told us they were unaware of any local audits. We asked for evidence of the impact of a local audit on care. We were told that audits were presented to surgical staff at the academic half days or audit day, and maintained by the clinical governance department. We were told that these audits were used to demonstrate instances of good practice, which led to improvements in standards. However, the hospital failed to provide us with examples of these completed audits for surgical specialties, and there was no evidence that learning from these audits had been undertaken or shared.

### Pain relief

- Patients we spoke with said that staff asked them whether they were in pain and gave them painkillers when they were required. One patient said, “I can tell the nurses when I am in pain and they check my medications to help me.”
- We saw that assessments of patients’ pain were included in all routine sets of observations. We noted that, as part of intentional ‘rounding’ processes, staff were encouraged to ask about levels of pain, although patients told us this did not always occur.
- A specialist pain team provided direct support to surgical wards and undertook pain reviews, supported by the outreach team and on-call anaesthetists. The dedicated pain team worked across inpatient sites at the trust, as well as with patients in the community. A clinical nurse specialist was designated at the hospital and provided direct support daily to staff and patients on surgical wards. The service was provided to both medical and surgical areas by means of a referral system.
- We could not see an evidence-based pain tool in the patients’ records we reviewed at Newham University Hospital.

### Nutrition and hydration

- Patients were positive about the quality of food provided. One patient said, “The food is not too bad, I’ve been given choices.”
- We observed that patients were served a choice of food and were referred to a dietician when screening suggested a risk of malnutrition or when medical problems compromised patients’ nutrition.
- We observed that surgical wards operated protected meal times, which worked in practice, and we saw that patients who were identified as requiring assistance were helped to eat and drink.
- Food that met people’s special cultural and religious needs was available. One patient told us, “The nurse told me a halal option was available for each meal, which is what I need.”

- Patients were assessed for the risk of malnutrition using an evidenced-based tool (the malnutrition universal screening tool). We saw from patients' records that screening was repeated as required.
- There was no evidence of auditing nutrition and hydration. There were no recent audits of nil by mouth times or fasting. The last audit of preoperative fasting knowledge of nurses on surgical wards was undertaken in the trust in 2011; no actions or changes were stated within the audit, and there was no evidence of learning.

### Patient outcomes

- The hospital participated in national audits. These included audits of surgical-site infections, hip fractures and bowel cancer operations.
- National audit results were compiled. We noted that a low number of cases compared with the number of patients treated were reported for a number of audits. For instance, in the National Bowel Cancer 2013 audit only 27 cases were reported, which represented 40% of the total. Senior managers we spoke with told us they were not aware why there was this discrepancy.
- The hip fracture audit in 2013 showed that the trust performed worse than the England average in seven of the 15 measures of best practice, which included all patients having a falls assessment and a senior geriatric review within 72 hours of admission. Of note are that 24.4% of cases were admitted to surgery in four hours, compared with England average of 51%, patients receiving surgery within 48 hours was 81% compared with the national average of 87%, and the mean total length of stay was 21.4 days compared with the national average of 19.2 days. Good practice noted in the audit highlighted that significantly more patients (84% compared with an average of 53.8%) had a preoperative assessment by an orthogeriatrician.
- Results from the National Bowel Cancer Audit in 2013 showed that eight of 24 best practice standards were better than the national average. For example, the hospital scored better than the England average for showing that all patients were discussed at multidisciplinary meetings. However, a number of best practice measures were worse than the national average; these included patients having a reported computerised tomography (CT) scan.
- The National Emergency Laparotomy Audit showed that the hospital did not meet a number of key recommendations for the provision of safe care for emergency general surgical patients. Low numbers of cases were performed: in the range of 51–100 annually. The audit results showed that: the hospital did not have a fully staffed operating theatre 24 hours a day, seven days a week; it had not audited emergency theatre or emergency service provision within the previous two years; it did not have explicit arrangements for review by the elderly medicine team; and could not provide for high-risk patients to be admitted to a critical care unit following surgery. We also noted that 19 out of 28 measures were not completed as required by the audit. We discussed the results with senior managers, who told us they thought that a number of results were reported inaccurately to the audit, but they were unsure why.
- In the clinical academic group (CAG) for surgery, the Summary Hospital-level Mortality Indicator– which compares the expected rate of death in a hospital with the actual rate of death at the hospital – was 65 compared with 95.
- Overall, the risk of readmission was above the national average for elective surgery, at 108 compared with 100, and better than the national average for non-elective surgery, at 90 compared with 100. Some specialties were found to be worse than the national average, particularly general surgery at 122 compared with 100, trauma and orthopaedics at 117 compared with 100, and breast surgery at 131 compared with 100.
- The revision rate submitted between 1 April 2014 and 30 November 2014 for hip operations was 0.8% within three years, and for knee operations was 0.5%. These rates were significantly better than the national average.
- Patient Reported Outcome Measures (PROM) showed that the outcomes for most patients undergoing knee replacement operations, hip replacement procedures and groin hernia operations were generally in line with the England average.

### Competent staff

- In the clinical academic group (CAG) for surgery, 65% of staff had received an appraisal between July and

November 2014. Among non-training-grade medical staff, the figure was 17%. These percentages indicated that the directorates were not on target to complete appraisals for staff by the year end.

- On the inpatient wards, ward-based staff completed a local induction, and the staff member would be supernumerary. Newly recruited staff that we spoke with confirmed that they had received this induction.
- Senior nursing staff told us that nurses completed competency-assessment booklets that covered a range of clinical competencies that the nurses were to demonstrate. Maple Ward showed us examples of booklets that staff were completing, but we were not provided with evidence that this was occurring on East Ham and West Ham Wards.
- Arrangements for the local induction of bank and agency staff were in place, but we were not provided with evidence that this occurred routinely on East Ham and West Ham Wards. This meant the wards were not assured that temporary staff were working safely.
- Senior staff told us that specific competencies of scrub nurses, such as undertaking a swab count, were not routinely assessed. Senior staff acknowledged that there were learning opportunities across hospitals that they had missed, where theatre-specific competency programmes were established across the trust.
- Senior managers told us that surgical staff engaged in the appropriate revalidation processes. At the time of our inspection, 61 appraisals had been completed and feedback had been received from those appraised.

### Multidisciplinary working

- Ward teams had access to the full range of allied health professionals. Team members described how they were able to access professional advice when required.
- Within surgical services, multidisciplinary working was more evidence on some ward areas than others. We identified some areas that had a commitment to multidisciplinary working, in particular Maple Ward at the Gateway Surgical Centre. A multidisciplinary team meeting took place regularly and involved surgeons, medical doctors, occupational therapists, dieticians and other specialists as required to plan the needs of patients from admission through to discharge.
- We saw that wards had access to mental health services from a mental health trust. Psychiatric assessments were carried out as a result of referrals.
- There had been a vacancy for the practice development nurse in theatres for over three months, and the post was being recruited to at the time of our inspection.

### Seven-day services

- Staff told us that weekday imaging including computerised tomography (CT), and ultrasound was available from 9am to 5pm, with on-call cover provided. Access to magnetic resonance imaging (MRI) was available from 9am to 8pm on weekdays and from 9am to 5pm at weekends.
- Pharmacy support out of hours was available when required. Access to interventional radiology was rarely required but available at other trust sites.
- Seven-day therapy services were available. Physiotherapy and occupational therapy teams provided a service to the inpatient wards between 8am and 6pm, and on-call rotas had been in place since April 2014 to ensure the seven-day service was adequately staffed.

### Access to information

- Clinical staff told us they had access to current medical records and diagnostic results such as blood test results and imaging to support them to care safely for patients.

### Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) formed part of the mandatory training programme, and was covered under training for safeguarding adults within the staff training booklet. However, junior doctors we spoke with told us the hospital did not provide formal training in the MCA.
- Staff we spoke with were able to talk about their responsibilities under the MCA. They were able to describe how to escalate concerns about a patient's mental capacity to the trust's lead for safeguarding adults.
- Senior nursing staff told us that formal best interests meetings were held to establish patients' capacity and determine best interests in line with the Department of Health code of practice for implementing the MCA.
- Staff understood the concept of deprivation of liberty and could give examples of where the safeguards had been applied or considered.
- During our unannounced visit, one patient was described as being confused. We found no evidence in

the notes that this patient's capacity had been reviewed. Staff showed us this had been escalated to the senior nurse, but were waiting for instruction over 24 hours after the patient had been admitted to the ward.

## Are surgery services caring?

Good

Feedback from most of the patients we spoke with was positive. Results of the NHS Friends and Family test of surgical services at the hospital were mostly in line with the England average. Most of the staff we observed interacted well with patients. Patients and their relatives told us they felt supported by hospital staff. They also told us that they felt involved in care.

### Compassionate care

- Overall, patients we spoke with were satisfied with their care. Feedback from most patients we spoke with was positive; they told us they felt well cared for. A patient told us, "They are angels on this ward; they all work so hard." Another said, "Nothing is too much trouble. I would give this ward 100%".
- We witnessed many positive interactions between staff and patients in surgical ward areas.
- Of Maple Ward at the Gateway Surgical Centre, patients told us, "I've chosen to travel here rather than use my local hospital, as it has an excellent reputation for hip surgery," and "The care on this ward is outstanding."
- A few patients spoke of the workload they witnessed staff having to endure. Some people told us, "The ward is always busy and short of nurses; things don't get done properly." They also commented, "The staff don't always have time to explain things."
- Surgical wards in the hospital performed below the England average for the monthly inpatients NHS Friends and Family test, with some variable results across the hospital. On Maple Ward, the average score in 2014 were 77, which was higher than the England average of 70. However, scores for patients on East Ham Ward scores were notably below 60, on average, in 2014.

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

- Most patients we spoke with understood their care options and were given enough information about their conditions.
- Patients' relatives told us they were encouraged to participate in care when it was appropriate to do so. One relative told us, "Since he moved to this ward, they have involved me in his care."
- Patients said they were kept up to date about their care and treatment. A patient reported, "The staff involved have been in to see me every day to give me an update, so I know what to expect now and when I am discharged."

### Emotional support

- Staff could refer patients to a mental health liaison service. We looked at a patient's notes and saw that a referral had been made when the patient expressed suicidal thoughts. We noted that the response was almost immediate and that appropriate mental health support was provided by registered mental health nurses.
- We were not made aware of any specific counselling or support services available to patients with regards to clinical care.
- We found that patients could access specialist nurses, although we noted that the post clinical nurse specialist for vascular patients had been vacant for over three months at the time of the inspection. Some staff told us that this meant these patients were not receiving holistic care and support.

## Are surgery services responsive?

Requires improvement

Evidence to indicate that the surgical service was planned to meet the needs of the local people was limited. The access and management policy did not ensure that services were planned to meet the needs of the local population. Emergency and elective care were not separated, and the level of postoperative care required following elective surgery was not factored in to ward repatriation.

Prior to the trust suspending the reporting on all 18-week referral to treatment target waits in September 2014, general surgery across the trust was consistently not meeting the target for admitted (adjusted) pathways. The effectiveness of these plans to reduce the backlog of patients waiting for treatment was limited.

Interpreting services were not always available or accessed in a timely fashion and considering the diversity of the local population, we did not see patient literature displayed in any languages other than English.

A patient with a learning disability was not provided with reasonable adjustments and there were no specific dementia specialist initiatives available to support staff who were delivering frontline care.

Patients and relatives were aware of how to raise a concern or a complaint. However, some staff were not aware of how complaints were managed, and received no feedback on their outcomes.

### Service planning and delivery to meet the needs of local people

- Evidence to indicate the service was planned to meet the needs of the local people was limited. Senior managers said that the highest needs within the local area served related to the diversity of languages spoken and the high social deprivation index within the Borough of Newham. With regards to languages, staff we spoke with told us that the hospital's advocacy service, which could provide interpreters, had become more difficult to access in the last 12 months.
- The access and management policy did not ensure that services were planned to meet the needs of the local population.
- East Ham and West Ham surgical wards did not reflect recommendations for delivery of surgical services by the Royal College of Surgeons. Emergency and elective care were not separated, and the level of postoperative care required following elective surgery was not factored in to ward repatriation.
- The Gateway Surgical Centre was promoting supported discharge arrangements for patients who had elective orthopaedic surgery, so they could continue their rehabilitation at home.

### Access and flow

- At Newham University Hospital, the average number of surgical inpatients was approximately 140 per month. Managers told us there were rarely surgical outliers on other wards, although this data was not kept.
- In 2014, 40 patients had been transferred from Newham University Hospital to The Royal London Hospital to access emergency care.
- East Ham Ward served a mixture of elective and non-elective patients on both wards from a number of surgical specialties.
- For non-elective surgical patients who arrived at A&E, we noted there was no surgical assessment unit and limited surgical cover in A&E.
- There was no surgery presence during handovers for the 'hospital at night' team, and site managers did not receive information in advance about surgical patients who may have been at risk of deterioration.
- Surgical lists commenced at 7am. Children and vulnerable people were prioritised and were often seen first on the list. There were no afternoon lists for children. There were no staggered admissions.
- Theatre scheduling took place two weeks in advance and was monitored weekly. A consultant anaesthetist and a theatre coordinator planned theatre lists. The booking sheet used for theatres did not cover surgical risk profile.
- The Department of Health monitors the proportion of cancelled elective operations and the hospital was not an 'outlier' when compared with other trusts. However, when we asked for theatre utilisation information we saw that a number of theatres were routinely less than 40% utilised. When we asked for clarification, managers told us this information was inaccurate, and lists had to be manually checked for accuracy. When we requested data on theatre utilisation, we were provided with a report that stated that 'knife to skin' time, or surgical time, was measured. Managers told us that the figures were wrong, because they were not based on the cases carried out. Anaesthetic time was not taken into account, thus a theatre having one case on a list might achieve a high utilisation percentage, while the percentage for another with multiple small cases would be low.
- The trust suspended reporting on all 18-week referral to treatment target waits in September 2014 and did not expect to be able to resume until 2015.
- Prior to the cessation of the submission of data, general surgery across the trust was consistently not meeting the national waiting time target of 18 weeks for admitted (adjusted) pathways (90% referral to treatment target) with 74.7%. Admitted pathways are waiting times for patients whose treatment started

during the month and involved admission to hospital; adjustments are made to admitted pathways for clock pauses, where a patient had declined reasonable offers of admission and chosen to wait longer.

- The theatre coordinator manually checked utilisation, cancelled operations and adjusted data accordingly, although cancellations were not shown. This system meant that the coordinator had to manually review records for the previous day to feed back on theatre performance.
- Plans to review patients who were delayed for treatment were in place and monitored by managers. However, the effectiveness of these plans to reduce the backlog of patients waiting for treatment was limited, because the accuracy of the information was not fully established and capacity was insufficient to meet demands. Discussions with commissioners to outsource this work had commenced, but outcomes of these discussions were unknown at the time of the inspection.
- On Maple Ward, enhanced recovery programmes were in place for patients accessing the orthopaedic and colorectal services. The services ran a twice-weekly joint school to help patients prepare for their operations. We saw that detailed information about the programme was available to patients.
- In relation to complaints from GPs about patients accessing services, we saw that local commissioners provided feedback and GPs were responded to.
- We saw evidence of this multidisciplinary approach to discharge planning in patient records. However, on East Ham and West Ham Wards, although the same range of specialists were involved in patient care, individual specialties met separately to discuss patients' needs; we could not see evidence that complex care or admission and discharge were planned collaboratively.

## Meeting people's individual needs

- Some systems were in place across the trust to provide support to frontline staff for patients with complex needs, including a clinical nurse specialist for learning disabilities, who worked across the trust, and access to advocacy services and Language Line for translation services. However, we observed, and staff and patients confirmed, that these services were not always available or accessed in a timely fashion. Staff routinely used relatives to help communicate non-confidential information to patients.
- The layout of the hospital and the surgical ward areas was suitable for patients with mobility impairments. In the Gateway Surgical Centre we saw that bathrooms and toilets were suitable for those with limited mobility. Supplies of mobility aids and lifting equipment, such as hoists to enable staff to care for patients, were adequate.
- We did not see patient literature displayed in any languages other than English.
- There was a hospital chaplaincy service. Staff were aware of how to contact spiritual advisors in order to meet the spiritual needs of patients and their families.
- We observed a patient with a learning disability for whom staff did not provide reasonable adjustments. The patient's relatives had made a learning disability passport for the patient, but we could not be sure that all relevant staff had reviewed and understood the contents. We noted no specific plan of care in either the nursing or medical records to address the patient's needs. We noted that specialist advice had not been sought from the clinical nurse specialist.
- We saw that a patient with a sensory impairment who also had very limited verbal communication and for whom English was not their first language was struggling to communicate with staff. Records showed that this patient had been discharged from the ward and readmitted within a day, and required monitoring and support for substance dependency. We reviewed this patient's nursing and medical records and found that staff failed adequately to address this patient's needs. Furthermore, staff routinely referred to this patient as being 'deaf', and in one instance a nurse documented that this patient was 'deaf and dumb'. Previous records showed that the patient required a sign language interpreter. The senior nurse in charge was unaware of the findings we described and agreed to address them immediately. This indicated that patients did not always receive reasonable adjustments in order to receive the right care.
- We did not see any specific dementia specialist initiatives available to support staff who were delivering frontline care. A post of dementia specialist had recently been removed from the trust structure, and staff were not sure who to speak with specifically about dementia, other than their peers or line managers.

# Surgery

### Learning from complaints and concerns

- Patients and relatives we spoke with were aware of how to raise a concern or a complaint.
- Some staff we spoke with told us they were not aware of how complaints were managed, and that they received no feedback on the outcomes.
- In the clinical academic group (CAG) for surgery at Newham University Hospital, 28 complaints had been received and responded to since July 2014.
- Senior staff described local resolution meetings with patients and relatives who had complained, at which they could offer face-to-face apologies and describe actions taken to improve care. Senior staff told us they had held eight local resolution meetings within the last year across Newham University Hospital and The Royal London Hospital.
- We requested specific details of how complaints were learned from. The trust failed to provide us with evidence to demonstrate this.
- One complaint was referred to and upheld by the Parliamentary and Health Service Ombudsmen (PHSO) in 2014. We asked for details of learning that was shared from the case at the time of the inspection, but the trust failed to provide us with this information. However, since the inspection, we were told by the trust that this information was available because all PHSO upheld complaints, reports, trust learning and action plans are shared with both the PHSO and complainant.

## Are surgery services well-led?

Inadequate

There was no evidence of a unified vision for surgery services being shared with staff and stakeholders. The governance and risk management arrangements were undeveloped and we were not assured that senior managers had oversight of the concerns affecting frontline staff, patient safety and their experience. This meant that concerns and risks that needed escalation and action were not dealt with and often not known.

The trust's board had neither full information nor oversight of issues affecting surgical services and staff reported that senior trust leaders were not visible on the hospital site. We noted that the duty of candour was not consistently applied.

Many of the frontline staff felt supported by their local leaders, including ward managers; but some clinicians felt that managers pressurised them into making decisions about care and treatment that were not in the best interests of patients.

Some senior nurses however, felt that managers and leaders were not supportive, and that concerns raised about staffing levels and the impact on patient care were ignored. Senior staff were aware of the report into widespread bullying and harassment across the trust, but felt that the actions taken by the CAG and trust board had no positive impact for staff at the hospital.

Most staff spoke positively about their work, colleagues and the hospital, although they felt disconnected from the trust.

We found that the Gateway Surgical Centre's design, layout, forward planning, engaged staff and integrated care with members of the multidisciplinary team was outstanding.

### Vision and strategy for this service

- We asked for evidence of a strategic vision for surgical services. Senior managers described good working relationships with commissioners, but plans not yet been formalised in a report.
- There was no evidence of a unified vision for surgery services being shared with staff and stakeholders.
- The trust's integrated business plan for 2014 to 2016 included plans to increase capacity at the Gateway Surgical Centre. Senior staff were planning to increase the number of knee operations from 950 in 2013/14 to 1,500 in 2015/16.

### Governance, risk management and quality measurement

- The governance and risk management arrangements within the surgery clinical academic group (CAG) across the trust were undeveloped. We were not assured that senior managers had oversight of the concerns affecting frontline staff and patient safety and experience. This meant that concerns and risks that needed escalation and action were not dealt with and often not known.
- The trust's October 2014 governance structure showed that services were divided into five CAGs, which reported the activity and performance of all the trust's locations,

including Newham University Hospital. Despite transitional weaknesses in the governance arrangements for cancer, the CAG was merged for surgical services in July 2014.

- Reports shared through the committee structure did not separate incidents, complaints, risks and performance activity by location, and therefore the trust's board had neither full information nor oversight of issues affecting surgical services delivered at the hospital.
- Throughout our inspection, we found that governance systems for surgical services at the hospital were not fully embedded. Senior staff were not fully aware of the key challenges in their areas, and methods for escalation through the CAG structure were not clear. Staff were unaware of the CAG's areas for improvement across the CAG.
- The top risk on the risk register for the CAG at the hospital was replacement of old anaesthetic monitors and operating tables, escalated in July 2014. Descriptions of actions taken to address how funding would be provided to replace these items were limited.
- Staff were expected to escalate local risks across the CAG, but this was not reflected in practice on the risk register. We noted there was no mention of staff shortages on East Ham Ward or learning from serious incidents, national or local audits.
- We were told that governance was aligned to risks reported through the service lines. Each specialist surgical area had its own local governance arrangements: the hospital-wide patient safety group and the trust-wide surgery and cancer services CAG board. Several risks, including staffing shortages, were not identified and escalated through these committees. We also noted regular poor attendance to these committees by surgical leaders.
- At Newham University Hospital, managers and senior nurses had devised local systems to capture and disseminate learning from incidents, complaints and audits. Managers described a governance day that was held in the hospital in July 2014 across the CAG for surgery. However, we were not assured that these systems were robust, due to the informal nature of some meetings and low levels of attendance.
- Managers were confident that most incidents were reported, because Newham University Hospital was a high reporting site for incidents before the merger in 2012.

### Leadership of service

- Leaders within the trust had no managerial control of surgical services provided, partly because of unreliable reporting and because the leadership team, who were in the clinical academic group (CAG), were responsible for services spanning multiple sites.
- The CAG was led by an executive group director (medical/surgical lead), an executive nurse director and an executive operations director; these senior managers were responsible for overseeing all of the trust's locations. The executive group director for surgery commenced in the post in July 2014; the post of executive operations director was vacant and had been filled temporarily on an interim basis since August 2014. This post was due to end in February 2015 and was not expected to never be filled again.
- We noted that the executive group director had an extensive remit, but insufficient non-clinical time in order to achieve this.
- The most senior leaders of the CAG held meetings at The Royal London Hospital. Staff reported that these leaders were not visible at the Newham University Hospital site.
- Many of the frontline staff at Newham University Hospital that we spoke with said they felt supported by their local leaders, including ward managers. However, some clinicians we spoke with felt that managers pressurised them into making decisions about care and treatment that were not in the best interests of patients.
- Some senior nurses felt that managers and leaders were not supportive, and that concerns raised about staffing levels and the impact on patient care were ignored. Surgical services at the hospital had to take part in the staffing-level review across the trust due to the state of the trust's finances, but senior staff felt that staffing ratios for staff at lower grades were not going to be adversely affected. A 1:7 ratio of nurses to patients was expected for wards across the trust, based on a mixture of acuity, evidence-based ratios, an internal nursing workforce plan, and local and national benchmarking. However, this1:7 ratio contradicted concerns raised by staff through incident reporting in relation to staffing ratios. Senior nurses had local arrangements in place to increase the numbers of healthcare assistants on inpatient wards. However, the trust did not assure us that nursing leaders understood the impact of nursing staff shortages on patient care.

# Surgery

- Senior staff were aware of the report into widespread bullying and harassment across the trust, but felt that the actions taken by the CAG and trust board had no positive impact for staff at Newham University Hospital.

### Culture within the service

- Most staff spoke positively about their work, colleagues and the hospital, although they felt disconnected from the trust. A junior doctor told us, "This is a brilliant hospital to work in; I would return." Nursing staff we spoke with felt the impact of staff shortages on a regular basis, though they spoke of receiving high levels of support from their immediate colleagues. Most staff were unaware of initiatives across the trust to reduce the levels of bullying and harassment.
- The duty of candour was not consistently applied. Staff with responsibility to investigate incidents had to identify whether patients involved in incidents, or their relatives, had been notified if an incident that caused moderate harm, severe harm or death had occurred. However, staff had not received training on new duty of candour legislation, and senior staff could not assure us that the legislation was being followed for each relevant incident investigation.

### Public and staff engagement

- Patients' views of surgical wards were being sought through the patient panel and the NHS Friends and Family test.
- Staff told us they were able to discuss suggestions to improve the service with their local leaders and line managers at Newham University Hospital, but were not engaged with influencing senior managers over decisions affecting their work.

### Innovation, improvement and sustainability

- Plans to increase theatre capacity were agreed with commissioners and reported in the elective surgery clinical working group's report. From the end of January 2015, plans to begin extended operating lists, including at weekends, to increase activity by 300%, had been in place. Two extra surgeons had been recruited to work across Newham University Hospital and The Royal London Hospital site in order to meet extra demand.
- The Gateway Surgical Centre's design, layout, forward planning, engaged staff and integrated care with members of the multidisciplinary team were outstanding.

# Critical care

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

## Information about the service

The intensive care unit (ICU) at Newham University Hospital, part of Barts Health NHS Trust, is an eight-bed facility with five level 3 intensive care beds and two level 2 high dependency beds. Six beds are within one area, and there are two side rooms, one of which, when not in use, is a storage area for equipment. There is a critical care outreach service seven days a week. The unit is part of the surgery and cancer clinical academic group.

Patients are admitted from the A&E department and other areas of the hospital, including following elective surgery. Patients requiring level 2 non-invasive ventilation can also be nursed on the acute care unit, which is part of the cardiovascular clinical academic group and separate to the main ICU.

We spoke with 26 members of staff of all grades including nurses, doctors, consultants, a dietician, physiotherapists, a pharmacist, an advanced practitioner and the stores manager.

We were unable to speak with any patients, but spoke with four relatives. We observed care and reviewed patients' care records.

## Summary of findings

The unit was grappling with a range of problems, including vacancies, staff attendance at mandatory training, and improving governance within the unit.

The key issues included nursing vacancies and poor uptake of mandatory training by nurses, which had resulted in the withdrawal of final-year nursing students and a temporary suspension (later lifted) on recruitment until staff were up to date with their training and able to support new staff. Insufficient nurses had completed the post-registration intensive care course, and the unit had experienced difficulties recruiting to the post of clinical educator.

Staff understanding in the difference between obtaining patients' consent and acting in their best interest in accordance with the Code of Practice of the Mental Capacity Act (2005) was not clear.

There was 24-hour consultant cover seven days a week and a critical care outreach team. Consultants thought the on-call rota was demanding, and because of capacity issues and nursing vacancies, thought they spent a lot of time managing patient flow through the unit rather than caring for patients.

Nursing staff vacancies and a lack of beds affected patient flow and meant that some patients had their surgery cancelled and others had to be transferred to another unit.

# Critical care

Care was based on national guidance, but there was a lack of awareness of and adherence to guidelines by nursing staff. Outcomes for patients were reported and monitored, but other aspects of governance needed to be improved, including clinical audits.

Multidisciplinary working was in place, the unit had a dedicated pharmacist, dietician and physiotherapist. Staff were positive about their working relationships, but formal meetings between different disciplines were limited.

Other aspects of patient care, such as their nutritional needs and pain relief, were managed well. We observed staff talking to patients in a kind and caring manner, but no mechanism was in place to obtain feedback from patients or their relatives.

Resources for relatives were limited, and visiting times were fixed; however, staff were flexible and relatives could visit outside set times.

The unit did not conform to modern building standards and had a shortage of space. The unit had started to address some of the issues, but progress was slow and some of the changes were reliant on the trust developing a clinical strategy. Within the unit, progress was hampered by the lack of a joined-up approach to improving service and quality and potential further changes to the nursing leadership.

## Are critical care services safe?

**Requires improvement**

To maintain and improve the delivery of safe care, some aspects required improvement, in particular attendance at mandatory training and the recruitment of nurses. Incidents were reported and investigated and there were some opportunities for learning from incidents. Mortality and morbidity meetings were being reintroduced, and medicines management, with the exception of the storage of intravenous fluids, mostly adhered to the trust's policy.

Staff adhered to infection prevention and control procedures, and the supply of personal protective equipment was sufficient. Equipment was clean and maintained, but the environment needed to be improved to bring it into line with national guidance. For example, space in the main room, which had six beds, was limited.

There were problems with the accuracy of records of attendance at training. This had affected the unit in a number of ways, including leading to the removal of final year nursing students because, although there were sufficient mentors, they were not up to date with training.

Nursing vacancies were also a problem, and recruitment had been temporarily suspended until staff were up to date with their training, to ensure that new staff received the appropriate support.

There was 24-hour consultant cover on the unit. Permanent consultants were accredited as intensive care consultants, and the permanent locum consultants were working towards being accredited.

Arrangements were in place to respond to patients at risk. The critical care outreach team provided a seven-day service, with cover provided by the site managers at night. Staff used the modified early warning score for early identification of patients at risk.

### Incidents

- The trust had a risk management policy dated December 2013 that was due for review in 2016. No Never Events were reported for critical care services in

the year preceding our inspection. (Never Events' are classified as serious, largely preventable patient safety incidents, which should not occur if the available preventable measures have been implemented).

- An electronic incident-reporting system was in place to report near misses or adverse events within the intensive care unit (ICU). Staff were aware of how to report incidents, and there was some evidence that learning from incidents was shared. A feedback function on the incident-reporting system meant that staff could ask for individual feedback. Incidents were discussed at the twice-daily handovers.
- Recent incidents reported between October and December 2014 included those relating to staffing levels, agency staff not turning up for a shift, and patients developing pressure ulcers and blisters around intravenous sites. Action had been taken in response to the incidents, including mitigating risk. We saw evidence of medicine incidents that had been reported, investigated and followed up with staff.
- Although there had been no reported serious incidents in the last six months, we were made aware of a serious incident which occurred in December 2013, but not been reported as a serious incident until December 2014. The staff in the intensive care unit did not report it as a serious incident and the orthopaedic team didn't realise it should be classed as a serious incident. It was the coroner who recommended the trust should review the incident, which was done by one of the intensive care consultants and who subsequently declared it as a serious incident on 1 December 2014.
- We were provided with the notes of the unit's mortality and morbidity meetings for April 2014 (attended by medical staff but no nursing staff) and June 2014 (an electronic presentation). We were told that mortality and morbidity meetings had recently been re-established. Mortality and morbidity meetings had been the responsibility of a consultant who had left several months ago, and the meetings had been suspended until January 2015 when another consultant had taken over responsibility for them. The first meeting was due to take place during our visit.
- There was a trust-wide mortality and morbidity group which the clinical director for intensive care across the clinical academic group (CAG) attended.

### Safety thermometer

- The safety thermometer was in use at the unit and displayed outside the entrances for patients and relatives to view. Information was shared at the nursing handover.
- During our visit, the overall number of nurses on duty for each shift had not been updated. Other information about the occurrence of pressure ulcers and whether the unit had the required number of nurses for each shift had been included for each day. A summary of information for the previous month was also provided.
- At the time of our visit, no patient had acquired a pressure ulcer on the unit for over six months, but there had been insufficient nursing staff on a number of occasions.

### Cleanliness, infection control and hygiene

- Staff training records showed that 100% of nursing staff had attended level 1, level 2 and level 3 infection prevention and control (IPC) training. The percentages of medical staff attending were lower at 45% for level 1 training and 55% for level 2 and 3 training.
- The unit had a lead nurse for IPC who attended link nurse meetings and carried out local audits. We saw a range of IPC policies on the intranet, including 'Infection Control Principles and Responsibilities' (October 2013).
- All staff we observed during the inspection adhered to the 'bare below elbows' policy and used personal protective equipment such as gloves and aprons when carrying out procedures or personal care.
- Gloves and aprons were located at each bed space, but they were all the same colour, making it difficult to see whether they have been changed between patients and procedures.
- Sharps bins were located close to patients' bedsides, and were no more than three-quarters full.
- There was no physical barrier between each bed space to reduce the risk of cross-space contamination.
- The unit had dedicated cleaning staff, and clinical areas were clean and tidy. Other areas such as the treatment room, sluice and relatives' room were also clean and tidy.
- Hand-washing facilities and hand gel were located outside the intensive care unit (ICU), immediately inside the unit, and near patients' beds.
- We observed staff following hand-washing protocols. Hand-washing audits for September to December 2014 had found 100% compliance.

# Critical care

- Data from the Intensive Care National Audit and Research Centre (ICNARC) showed that infection rates for the unit were lower than those of similar units in England. Information for the period April to December 2014 showed there had been people testing positive for the presence of MRSA bacteria in their blood.
- Rates of ventilator-acquired pneumonia were audited in compliance with the Department of Health's 2012 'Save Lives' guidance. For September to December 2014, the VAP rate for all ventilated patients was 10%, and it was 20% for those ventilated for more than 48 hours.

## Environment and equipment

- Security on the intensive care unit (ICU) was good. The ICU was locked, and staff used a swipe card system to access it. For visitors, access was via an intercom system. Once inside the ICU, visitors used one of two entrance doors, depending on which bed space the patient they were visiting was in.
- Following our last inspection, in November 2013, when we found a lack of storage area, one of the side rooms, when not in use, has been used to store equipment. When the side room had to be used for a patient, the equipment was moved to an empty bed space.
- Space in the main room was limited, and beds remained close together. The ICU did not comply with modern building standards (Health Building Note 04-02: Critical care units), and this was not recorded on the risk register.
- The ICU had a part-time stores manager who was responsible for maintaining and ordering equipment four days per week.
- The ICU had an ongoing equipment maintenance programme. All equipment had stickers on with the date it was cleaned and the name of the member of staff who had cleaned it.
- Resuscitation equipment was located next to the nurses' station in the main room. It had been checked twice daily and there were no gaps on the checking form.
- The ICU had been painted since our last inspection. Staff were positive about the changes the new matron had made in terms of improving storage space, buying new equipment and redecorating the unit.

## Medicines

- The ICU had a dedicated pharmacist who visited the unit daily and attended ward rounds during the week. Pharmacy support was available at weekends.
- Medicines were stored in a locked room, and controlled drugs were stored in a locked metal cupboard within a locked cupboard; the nurse in charge held the keys. We saw records that showed that the number of controlled drugs had been checked daily. Pain relief drugs for administration via epidural were kept in a separate locked cupboard. Two nurses checked and administered all controlled drugs.
- The medicines fridge was kept in a locked room and the temperature recorded daily.
- Intravenous fluids were stored separate from other medicines, in the same room as the blood gas analyser machine. They were stored in separate boxes. The room did not have any ventilation and the door had to be left open to prevent the temperature becoming too high and adversely affecting the blood gas analyser machine. This potentially put the intravenous fluids at risk of being contaminated. We discussed this with the matron, who told us they had initially moved the intravenous fluids to the room with the other medicines, but to store them would have meant removing them from their labelled boxes, which was not considered good practice. The matron had also tried to get the side room designated as the official storage room, which would mean it could be locked, but had not yet had agreement for this, because sometimes two patients needed to be nursed in isolation. Having reviewed the options, the matron decided that keeping the intravenous fluids in separate boxes in separate sections of the unlocked room posed the least risk, given that access to the ICU was via a swipe card and only two people could visit at a time. The risk had been escalated, and the lead consultant was aware of the problem.
- Medicine administration records we reviewed showed that medicines had been prescribed in line with prescribing guidance, and medicines administered had been signed for.
- Intravenous fluids were prescribed on a separate chart. Intravenous fluids for arterial lines and central venous catheters had been prescribed, but nursing staff had not always recorded the date and time they were commenced.
- Each individual patient's medicines were kept in a locked drawer on the trolley next to their bed. The trolley contained a range of equipment and observation charts.
- We saw evidence that, between August and October 2014, three medicine incidents had been reported and

investigated, and action taken. Action after a patient received the incorrect dose of noradrenaline via an infusion pump included escalation to the critical care management group.

### Records

- Records were stored next to patients on their equipment and medicine trolley. Each patient had a critical care chart where nurses recorded a range of information, including their vital signs, ventilator settings, level of consciousness and enteral feeding. The charts were also recorded the nursing care a patient received, which made it difficult to review the history of the patient and check whether an aspect of care was not required or had been omitted in error. It also meant that nursing records were separate from the rest of the multidisciplinary team records.
- In addition to the chart, each patient had a folder containing daily treatment plans and details of assessments and treatment delivered by physiotherapists, medical staff and other members of the multidisciplinary team.
- The records we reviewed were up to date and showed evidence of discussions with relatives about the patient's progress.

### Safeguarding

- The trust had a safeguarding policy dated June 2013 (due for review in 2016). Staff told us they would escalate concerns to the nurse in charge or contact the lead safeguarding nurse.
- On the intensive care unit (ICU), 91% of medical staff had completed level 1 and level 2 adult and children safeguarding training, and 100% of nursing staff had completed level 1 and level 2 adult and children safeguarding training. Administrative staff had completed level 1 training for both children and adults.

### Mandatory training

- The trust provided information about all staff's attendance at mandatory and statutory training. For example, 100% of the administrative staff working in the intensive care unit (ICU) had completed their fire training and moving and handling training.
- Information provided by the trust showed that attendance at mandatory training varied among different staff groups. For example, 87% of nursing staff had attended basic life support training, whereas the percentage of medical staff who had completed their basic life support training was lower, at 36%; this was against a target of 90%. The critical care outreach team had completed all of their mandatory training.
- The matron of the ICU told us that since coming into post (the matron was appointed February 2014 and took up the post completely in April 2014) they had found that some of the information about training was not reliable. Part of the problem was staff not having completed the training, along with changes in how the training was delivered and recorded; for example, some training had changed from e-learning to a booklet that staff signed to confirm they had read it. Other reasons were changes to the information (maybe one small detail) in the training, which meant staff had to repeat the training, even if they had only recently completed it, otherwise it would not show up on the system.
- There were some areas where staff were not up to date were mentorship, the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards training. Relevant staff had been scheduled to attend these training later in January 2015.
- Because of concerns about training, the matron had contacted the university from which the hospital received nursing students and asked for them to be withdrawn until staff were up to date with their training and able to support them appropriately.
- The university carried out its own audit of placement, in August 2014, and found that, "a review of current CPD shows placement does not meet mandatory training requirements" and "a welcome pack was not available for students and no student evaluations had been carried out for over six months". There were too few mentors for the number of students, and several inactive mentors on the register needed updates "as soon as possible". The ICU had 17 trained mentors, but "not all met the NMC [Nursing and Midwifery Council] requirements".
- A series of actions were agreed. The decision to withdraw final placement students was to be reviewed at the next annual audit in 2015. We asked the matron whether a date had been agreed for the actions to be reviewed, but the matron seemed unsure.
- We asked staff about the decision to withdraw the students. Although staff understood the reasons, they had found it difficult, although they acknowledged they had "let things slide".

- The matron had started to cross-check the training and had plans in place to ensure that all staff were up to date with training. This included taking small groups of staff out for training during January 2015.

### Assessing and responding to patient risk

- On the intensive care unit (ICU), a range of risk assessments were carried out on patients, including of pressure area care and the ventilator care bundle (the patient's bed being elevated to 30 degrees, for example, to reduce the risk of ventilator-associated pneumonia).
- The hospital's critical care outreach team consisted of three band 7 nurses and two critical care technicians. They were the link between the wards and the ICU.
- The modified early warning score was used to monitor patients deemed at risk of deteriorating.
- The critical care outreach team reviewed all patients who had a modified early warning score of 3 or above, patients discharged from the ICU, patients who had had cardiac arrests, and patients with an underlying condition such as a tracheostomy or who were on non-invasive ventilation. They also reviewed patients who might not have had a score of 3 or above but who staff were worried about because "the patient was just not right". Referrals came from both nurses and doctors.
- The report of the critical care outreach team for January to December 2014 showed the number of patients referred from each ward and the modified early warning score on referral, which ranged from 1 to 11. Most patients were referred with a score of 6.
- Of those patients referred to the critical care outreach team 77% had a positive outcome. For 18% the outcome had not been recorded.

### Nursing staffing

- The nursing establishment on the intensive care unit (ICU) was five band 7 nurses (one was on maternity leave), 12 band 6 nursing posts, and 21 band 5 posts. At the time of our visit, the ICU had 14 band 5 nurses in post. There had been a temporary suspension (now lifted) of recruitment in 2014. The minutes of the senior staff meeting on 2 September 2014 noted the band 5 vacancies but stated that "Currently no room for new staff due to lack of support from current staff in need of training themselves", which was restated at the meeting in October 2014.
- Use of bank and agency staff between March and November 2014 ranged from 8.6% to 14.35%. Where possible, the ICU used bank staff, but on occasion were unable to fill shifts, which meant patients were either transferred to other ICUs or elective surgery was cancelled. Information showed that between January and December 2014, the ICU had the highest percentage of bank shifts across the ICUs (Newham University Hospital, Whipps Cross and The Royal London Hospital), and for seven of the 12 months the highest percentage of agency shifts.
- The matron also covered the ICU at Whipps Cross Hospital. When the matron initially took over the post, they spent four days at the ICU in Newham University Hospital and one day at Whipps Cross Hospital. In January 2015, the time the matron spent at Newham University Hospital was decreased to three days.
- The band 7 nurses were supernumerary, which met the core standard 1.2.4 for intensive care units in the 'Guidelines for Provision of Intensive Care Services (2013)': "There will be a supernumerary clinical coordinator on duty 24/7 in Critical Care Units."
- Consultants thought there were insufficient nursing staff. They gave an example, of the day before our inspection, when seven nurses should have been on duty, but there were only five. This resulted in one patient being transferred to an ICU in another trust, one patient having their surgery cancelled, and a patient who had taken an overdose being nursed on the ward when they should have been in the ICU.
- We observed a nursing handover from day to night staff, which was detailed and included discussion of pressure ulcers, staffing levels and equipment.

### Medical staffing

- The consultant establishment for the intensive care unit (ICU) was 4.5 whole–time-equivalent staff. Three full-time and three part-time consultants were currently in post, who were a mix of permanent staff and long-term locums.
- At our last inspection, in November 2013, we were told there was no intensive care consultant after 5pm and at weekends; the ICU was covered by a consultant anaesthetist. At this visit, we were told that this had improved and an intensive care consultant was now available after 5pm and at weekends. This had been achieved by reducing the number of consultant sessions provided to the critical outreach team.
- We established that the regional advisor in intensive care medicine (appointed by the Faculty of Intensive Care Medicine – FICM) had approved each of the

permanent consultants as consultants in intensive care medicine, with FICM accreditation (or equivalent), before their appointment. The long-term locum consultants were working towards the equivalent of FICM accreditation.

- Consultants provided seven-day cover from 8am to 5pm during the week, and stayed to provide cover if necessary outside these hours; they were also on site for six hours on Saturday and Sunday. The consultants also did 'one-in-three' 24-hour cover, and seven-day cover every fourth week. Some of the consultants we spoke with thought that the on-call rota was "too demanding".
- The consultant-to-patient ratio was 1:8, which was within the range recommended by the core standards for intensive care units (2013).
- The ICU was not a training unit but was funded for seven clinical fellows; 6.5 were in post. The clinical fellows were the equivalent to a specialist registrar 3 or above and were each assigned a consultant as a mentor. They also still supervised medical students for two weeks in the students' final year.
- During our visit, we observed handover from night to day staff. The handover was thorough and followed a standard format, covering each of the systems (neurological, respiratory, cardiovascular system etc) and future tests such as x-rays or if the patient had to be transferred out for a clinical reason.

### Major incident awareness and training

- The trust had a major incident plan. We were told that the major incident plan and business continuity plan for the intensive care unit (ICU) were being reviewed and updated.
- Records showed that 73% of medical staff and 100% of nursing staff had attended emergency planning training.

## Are critical care services effective?

**Requires improvement**

Some aspects of care and treatment were effective. This was reflected in some of the patient outcome data: the intensive care unit (ICU) was around the national average for most of the national quality indicators, except for out-of-hours discharge and non-clinical transfers.

Delivery of evidence-based care was demonstrated by complying with some national guidance, although nursing staff did not always show an awareness and appreciation of the need to adhere to guidance.

The ICU had a multidisciplinary approach to care which included having a dedicated physiotherapist, pharmacist and dietician. Although there was evidence of good multidisciplinary working, formal multidisciplinary meetings did not happen on a regular basis.

An insufficient number of nurses had undertaken the post-registration intensive care course (which meant the service was not meeting one of the core standards for ICUs), and few nurses had had an appraisal.

Patients' nutrition and hydration needs were assessed and met.

### Evidence-based care and treatment

- There was evidence of use of and compliance with some national guidance, such as that of the National Institute of Health and Care Excellence (NICE) and the Intensive Care Society.
- The intensive care unit (ICU) used 'care bundles' (a 'bundle' is a structured way of improving the processes of patient care and improving outcomes) which were evidence based. The patient's intensive care chart recorded which care bundles were in use; for example, ventilator care and surviving sepsis.
- Compliance with care bundles was audited. For the period from July to December 2014, the ICU achieved 100% compliance with the care bundles to reduce ventilator-acquired pneumonia and for urinary catheter insertion and ongoing care.
- Guidelines underpinning the care bundles were available on the local intranet. However, one consultant told us that nursing staff in the intensive care unit did not refer to guidelines as much as on other ICUs; they delivered the care but did not always check it against the guidance.
- This finding of lack of awareness and reference to guidelines was supported by information from the matron, who found that staff were carrying out some procedures, such as removing vascaths (used for haemodialysis), without being aware whether guidelines were available and whether they were following the correct procedure. On one occasion, a nurse had blocked off an arterial line to allow the patient to move around more easily. This is

contraindicated, because the line should be used for continuous monitoring. It could cause the line to become blocked, and it increases the risk of infections due to multiple breaks in the circuit, but blocking an arterial line had been accepted practice on the ICU. The incident was recorded in the notes of the September 2014 senior staff meeting.

- In terms of NICE clinical guideline 83 (2009) on rehabilitation after critical illness, patients on the ICU were seen and assessed by a dedicated physiotherapist. Once patients were discharged from the ICU, they were seen by the physiotherapist for the ward within 24 hours of discharge. However, nurses and physiotherapists told us that there was no dedicated rehabilitation clinic for patients following discharge.
- The ICU submitted data to the Intensive Care National Audit and Research Centre (ICNARC). This demonstrated that the care delivered and mortality outcomes for patients were benchmarked against the performance of similar ICUs nationally. The ICU had an audit coordinator who assisted with collecting data and provided reports on the findings of various audits, including ICNARC case mix, compliance with care bundles and the management of sepsis.

### Pain relief

- The ICU used a standard pain scoring chart and had access to the hospital's pain-management team.
- Nursing staff had been trained in patient-controlled analgesia and epidural pain relief.
- We were unable to speak with any patients, but the pain charts we reviewed showed that patients' pain had been assessed.

### Nutrition and hydration

- All patients, including those who were able to take food and drink orally, had their nutritional needs assessed and received input from the dietician in the intensive care unit (ICU), who visited the unit daily to review patients.
- Staff used the malnutrition universal screening tool (MUST). Feeding regimes were reviewed and adapted according to patients' needs and were based on National Institute of Health and Care Excellence (NICE) guidance. There was also a standard feeding regime that staff could initiate until the patient was assessed by the dietician.
- When patients were transferred to a ward, they were handed over to the ward dietician.

### Patient Outcomes

- Intensive Care National Audit and Research Centre (ICNARC) data showed that the intensive care unit (ICU) was in line with the national average for similar ICUs, except for out-of-hours discharges (19.9%), unplanned readmissions within 48 hours (29.4%) and non-clinical transfers. Although the ICU was not in the red zone for any indicator, non-clinical transfers were the closest to it.
- The standardised mortality ratio based on ICNARC scoring was within the expected range.
- Between January and December 2014, the average length of stay for patients on the ICU was 4.5 days.

### Competent staff

- The ICU was not meeting core standard 1.2.6 for intensive care units in the Guidelines for Provision of Intensive Care Services which states that: "Each critical care unit will have a clinical nurse educator." The clinical educator post was vacant, and although it had been advertised twice and candidates interviewed, no one had yet been appointed to the post. In the meantime the clinical educator from Whipps Cross Hospital had provided some support.
- The number of nurses undertaking the post-registration intensive care course had decreased. In August 2014, 42% of nurses had completed the course, which meant that the ICU was not meeting core standard 1.2.8 for intensive care units (2013) that: "A minimum of 50% of nursing staff will be in possession of a post registration award in Critical Care Nursing." Since taking over the ICU, the matron had taken action to improve the situation; two more nurses have now completed the course, with three more allocated to modules.
- The ICU had two advanced practitioners who had been trained to care for level 2 patients under the supervision of a registered nurse.
- We were told that appraisals had been underway when the matron took over the role, but once the matron became aware of the problems with mandatory training appraisals had been stopped. Information provided by the trust shows that out of 40 nursing staff, including the critical care outreach team, six had had an appraisal in 2014, one person was on long term sick leave and two staff were classed as probationary.
- Medical staff told us they were up to date with their appraisals, but we have not been provided with any

documentary evidence to support this. They also told us they had "very good" training about revalidation but were concerned that financial support for study leave had recently been withdrawn.
- The new electronic appraisal system went live in April 2014. However, the trust told us there had been problems with access across the trust, which it was working to resolve. Therefore, the staff pulse survey was the process the trust was using to obtain information to inform the staff appraisal system whilst the issues with the electronic appraisal system were resolved.
- We were told there had been a lack of clarity about expectations and a lack of consistency in how the band 7 nurses worked; the matron found they were not meeting all aspects of the role. To overcome this, additional leadership training had been put in place to support the nurses' development.
- We were told there was an induction programme for new staff. We asked for a copy of the programme along with the induction checklist for agency staff, but staff were unable to find them during our visit.

### Multidisciplinary working

- Care was delivered through a multidisciplinary approach involving nurses, doctors, pharmacists, physiotherapists and dieticians.
- A multidisciplinary ward round each morning included the pharmacist, who visited the ICU daily.
- The ICU had dedicated physiotherapists who attended the ICU each morning between 8.30am and 10.30am (and outside these hours if required), with a service at the weekend. The physiotherapists provided care for patients throughout their stay in the ICU, assisting with respiratory care and mobilisation of patients.
- The critical care outreach team, a nurse-led service, provided a seven-day service with the site managers providing cover overnight. The team liaised with the ICU about patients who were discharged, and followed them up on the ward.
- In terms of formal meetings, the ICU had recently started monthly meetings to which all members of the multidisciplinary team were invited. Attendance, however, had been limited.

### Seven-day services

- The ICU had seven-day consultant cover from consultants who were present on the unit during the week and at weekends.
- There was access to radiology and physiotherapists seven days a week.
- Although the matron was not on site five days a week, on the days the matron worked at Whipps Cross Hospital they phoned the ICU for an update and were available to attend if necessary.

### Access to information

- Paper records were used to record patient care, and notes were kept at each patient's bedside.
- A standardised handover form for both nurses and doctors was used to update incoming staff about patients and other issues on the intensive care unit (ICU).
- When patients were discharged from the ICU, staff gave a handover via the telephone, accompanied patients to the ward, and gave a handover to the nurse who would be looking after them. The ICU used a printed form that medical staff completed and that included all the information about the patient's admission history, treatment and care.

### Consent and Mental Capacity Act and Deprivation of Liberty Safeguards

- Ninety-one per cent of medical staff on the intensive care unit (ICU) had completed training on consent and the Mental Capacity Act (MCA) 2005. Training for nursing staff was due to take place during January 2015. Day-to-day care and treatment decisions, such as when administering medicines, giving personal care, nutrition and hydration, and performing tests, were made by the medical and nursing teams in people's best interests.
- Nursing staff told us if a patient was unable to give consent, they would seek consent from the family. However, staff may have been confused in the difference between consent and best interest involvement of the family. There was no evidence in records that families gave consent on behalf of patients as this would be not be in keeping with the Code of Practice of the MCA 2005. We did however see evidence in a patient's notes of a discussion with the patient's family about performing a medical procedure.
- Although patients' sedation levels were assessed daily, we saw no evidence that they had their mental capacity assessed as their condition changed.
- The trust had a restraint policy, which staff were unable to locate (but which is referred to in the safeguarding policy), and an interim protocol for managing Deprivation of Liberty Safeguards (DoLS).

# Critical care

- The ICU used hand control mittens to maintain patient safety as required (Hand control mittens are designed to restrict the movement of one or both hands and used with patients who have removed essential lines/tubes). During our visit one patient had mittens on. We checked the medical records and found that the appropriate risk assessments had been carried out, along with a DoLS application and a request for an extension DoLS authorisation.

## Are critical care services caring?

Good

The relatives we spoke with were generally pleased with the care their relatives received, but would have appreciated more involvement in the patients' personal care and more information.

During our inspection we observed patients being treated in a kind and caring way. Staff maintained patients' privacy and explained what they were doing before carrying out any care. We saw that discussions with patients' relatives had been recorded in the patients' notes.

### Compassionate carel

- In the trust's last inpatient survey, published in April 2014, the trust scored 2.2 out of 10 for seeking patients' views, which was low but the same as other trusts that took part in the survey. For respect and dignity, the trust scored 8.4 out of 10, and for privacy for examinations, 9.4, which is higher, and the same as for other trusts that took part in the survey.
- We observed staff maintaining patients' privacy and dignity when delivering care; curtains were pulled around the bed when carrying out any procedure or personal care.
- We also heard staff talking to patients, explaining what they were doing, in a compassionate manner.
- We were unable to speak with any patients, but spoke with four relatives who were generally positive about the care their relatives had received. They told us the staff were kind and caring and had wavered the usual visiting times for them.
- Staff told us that feedback forms were available in the visitors' waiting room, but none were there when we looked. The matron told us that when they took over the post, they checked the collection box and found no comment cards.
- Thank you cards and emails from relatives were shared with staff. We saw an email from a relative in December 2014 thanking staff for the "dedicated and dignified" way they had cared for their relative.
- Other than cards and emails, the ICU did not have a system in place to obtain feedback from patients and relatives in order to review and improve the service.

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

- Discussions with relatives about their progress and treatment plans were recorded in patient notes.
- Relatives we spoke with were aware of the treatment plan for their relative. One person thought that the nurse "knew" their relative. Another person thought there had been little opportunity for involvement in their relative's personal care, whilst another thought that some staff were more proactive than others in sharing information.

### Emotional support

- We asked about emotional support services for patients and their relatives, and were told that the nurses and doctors looking after the patient provided emotional support.
- There was no specific counselling support service for relatives when a patient might be reaching the end of their life. Staff told us the faith team was very good; the local imam was always available to support families, and knew some of them from the community.

## Are critical care services responsive?

Requires improvement

The intensive care unit (ICU) needs to improve its responsiveness to patients. Problems with capacity and with nursing staff levels meant that patients' surgery was sometimes cancelled or patients were transferred to another hospital. There were also delays in transferring patients to the ward.

# Critical care

The ICU serves a diverse population, and an interpreter service was available via the phone or face to face. Visiting times were fixed, but the ICU was flexible and people could visit outside the fixed visiting times.

Amenities for relatives were poor; there was a visitors' room, but no overnight accommodation or tea/coffee making facilities. The ICU had received few complaints in the last six months.

### Service planning and delivery to meet the needs of local people

- Long term service planning and delivery was dependent on the trust developing a clinical strategy so that it was clear which services were going to be delivered at which hospital, which in turn would determine the number of intensive care/high dependency beds required.
- At a local level on the intensive care unit (ICU), service delivery was sometimes hampered by a lack of nursing staff and beds, which meant the unit was unable to admit patients. Although safe, the ICU did not meet the requirements for modern critical care facilities. There were no immediate plans to upgrade facilities.
- The withdrawal of nursing students was a potential risk to the ability of the ICU to recruit more nurses. The situation for medical staff was similar, because the ICU was not a training unit.
- The clinical director was aware of the potential problems and was trying to develop joint specialty posts (consultants who work part-time on the ICU and part-time in another specialty such as accident and emergency) to increase the number of consultants on the ICU and reduce the amount of on-call time required.

### Meeting people's individual needs

- Eighty per cent of the population of Newham come from minority ethnic backgrounds, with Asian being the largest constituent ethnic group at 43.5% of the population. An interpreter service was available, which could be provided via phone or face to face.
- For patients with learning disabilities, we were told that staff would contact the lead nurse for learning disabilities for advice. Staff told us they liaised with patients relatives or carers if they lived at home or if they lived in a community support scheme they liaised with the relevant staff.
- For patients who had dementia, if the patient was admitted from a care home the ICU would contact the care home to ask about the patient's care plan. The ICU had no specific care plan for patients living with dementia.
- For relatives and friends, there was a waiting room that was kept locked outside visiting times, which were 3.30pm to 7.30pm. The room contained several chairs and some pictures on the wall; leaflets about the Patient Advice and Liaison Service were on a small table.
- There were no facilities to make tea and coffee, but we were told there were plans to install a vending machine. There were also no facilities for relatives and friends to stay overnight.
- The visiting room was the only room available where staff could speak with relatives. On one occasion young children in one family were playing while members of another family were visibly distressed.

### Access and flow

- The intensive care unit (ICU) provides a service with the capacity for seven beds to a community of over 300,000 people.
- The ICU used the same diary system as that at Whipps Cross Hospital ICU for booking patients in.
- The ICU did not have an admission policy, but we were shown a standard operating procedure.
- Data for January and December 2014 showed the ICU had 81% occupancy (excluding closed beds), with a total of 403 patients admitted. For a five-week period commencing 15 December 2014, occupancy was between 102.9% and 85.9%. Evidence has shown that occupancy greater than 85% can have an impact on the quality of care provided.
- For the period from January to December 2014, the percentage of patients discharged to the wards between 10pm and 7am was 19.9%. The core standards for intensive care units in the Guidelines for Provision of Intensive Care Services (2013) state that discharges should occur between 7am and 9.59pm. Overnight discharges have, historically, been associated with excess mortality, and patients have found them unpleasant. Fifty-six per cent of patients experienced a delayed discharge (greater than four hours from when the decision was made to discharge them) from the ICU.
- Also for the period from January to December 2014, 10 patients were transferred out for non-clinical reasons and 25 for clinical reasons.

# Critical care

- If a bed was unavailable due to staffing or capacity issues, a patient already on the ICU could be transferred to another ICU in the trust. Alternatively, planned admissions following surgery might have to be cancelled. Between 27 October 2014 and 18 January 2015, five patients had their surgery cancelled because an intensive care bed was not available.

### Learning from complaints and concerns

- The trust had a complaints policy dated 24 October 2014.
- The intensive care unit (ICU) had received one complaint between 1 December 2013 and 30 November 2014. The complaint was received in May 2014 and closed in September 2014, but there was no information about what action had been taken.
- Information about complaints and the Patient Advice and Liaison Service was available in the visitors' waiting room.
- A patient's relative told us that staff were available to discuss any issues with complaints.

## Are critical care services well-led?

**Requires improvement**

Leadership on the intensive care unit (ICU) needs to be improved. Changes in the nursing leadership had affected the delivery of care and the professional development of nurses. The change of consultants had affected governance systems, as demonstrated in the mortality and morbidity meetings and the risk register, and there was no continuous improvement plan. Although nursing staff told us they were happy working on the ICU and were pleased with the changes introduced by the matron, their motivation was low.

Mechanisms to engage the public and staff in moving the service forward were limited or non-existent. Some work was being undertaken to address some of the issues, but there was a lack of a joined-up approach. Further plans to review the nursing leadership in the ICU will result in more changes for staff.

### Vision and strategy for this service

- The short term strategy was to get nursing staff get up to date with training, improve the nursing leadership within the ICU, recruit to the post of clinical educator, and secure the return of nursing students to the ICU.
- For medical staff, the strategy was to recruit more consultants in order to provide a more sustained on-call rota, which will depend on developing joint specialist roles that attract medical staff, and to develop effective working relationships with other departments, including the department of anaesthesia.
- More level 2 beds were needed. The clinical director had an overarching plan for critical care across the three hospitals the director covered, which included Newham University Hospital, but it was dependent on the trust developing a clinical strategy.

### Governance, risk management and quality measurement

- Some quality initiatives and risk management processes were in place on the ICU: collection of Intensive Care National Audit and Research Centre (ICNARC) data, reporting of incidents, and involvement in national audits.
- Outside the ICU, the critical care service group was attended by the matron and the patient safety committee, and the trust's mortality and morbidity group was attended by the clinical director.
- Processes on the ICU which were in place during our last inspection were being re-established, for example regular mortality and morbidity meetings, and there were plans to introduce audit meetings.
- The risk register for the ICU had one item on it: the lack of a portable ventilator and of cardiac monitoring equipment for patients requiring a magnetic resonance imaging (MRI) scan. The risk register made no reference to nursing staff levels, even though we were told this was a concern, and capacity. Although the matron identified a whole series of concerns, they told us it was difficult to get them recorded on the risk register.
- The risk register for the hospital for 17 December 2014 does not contain any issues relating to the ICU, although we were told it was the ICU that senior staff were most concerned about. This was a risk in itself.
- The improvement plan the matron developed for the ICU, dated 16 October 2014, contained a list of actions to resolve the issues around training and leadership and

potential risks, along with some actions to mitigate the risks. Although the improvement plan was developed in October, we were told it took several email exchanges between the matron, clinical director and deputy director of nursing for the clinical academic group (CAG) for the plan to be approved.
- Forums where nurses can discuss quality activities included the handover and also monthly team meetings, which have been limited.
- The ICU was not part of any critical care network.

### Leadership of service
- The ICU was currently led by a band 8 matron and a consultant clinical lead.
- The nursing staff had experienced three changes in leadership over the last three years, which had affected the motivation of staff, hence the concerns above that had been identified by the matron. We were told that further changes were ahead for the nursing leadership.
- The matron, although working across two sites and having a large remit, had not involved the band 7 nurses in sharing some of the responsibilities, which may have helped with the workload and been a development opportunity for the nurses.
- The medical leadership had been more stable, but a number of consultants had left in 2014, which had affected the ICU's governance arrangements. The clinical director covered the ICUs at Whipps Cross and The Royal London Hospital as well as Newham University Hospital. The clinical director, although not on the rota for the ICU, was available, and they met the ICU consultants at regular meetings, for example the critical care service group meeting.

### Culture within the service
- Within the intensive care unit (ICU), team working between nurses and doctors was good, and other members of the multidisciplinary team spoke positively about working on the ICU.
- Staff we spoke with told us they were happy working on the ICU, although some of the medical staff felt their rotas needed to be improved, and the lack of staff and beds meant they spent a lot of their time sorting out where patients would be cared for. They also thought that more secretarial support would free them to focus on patient care. The clinical director felt the need for more management support within the CAG structure and more secretarial support, in order to focus on patient care.
- Although nursing staff were providing good care, the changes in nursing leadership had a negative impact on their motivation to continue to look for ways to monitor and improve the quality of care provided.
- In terms of being part of a larger trust, staff knew they were part of Barts Health NHS Trust but were unfamiliar with the term ‘The Barts Way' (Way of delivering services in trust).

### Public and staff engagement
- There was little evidence of public engagement. For patients and relatives, there was no formal mechanism to give feedback about the service, other than complaints or thank-you cards.
- Nursing staff were positive about the changes being made by the trust's senior leadership, but there was little evidence that they had been involved in identifying the problems and finding ways to address them. Senior staff had taken the decisions, and the meeting on 16 October 2014 stated that letters would be sent to staff, and medical staff would be informed of the plan.
- Information about the plan for future changes was shared with staff at the meeting on 22 October 2014, at which stage it was still awaiting approval from the critical care service group.

### Innovation, improvement and sustainability
- Innovation on the intensive care unit (ICU) was limited: it had introduced weekly tracheostomy care rounds. A consultant and the critical care outreach team reviewed all patients on the wards who had had a tracheostomy on the ICU.
- The nursing lead and the clinical director had separate plans to address some of the more immediate issues on the ICU, but there was no joined-up plan to develop the service.
- Although there were examples of clinical audit and some improvement activity, we did not find a coherent, joined-up vision of a quality improvement plan.

# Maternity and gynaecology

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

## Information about the service

Newham University Hospital provides maternity services to women in the London Borough of Newham and the Barking and Dagenham wards of the London Borough of Barking and Dagenham. There were 6631 births in 2013/ 2014.

The hospital has a range of antenatal and postnatal services, including early pregnancy diagnostics, and inpatient and outpatient antenatal screening and assessment. All women attend the hospital for their first antenatal appointment. Community midwifery services deliver antenatal and postnatal care for low risk women in the catchment area. Specialist antenatal clinics are run for women with additional conditions such as diabetes, or mental health, heart, kidney or neurological problems.

The maternity unit has two delivery areas. The central delivery unit (a shared consultant/midwifery led unit ) has 15 delivery rooms. There is a co-located birth centre with 10 birthing rooms. There are two obstetric theatres. The inpatient ward (Larch Ward) has 41 beds for antenatal and postnatal care, and induction of labour. Six of these are fee-paying amenity rooms where a partner can stay overnight. Two bays on the ward were closed at the time of our inspection.

A small homebirth team is supported by the community midwifery service. A free-standing birthing centre at Barking has four beds. We did not include the birthing centre in this inspection.

A confidential maternity helpline answers queries from women seven days a week between 10am and 8pm. An assessment unit is open from 8am to 8pm on weekdays. There is a 24-hour triage area next to the labour suite.

An emergency gynaecology unit runs on weekdays for women with pregnancy- and non-pregnancy-related acute gynaecological problems. There is also a multidisciplinary clinic for women with chronic pelvic pain. The 20-bed gynaecology inpatient ward (Beckton) has an ambulatory unit for day-case procedures. Some gynaecology procedures are also carried out in the Gateway Surgical Centre, away from the main hospital. The inpatient ward in the Gateway Surgical Centre is Clove Ward.

We inspected all maternity and gynaecology areas within the hospital and spoke with nine women and four relatives. We spoke to over 40 members of staff, including maternity support workers, midwives, nurses, doctors of all grades, administrators and senior managers, and domestic staff. In addition, we held meetings with midwives, trainee doctors, consultants and administrative staff to hear their views. We also reviewed information provided by the trust, such as audits and safety outcome data.

# Maternity and gynaecology

## Summary of findings

There were shortages of midwifery staff and insufficient consultant cover at the time of our inspection. Midwives were tired and overstretched, and shortages of midwifes in inpatient areas had been exacerbated by the decision to stop using agency midwives. Additional permanent midwifery staff had recently been recruited and the service had submitted a paper to the trust board outlining the case for further recruitment.

Consultant cover on wards was less than the recommended number of hours. Out-of-hours medical cover at all levels was overstretched, leading to delays in care. The trust had not approved the proposal to fund additional consultant posts at the time of our inspection.

Staff thought the senior leadership was remote and that leaders imposed decisions rather than listening to the concerns of staff and supporting their ideas for improvement. Staff at the hospital felt like the 'poor relations' to staff at The Royal London Hospital, even though Newham University Hospital had the larger maternity unit.

The inpatient environment was spacious and clean. Women were involved in choices about their care, there were initiatives to encourage natural birth.

There was a focus on learning from serious incidents and from complaints. Staff of all professions and grades were conscious of the importance of reporting and learning from incidents. Improvements had been made in the way that complex complaints were dealt with, to ensure that people were kept fully informed about investigations. Serious incidents were investigated and actions identified. However, the response to incidents not categorised as serious was not consistent.

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

There was an effective training programme for midwifery staff, although many midwives felt they did not have time to develop their skills outside the framework of mandatory training.

Trainee doctors were well supported and had opportunities to put their learning into practice. Maternity and obstetric staff demonstrated a strong commitment to the women coming to the unit and showed a desire to improve services.

A values and behaviour programme had been launched in maternity services trust-wide to improve the way midwives interacted with women and with each other, and to improve the standard of care. Feedback from women using the service indicated that mothers' experiences had improved, and staff felt the training had been beneficial.

The termination of pregnancy service was well run and we had no significant concerns about the gynaecology service.

# Maternity and gynaecology

## Are maternity and gynaecology services safe?

Inadequate

Midwifery and consultant obstetric staff were often under pressure because of the high number of births in the maternity unit and because of staff shortages. The recommended consultant cover for a unit of this size (over 6,500 births per annum) is 168 hours a week, which units had been recommended to achieve by 2010.The maternity unit at the hospital had 74 hours' consultant cover.

The unit had a high proportion of complex cases. We observed midwives to be overstretched, a situation exacerbated by a decision not to use agency midwives. Inevitably, staff shortages caused delays to the care and review of patients, access to appropriate further care and treatment, and discharge of mothers and babies after birth, as well as compromising one-to-one care in labour. Twenty midwives had recently been recruited and a paper had been submitted to the trust board outlining the case for more midwives based on an external assessment showed that more midwives were needed.

The security of babies in maternity services had been identified as a risk because of insufficient staff to monitor access.

Clinical staff on Beckton Ward fell below the trust's targets for mandatory fire training (75%) and training in moving and handling (63%).

Although the National Patient Safety Agency's intrapartum scorecard was sometimes used to demonstrate activity on the labour ward retrospectively, it was not being used effectively to manage patient flow.

Serious incidents were investigated and actions identified. Staff met with families to answer questions and keep them informed of the investigation and its outcome. Processes were in place to assess and manage risk, which were promoted by close multidisciplinary working. This included systematic antenatal assessment of women at risk and the use of team briefings and checks in obstetric theatres. Most staff were up to date with their mandatory training, including multi-professional team training in obstetric emergencies.

### Incident reporting

- There been no recent Never Events in maternity. Staff reported that learning had taken place from a Never Event elsewhere in the trust.
- Since April 2014, 16 serious incidents had been reported at this unit. These incidents were appropriately managed according to a standard trust-wide procedure that promoted adherence to the duty of candour and involved meeting families involved both at the time and after an investigation had been completed.
- The format of the investigation reports were appropriate, with a timeline and a section for other contributory factors. There was some delay in entering actions taken on the electronic record, but we were assured that actions had been taken but not yet entered on the system. A risk midwife monitored adherence to processes. At January 2015, the investigations of five serious incidents were awaiting completion .
- During 2013/14, 290 incidents had been reported. These ranged from staff shortages to clinical incidents such as post-delivery bleeding. A midwife said, "Of course we have to report incidents. If not, managers won't be aware of the problem."
- Staff were provided with information about incidents through newsletters and memos from the governance team. However, some staff said that feedback to individuals who reported incidents was not always provided.
- Incidents in both gynaecology and maternity services were reviewed at a weekly multidisciplinary risk forum to identify potential serious incidents or other incidents requiring the involvement of a consultant. A supervisor of midwives attended the maternity meeting and took part in the investigation of complaints and incidents when appropriate. Other staff were encouraged to attend the meetings. The highest number of incidents in December 2014 related to staff shortage and workload.
- Mortality and morbidity meetings were held regularly, and doctors gave presentations on specific cases. It was not clear how learning was drawn from these meetings to influence future practice, because no minutes or action plans were recorded.
- In gynaecology, across all trust sites there had been 69 incidents in the past year, five of which had been classified as serious incidents. Many of the incidents related to staff shortages on the ward.

# Maternity and gynaecology

## Cleanliness, infection control and hygiene

- The areas we visited were clean and tidy. We saw evidence that cleaning staff adhered to standards, practices and the required frequency of cleaning. The intrapartum areas were appropriately designated as very high risk areas and audited weekly. Other wards were designated as high risk areas and were audited monthly. We saw good results from infection control audits. Women told us they were satisfied with the standard of cleanliness.
- We saw 'I am clean' stickers with the day's date to indicate a clinical item was ready to be used again, in all the areas we inspected.
- Staff followed 'bare below the elbows' guidance. We observed staff using personal protective equipment, such as gloves and aprons, when appropriate to do so. Hand sanitising gel was available within the clinical areas, and we saw reminders to staff and visitors to use it.

## Safety Thermometer

- A whiteboard in inpatient areas had a 'safety cross' completed for each day for the month. This gave an easily understandable overview of care, similar to the national NHS Safety Thermometer. Most of the standard indicators were not relevant to maternity services; we were told that staff were working on a report better tailored to maternity services.

## Medicines

- When we inspected the hospital previously, in November 2013, we found that maternity services were non-compliant with regulation 13 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2010, on management of medicines. When we inspected this time the hospital was compliant.
- The maternity unit had a daily visit from a named pharmacist. Stock arrived weekly and topped up by a pharmacy technician.
- Medicines were safely managed, accurately recorded, in-date and securely stored in locked rooms or locked fridges. Fridge temperatures were monitored daily. We checked the controlled drugs register and saw that daily stock checks were recorded in a register and the stock level was correct. We noted that bottled drugs, such as Oramorph, had been dated when opened, in line with good practice.
- We checked six drug charts on the postnatal ward and saw no missed doses on charts and that allergy status was recorded.
- Patients' own medicines could be brought to the ward, and we saw baskets used to store these. We were told that the pharmacist would check that brought-in medicines were compatible with any prescribed in the maternity unit.
- We noted that intravenous fluids were boxed on a trolley but not locked up, which was contrary to recommended practice.

## Environment and equipment

- The maternity unit had standard resuscitation trolleys for use in an emergency. Staff were allocated to check resuscitation equipment, and we saw that checks were recorded.
- Midwives said there were not enough cardiotocography (CTG) monitors and some were in poor condition. New monitors were being trialled with a view to purchase.
- The obstetric theatre suite met current design standards, was well equipped with sufficient stock of sterile instruments and consumables, and was well maintained.
- In the theatre used for gynaecology, the ultrasound scanner had recently been condemned on grounds of age. The lack of a scanner would restrict some women's choice of treatment.
- The resuscitation trolley was stored in the booking clinic in the second antenatal area which had more space. The trolley drawers were not tagged, so were accessible to unauthorised persons. We were told it was not the trust's policy to tag resuscitation trolleys. This was not good practice in an area where small children could be.

## Records

- Women carried their own pregnancy-related care notes in handheld records (the green notes), taking them with them when they attended the maternity unit and for examinations with their community midwives.
- The hospital had an electronic patient record system, but the electronic system had not yet been implemented in community midwifery services. This limited the information available electronically. This issue had been on the risk register since 2008 because it affected patient experience and national reporting.
- Local audits had identified record keeping for women during labour and birth as a concern. Some records were audited each month against the Royal College of

Nursing guidance for record keeping. We saw reminders to staff about legibility, the procedure for correcting errors, and quantifying records appropriately. Hospital notes were stored securely. The records we looked at were in chronological order and completed appropriately.

### Safeguarding

- There was a specialist midwife and a named midwife for safeguarding. There was a well-established midwifery team, Acorn, for supporting mothers at risk.
- All permanent staff providing direct care to pregnant women had level 3 safeguarding training. At January 2105, 96% of staff had attended level 3 training. Staff with no direct contact with women and babies completed level 2 training online. There was training for first-year trainee doctors on perinatal mental health and safeguarding.
- Relevant staff had attended safeguarding supervision based on the Signs of Safety model, and there was a process for monitoring completion.
- The security of babies in maternity services had been identified as a risk because of insufficient staff to monitor access. Access to wards was through two sets of doors controlled by swipe card. The viewing panel in the postnatal ward for staff to check who wanted access did not work. Visitors were admitted without checking their names or who they were visiting, which was a potential risk to women and babies. On the labour ward, a visitor log was kept by the person at the reception desk. The only mitigation was continuous recorded CCTV in the main reception, observable by security staff. Staff said there were only two site security staff.

### Mandatory training

- Most staff had completed their statutory and mandatory training, although completion was just below trust's target of 90%. Training was updated in four mandatory study days each year. Line managers monitored completion of training, which now included customer care. Attendance at mandatory training was 76% for infection control, 80% for medicines, 90% for moving and handling, and 79% for information governance.
- There was mandatory multi-professional team training for cardiotocography (CTG) assessment, and 'skills and drills' to rehearse obstetric emergencies. Every member of staff was given a copy of the PRactical Obstetric Multi-Professional Training (PROMPT) manual.
- Clinical staff in Beckton Ward fell below the trust's targets for mandatory fire training (75%) and training in moving and handling (63%).

### Assessing and responding to patient risk

- The main risk was medical and midwifery staffing. Not every mother was able to have one-to-one care in labour at the current level of staffing. Midwives did not always take breaks and often reported working beyond the end of their shift. We saw that six incidents were recorded on the noticeboard where mothers had not had one-to-one care while in labour during January 2015. However, midwives thought this number was an underestimate. They also pointed out that prioritising one-to-one care of women in labour at times of staff shortage created a risk that other women did not receive appropriate care. We saw a recent example of a woman not receiving one-to-one care pre-delivery, and the woman's care was compromised as a result.
- The lead midwife in each inpatient area assessed staffing levels for each shift. On identifying risk, and according to the escalation policy, the lead midwife contacted the on-call manager. However, we heard from staff and saw on incident reports that managers were sometimes unavailable. Unfilled shifts were the norm, so midwives were regularly relocated from less critical areas to support the labour ward. The escalation policy was used more often at night than during the day. Options were to contact on-call bank staff, community midwives, home birth team members, birthing centre midwives or the on-call supervisor of midwives. We heard that a supervisor of midwives had been called every night on the week they were on call. Midwives said that coordinators did not usually help on the ward, although medical teamwork was good.
- Although the National Patient Safety Agency's intrapartum scorecard was sometimes used to demonstrate activity on the labour ward retrospectively, it was not being used prospectively to manage patient flow.
- The risk of delayed recognition of pathological cardiotocography (monitoring the foetal heart) had been reduced through annual multidisciplinary training.
- There was evidence that the risks to women's care associated with being unable to meet the recommended hours for consultant presence on the labour ward as recommended by the Safer Childbirth

London Safety Standards and the Royal College of Obstetricians and Gynaecologists had been identified some time ago. The case had been made, but the trust had not agreed funding at the time of our inspection.

- Early booking improved the chances of women receiving appropriate care. The proportion of women booked before 12 weeks had risen steadily over the year and was on target at 90%. We saw good systems to identify women with complex social needs. There was also contact with adult social services to address the needs of women with learning disabilities.
- The risks to women undergoing obstetric or gynaecological surgery were reduced by multidisciplinary engagement in pre-list briefings and by following the five steps of the World Health Organization (WHO) surgical safety checklist. These checks were recorded on the electronic patient record. Staff said checks were "almost always" done. We saw an audit and reviewed records for women who had a caesarean section, which showed that checks were completed appropriately.
- All inpatients were monitored using the modified early obstetric warning score (MEOWS) to assess their health and wellbeing. As necessary, midwifery staff completed observations on babies and recorded these on the neonatal early warning score (NEWS) charts. We reviewed some of these charts and found them appropriately completed, enabling mothers or babies to receive additional medical support if required.
- Staff had access to emergency trolleys in the event of an obstetric emergency.

### Midwifery and nursing staffing

- The current mother-to-midwife ratio was 1:33 compared with a trust target of 1:32. There were 20 vacancies at the time of our inspection, including for specialist midwives and community midwives. Some staff had been recruited to fill these vacancies over the next two months, which would reduce the ratio to 1:32. However, Birthrate Plus (a framework for maternity workforce planning) showed that a ratio of 1:26 was appropriate to the acuity levels of mothers giving birth at the hospital. Of births at this unit 56% were in the higher risk group because of pre-existing health issues, risk of premature or still birth, and postpartum complications. A business case was being made to further improve the mother-to-midwife ratio. To meet the recommended ratio, 35 additional midwives would be needed.
- Agency midwives had been rarely used in the previous few months because of concerns about the quality and safety of their work. Midwives considered that agency staff who worked regularly at the hospital had provided reliable care, and that the decision to stop using them placed unreasonable demands on remaining midwives when there were insufficient bank staff to draw on.
- During the month of our inspection only one Band 7 midwife (ward coordinator) was on duty in the delivery ward at weekends, which placed significant responsibility on the midwife in that role.
- The pressure on community midwives had increased because of an unusually large number of women in the local area using the service only for postnatal care.
- Nurses provided care for women in high dependency beds and worked in theatre and recovery.
- A recently appointed clinical educator would be supporting new staff, which included staff from overseas.
- The national shortage of sonographers affected both gynaecology and maternity services. In maternity services, some midwives had been trained in sonography, and agency staff were used to fill gaps in the rota. The gynaecology services had proposed training their own nurses in sonography, and trust-wide cover arrangements were being put in place for when the lead sonographer was away.
- There were insufficient bank staff despite efforts being made to encourage staff to work extra shifts. A system of paying a retainer fee for bank staff to be on call had been introduced in December 2014, which had been used over the Christmas period.

### Medical staffing

- Twelve consultant obstetricians and gynaecologists were working at the hospital. The recommended consultant presence for a unit the size of Newham University Hospital is 168 hours, but the hospital was providing 74 hours of consultant cover, for both maternity and gynaecology. The risk of inadequate consultant presence had been recognised for some time. A business case had been made in April 2014 to take cover up to 98 hours a week, but no decision had been made at the time of our inspection. Midwives pointed out that the absence of a consultant meant that women on the maternity unit out of hours inevitably received a less responsive service than during the day. This imposed additional pressure on already-busy

midwives and trainee medical staff. Two registrars were leaving, and the deanery could not offer replacements. Medical staff did not know whether the hospital would fund these essential posts.

- At weekends, a senior registrar covered A&E, gynaecology, the maternity assessment unit (MAU) and two maternity wards, which often led to delays in attending to women. Women mentioned having to wait a long time to see a doctor. Medical cover at all levels was spread very thinly.
- Staff said on-call consultants were always available for advice and would come to the hospital when appropriate. We were told that other consultants, who were not on call, also attended out of hours when there was high demand and women or their babies were at risk, but this meant that patient safety was heavily dependent on the goodwill of medical staff. We did not see data on how often a second consultant came in.
- Consultants were concerned that the current level of cover was potentially unsafe. For example, trainees were undertaking clinical activities such as elective caesarean sections with less supervision, because consultants were dealing with labour ward emergencies. Such emergencies also had an indirect impact on the patient experience when clinics or ward rounds were delayed because doctors were unavailable. We did not see data on how often consultants were late for or absent from clinics.
- Time pressures on medical staff meant it was often not possible for doctors to review women on the MAU. Sometimes, before the maternity unit closed at 7.30pm, women then had to transfer to triage. On the day of our inspection, eight women had not been reviewed before the MAU closed.
- Medical staff attended gynaecology patients appropriately during weekdays, and the on-call consultant saw women needing consultant review. However, a consultant gynaecologist was not always on ward rounds. Medical staff considered that the complexity of some cases in gynaecology justified both a gynaecology consultant and an obstetric one.
- We witnessed a safe and effective medical handover with multidisciplinary input and proposed plans of management for the women.

### Theatre staffing

- There was a dedicated theatre team for one obstetric theatre (theatre 8), with a consultant anaesthetist from 8am to 7pm on weekdays and for six hours on Saturdays and Sundays, as well as 24-hour staff-grade cover. There was not a full second theatre team even though the second theatre (theatre 7) was often in use. When a second theatre was needed, staff called on the hospital's emergency theatre team. When two theatres were used simultaneously, this was reported as an incident.
- A business case was being prepared for more theatre staff. The matron regularly filled in when staff were absent from theatre. There was often no midwife to go into theatre. There was only one operating department practitioner (ODP) for the delivery suite, so midwives had to call on ODPs from the main theatres for epidurals. This delayed pain relief for some women. Staff said the absence of an ODP could mean choosing which emergency to deal with first, "a caesarean or an ectopic pregnancy". We were told that sometimes three theatres were needed for obstetrics.
- There was a dedicated consultant anaesthetist on weekdays from 7am to 7pm, and a dedicated middle grade doctor between 8am and 9pm. Although we were told that an anaesthetist always attended the morning handover, there was no signature of attendance. Locum anaesthetists were sometimes used, but they were doctors who worked regularly at the hospital

### Other staff

- There was no gynaecology or obstetric physiotherapy on the Newham University Hospital site, on grounds of financial cost.

### Major incident awareness and training

- The trust had a plan to support emergency planning, which staff in the maternity unit were aware of and understood.
- The escalation procedure was regularly used to address unsafe care in the labour ward. The maternity unit had not closed in the past year, but had had to accept patients diverted from The Royal London Hospital on several occasions.

# Maternity and gynaecology

## Are maternity and gynaecology services effective?

Good

There was a systematic programme to review and update guidelines in line with recommended standards. Staff working in each area of maternity and gynaecology knew how to access professional guidance. Midwives were supervised and supported to maintain their competencies and for professional development.

The maternity unit collected maternity data to determine its performance against recognised indicators, and produced a monthly dashboard so managers knew how the unit was performing against service targets. The dashboard was not shared with staff. There were regular local audits to assess and evaluate the effectiveness of care; the results of these were presented to staff, with action points identified and proposals for follow-up audits as appropriate. We saw good examples of failsafe databases for screening to double-check that tests had been done.

The outcomes for women and their babies in maternity services were within expected limits. Women received antenatal and postnatal care in community settings, in addition to antenatal appointments at the hospital when appropriate. Pathways for high-risk women were clear. Multidisciplinary working in maternity and gynaecology services was effective. Trainee doctors reported that they were generally well supported and had wide-ranging opportunities to put their learning into practice.

### Evidence-based care and treatment

- There was a programme to review clinical guidelines with reference to the National Institute for Health and Care Excellence (NICE), the Royal College of Obstetricians and Gynaecologists (RCOG) and other relevant bodies. Senior midwives, including the supervisor of midwives, also played a role in developing guidelines. However, there had been delays at trust level in uploading maternity guidelines to a dedicated section of the intranet, so some revised guidelines were not yet available. Medical staff told us that when up-to-date local guidelines were not available, they accessed current NICE or RCOG guidelines; they also demonstrated how they did this.
- We saw evidence of regular audits of procedures and practice, the findings of which were disseminated with actions identified. There were monthly audit meetings in maternity and in gynaecology services. Medical staff told us that if they were unable to attend the meeting, information from audits was emailed to them. In gynaecology services, audits included those of guidelines for management in early ectopic pregnancy and miscarriage. The findings were presented to an audit meeting, and this had led to changes in the choices given to women for follow-up checks.
- The trust contributed data to the National Neonatal Audit Programme (NNAP) and to the Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK). Managers had responded to the aim of reducing stillbirth by appointing a bereavement/ MBRRACE midwife.
- There were regular morbidity meetings in gynaecology and joint monthly perinatal morbidity and mortality meetings. We saw presentations prepared for these meetings, but actions were not recorded in the minutes, so it was not clear how these had an impact on practice.
- Transitional care had been introduced but had then been suspended, and we were not informed of plans to reintroduce this service. (Transitional care is recommended practice and is provided on a postnatal ward so that babies who need treatment such as antibiotic medication can stay with their mothers.)
- Care bundles for common conditions had been introduced in maternity triage to promote consistency of care for women presenting with symptoms such as vaginal bleeding, ruptured membranes and reduced foetal movements. The intention was to reduce hospital admissions, which had been 1,490 in 2013/14.
- In 2013/14, the hospital had introduced the Northgate failsafe system for blood spot tests on babies, which tested for six inherited diseases. This system was reported to be working well.
- We saw an efficient termination of pregnancy unit with appropriate multi-professional input, scanning, choice of method, and high quality administrative support to ensure that the correct paperwork was completed for government monitoring.

### Pain relief

- Women's care records contained information about pain relief. We saw that women's options included epidural analgesia, opiates, nitrous oxide (gas and air),

and Paracetamol. Water birth facilities were also available on the birth unit to help women relax. Most women taking part in the feedback exercise earlier in 2014 said they had been offered the choice of pain relief they wanted.
- The epidural rate was 20%, based on patient choice.

### Nutrition and hydration

- Women said that food was adequate and snacks were available outside meal times.
- The maternity service was working towards level 3 of the UNICEF UK Baby Friendly Initiative to promote good care for newborn babies. Uptake of breastfeeding on the Newham University Hospital site had been slightly lower than elsewhere in the trust, so an infant feeding coordinator had been appointed to introduce sessions for new mothers and improve monitoring of breastfeeding. About 70% of women were at least partially breastfeeding when they left the hospital.

### Patient outcomes

- Data was collected on key indicators of maternity and neonatal outcomes. These were summarised in a maternity dashboard.
- In the quarter October to December 2014 , there had been 1,550 births, of which 62% were normal deliveries, 11% instrumental and 28% caesarean deliveries. The overall emergency caesarean section rate was higher than the national rate of 26%. The hospital had an action plan to reduce the number of caesarean sections. The hospital had had a much higher rate of caesarean section in 2012/2013 but had successfully reduced this. The clinical and social situation of many women giving birth in the maternity unit meant there were often strong reasons for caesarean sections. Instrumental deliveries were slightly above the hospital target: 57 in December against a target of 53 a month.
- There was a plan for optimising normal birth, including providing counselling for women who had had a previous caesarean section. An audit showed that 59% of all women had a successful normal birth. The hospital was also promoting home birth and the use of the birthing centre.

### Competent staff

- Staff we spoke to were clear about their responsibilities and reported having a range of learning opportunities, for example weekly sessions on labour management and guidelines for medical staff and midwives. Sessions were well attended and covered topics such as cardiotocography (CTG) interpretation, audits and case reviews.
- Midwives, nurses, maternity assistants, theatre staff and administrative staff told us their training and appraisals were up to date. We asked for but did not receive information on appraisal rates.
- Supervisors of midwives had a role in developing midwives' skills and expertise. There were 12 supervisors of midwives. The ratio of supervisors to midwives was 1:19, higher than the recommended ratio of 1:15, but we noted the supervisors of midwives had very uneven caseloads. Several midwives we spoke with said they valued the support from their supervisors.
- Staff were responsible for their own training updates using a training passport. There was a preceptorship programme for band 5 and 6 midwives. A three-person midwifery education team worked across the trust's sites. The practice development midwife had no administrative support, which led to difficulties in maintaining a database of completed training. A clinical educator had been employed to support recently recruited midwives from Spain and Italy to the hospital.
- The education team was looking at a skills gap analysis that had been undertaken and putting in place development opportunities for midwifery staff. Some staff said it was difficult to fit in training beyond mandatory training, and said that training was sometimes cancelled (for example, a study day planned for December had been postponed until March). Staff said that staff shortages led to midwives being taken off training. Community midwives said they had fewer training opportunities than they had before.
- Consultants and trainee middle-grade doctors told us that working on the maternity unit gave them a wide range of practical learning experiences, and that formal and informal teaching was good quality.

### Seven-day services

- Antenatal and scanning clinics were offered from Monday to Friday, sometimes with catch-up clinics at weekends after bank holidays.
- Midwifery staffing was set at the same standard day and night, every day. There was morning-only consultant cover at weekends and reduced lower grade medical cover at nights and at the weekend, which was a potential risk to patients.

- When the hospital's out-of-hours pharmacy service was discontinued, The Royal London Hospital provided pharmacy cover as they remained open 24 hours a day, seven days a week.

### Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Women told us they fully understood the choices they made and had consented to, such as the options for screening or the reasons for elective caesarean section.
- Joint work with social services departments on assessing the needs of women with learning disabilities included discussions about capacity. Midwives had training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- We identified a specific consent issue in relation to termination of pregnancy or miscarriage. In the Gateway Surgical Centre in particular, women were not always asked about disposal of products of conception. Good practice is for women to sign consent to the disposal method, which should be through burial or cremation and not in hospital waste.

## Are maternity and gynaecology services caring?

Good

Most of the patients we spoke with were positive about staff, as was the feedback we received. Our observations confirmed that staff were mostly caring and friendly.

Women and their families had information explained in ways they could understand.

### Compassionate care

- We observed nursing, midwifery and administrative staff interacting with women with kindness and understanding, even when they were under pressure. Staff demonstrated an awareness of the importance of maintaining women's dignity and privacy.
- Recent feedback from women indicated that their confidence in maternity services staff had improved. The results of the 2013 national maternity survey found that Barts Health NHS Trust scored close to the national average on the question about the kindness and understanding of staff after a birth. We received mainly positive comments about care on the postnatal ward. However, one mother spoke to us about lack of support on the postnatal ward after a difficult birth, after which her baby was in special care.
- A woman who had been admitted for gynaecological observation said the doctor had explained her care and treatment fully and encouraged her to ask questions.

### Patient understanding and involvement

- Mothers using community midwifery were given a named midwife by 16 weeks. The target was for women to be looked after by a team of three midwives, to provide continuity of care. The community midwifery team were meeting this target in 90% of cases.
- Patients reported feeling involved in their care and said how well doctors and midwives explained the care and treatment at antenatal appointments and answered any questions they had.
- When there was a miscarriage, stillbirth or termination because of foetal anomaly, women were given a full explanation about the choices available to them: doing nothing, surgical management or evacuation under anaesthetic. Where possible, mothers were also given choices about the management of ectopic pregnancy. Parents were also asked how they would like to manage the disposal of the baby or the foetal remains.

### Emotional Support

- A multi-faith chaplaincy also offered a bereavement service and emotional support to families that needed it.
- Women who had suffered foetal loss or stillbirth were offered debriefing and counselling. The service was culturally sensitive to the needs of different women and their families. In the event of a baby's death, the family was given a named link with the hospital, who was either the bereavement midwife or a supervisor of midwives.

## Are maternity and gynaecology services responsive?

Requires improvement

Women were able to discuss the type and place of birth they wanted, at antenatal appointments. Action had been taken to increase the choice of a normal birth for women using the maternity services. Women were assessed at their

first maternity appointment and allocated to an appropriate pathway, with access to specialist clinicians. Community care was responsive to women's needs. However, the flow of women through antenatal and postnatal clinics at the hospital and through the inpatient maternity unit was sometimes affected by staff shortages, which resulted in unnecessary delays. The gynaecology service did not always meet referral-to-treatment times.

### Service planning and delivery to meet the needs of local people

- Women were asked about their preferred place and type of birth on booking. This was reviewed throughout the pregnancy. The consultant midwife for normality and public health had coordinated initiatives to promote normal birth. Weekly hospital tours were available.
- The helpline offered easy access to advice for women who were pregnant. The service received about 750 calls a month. We were given examples of the service being able to reassure women or signpost them to other services so that they did not come to hospital unnecessarily. When staff judged that a woman needed to come to the hospital, midwives on the helpline liaised with the maternity assessment unit to try to prevent delays in treatment.
- Women were told to come to the maternity assessment unit with problems rather than calling their community midwife as they may be told to do in other units. This meets the needs of many in the local population who do not speak English, because in the maternity assessment unit they can access interpreters.
- A range of specialist midwives were available for women in vulnerable circumstances and for women with HIV and other infectious diseases.
- Counselling was offered to women whose screening results meant they needed to make a further decision about diagnostic testing, for example for when screening indicated that the baby may have Down's syndrome. The hospital had an effective system for checking that all relevant women had been offered, and had accepted or declined, screening.
- Parents were able to stay in the maternity unit, in an area with an adjoining room where they could view their baby, away from the main ward. Bereaved families could stay there, and there was a shower (not en suite) and a room where they could view their baby. A memory box was available if the parents wanted one.
- The Early Pregnancy Unit/Emergency Gynaecology Unit offered a one-stop service with a full range of medical and surgical treatment options to manage miscarriage and ectopic pregnancy and offer women a clinically appropriate choice of care. The team of nurse specialists, consultants and sonographers worked effectively together to provide a responsive and effective service. Feedback from patients was very positive.
- There could be five doctors in the gynaecology clinic, but with only a nurse and healthcare assistant in the area, women had to wait for a chaperone.
- We found that staff had a good understanding of the needs of their local population.
- Services for termination of pregnancy were available at the hospital and in the community. All women were offered counselling and referred to community gynaecology services for contraception. Women coming to the hospital were treated in the gynaecology ward or the labour ward if in the later stages of pregnancy, in line with good practice.
- The maternity unit had been refurbished three years ago and was spacious and bright. Women had been consulted, and the different areas had been colour-coded to help women, in particular those with limited English, to find their way around.
- Accommodation in one of the two antenatal areas was cramped and unsuitable for long waits. Staff told us that women with diabetes attending the clinic might be there for four hours. The area had no window and was poorly ventilated. There was limited space for pushchairs and no vending machine. There was no emergency buzzer.
- The gynaecology outpatient area was also small and overcrowded during our visit.

### Access and flow

- Women were able to refer themselves by telephone or online, or could be referred by their GP. Women referred from outside the area were seen at the antenatal clinics in the maternity unit. Low risk women living within the catchment areas were seen by a community midwife for their first booking at the hospital and then allocated to a named midwife in the community midwifery team at a GP's surgery or children's centre near their home. Several women commented on the flexibility of the service when they wanted to rearrange an appointment.
- A maternity assessment unit (MAU) was open from 8am to 8pm on weekdays for assessing women referred by

GPs and triaged for monitoring. Women reported long waits to see the midwife (there was often only one on duty, who also had to answer the door and cover the helpline) and for review by a doctor (who also covered the antenatal ward). There were also long waits for medical review on maternity triage and in gynaecology services.

- Staff reported regular difficulties meeting demand in the maternity unit. This caused delays, including in planned induction of labour and in elective caesarean sections. Doctors sometimes delayed category 3 caesarean sections (women needing earlier-than-planned delivery, usually done within 24 hours) because of concern about keeping one theatre free for an emergency. The longest delay had been five days.
- Women who came for induction of labour were sometimes asked to return home or had to wait until a bed was available on the antenatal ward. We were told that elective caesarean sections were frequently delayed, and we were given an example of a woman who was kept 'nil by mouth' for over 12 hours – unnecessarily, because the procedure was not carried out. We were told that communication of the labour suite and theatres with the antenatal ward was poor, which meant that women were not told what was happening.
- The assistant who made discharge arrangements often came in outside their contracted hours to help with paperwork on the postnatal ward. No cover was provided when the assistant was absent. On the day of our inspection, 20 babies needed to be checked before discharge. Midwives did not help with this.
- The gynaecology ward had had very high bed occupancy since September 2014, and was also used for women who were not gynaecology patients.
- The percentage of gynaecology patients being treated within 18 weeks of referral was 92%; 116 patients waited over 18 weeks in January. Six patients had not been seen for appointments for cancer within the 14-day target, but this was because the women had chosen to delay.
- Cancellation rates for gynaecological surgery were low; for example, in October 2014 there had been 14 cancellations, including four because the unit had insufficient theatre time and four because the women did not attend.

### Access to information

- Most women we spoke with who were receiving maternity or gynaecology services said midwives and doctors had explained things clearly as well as giving them written information. It had been decided not to produce leaflets in languages other than English, because of the high number of languages spoken in Newham. However, the back of the leaflets gave a number to contact Barts Bilingual Health Advocacy and Interpreting Service for help in interpreting the leaflets in other languages.
- Leaflets could be downloaded from the intranet and staff could access help with interpreting by telephone. Interpreters from the interpreter advocacy service on site or telephone interpreting services were used.
- The advocacy service had been reduced for financial reasons and staff had to use Language Line more often, but this was more time-consuming. We were told that Language Line was also less satisfactory if patients had to give consent for treatment. We were not informed of any monitoring to ensure that Language Line services were used appropriately.
- Staff said it was not always possible to assess whether women had fully understood their care. However, at 22 weeks, women were given a questionnaire help assess whether they had understood the information given to them at 16 weeks.
- Women were given an information pack when they were booked for maternity services. They were also given a comprehensive discharge pack, which included advice on breastfeeding and how to identify a sick baby.
- Written information was given to women when they were discharged from gynaecology services, with the telephone number of the ward in case of queries.
- Well-designed and clear information was on display in waiting areas, including on breastfeeding, induction of labour, vitamin K, perineal tears, jaundice and antenatal classes.

### Learning from complaints and concerns

- Patients and their families were encouraged to provide feedback on their experiences. Complaints and concerns were addressed, when possible, at the time they were raised.
- Thirty-six complaints had been made between January and December 2014. This number was very low. The

main issues related to staff attitude, delays in care and being sent home in early labour. There was evidence of action to address these issues through education and the development of an early labour care bundle.
- Complaints were generally dealt with within 25 days. Complex complaints were managed by arranging meetings with staff and following good practice on being open. When complaints were linked to a serious incident investigation in maternity services, women or their partners were given a named contact and there was a process to make sure the family was kept fully informed of the results of the investigation. Resolution meetings with senior staff had been introduced successfully in gynaecology.
- There were regular reviews of complaints to identify themes and identify action. The themes were shared with staff.
- We were told that the number of gynaecology complaints was rising across the trust, with communication being the main theme. We did not see specific information on complaints about gynaecology at this hospital.

## Are maternity and gynaecology services well-led?

**Requires improvement**

Overall leadership of quality in maternity and gynaecology services was provided by the women's and children's clinical academic group (CAG).

The medical and midwifery staff at the hospital showed commitment to providing a safe and effective service for women. There was evident frustration over staffing levels and a sense that management did not understand the challenges on staff in this large maternity unit. Morale among many midwives was low, which was reflected in their unwillingness to work on the bank. Managers mentioned difficulties in gaining the support of midwifery staff affected by the changes the trust had imposed.

The risk register was not reflective of current risks, as it did not include the low levels of consultant cover in maternity services.

A values and behaviour programme had been running for over a year to improve the way staff interacted with women and with each other and to improve the standard of care. Feedback indicated an increase in patient satisfaction, and midwives said the training had been of value.

The termination of pregnancy service was well run.

### Vision and strategy for this service

- The trust aimed to improve the patient experience and had a strategy for achieving this. A values and behaviour programme was running in maternity services, and staff were invited to take the 'Great Expectations' pledge to improve the way they interacted with women and with each other and to improve the standard of care. Patient satisfaction had improved measurably over the 2013/14.
- There was an overall objective of increasing the number of births without medical intervention, reflecting the trust's objectives.

### Governance, risk management and quality measurement

- The merger in 2012 which created the Barts Health NHS Trust had resulted in changes to the way that strategic planning and clinical governance were delivered. In addition to the women's and children's clinical academic group (CAG) board meetings and clinical governance meetings, there were monthly improvement boards for gynaecology and maternity.
- Cross-site meetings of leads for services such as the emergency gynaecology units enabled staff to work at other locations to develop their skills and share learning. Enforced job relocation to other sites had led to some staff dissatisfaction, however.
- The trust produced was a monthly maternity performance dashboard as an indicator of issues such as delivery rates, caesarean section rates and women booked by 13 weeks, which gave a valuable at a glance overview of performance.
- Although the trust was aware that it was very far from meeting recommended staffing standards for the size of the maternity unit, it had been very slow to react and plan for improvement. The increasing practice of reporting data trust-wide obscured the strengths and weaknesses of specific units and may have made it more difficult to achieve change.

# Maternity and gynaecology

- Women's services had introduced effective processes to review complaints and serious incidents and were in the process of increasing the clinical governance resource to embed these improvements.
- The local commissioning group had provided funding for the hospital's maternity liaison services committee (MSLC), which met quarterly. We saw evidence of the MSLC's contribution to the service, such as providing feedback from women, with actions identified by the maternity service.
- The low level of consultant cover was not on the risk register. We reported this to the CAG lead.

### Leadership of service

- A training programme for lead midwives had encouraged them to adopt a more active management role. Lead midwives told us this had increased their confidence in leadership. The midwives held a weekly meeting to discuss concerns and ways of managing demand.
- Consultants provided visible leadership within the maternity unit and were always prepared to assist colleagues. We observed exemplary teamwork in the delivery unit among the medical team at all levels but this was not matched by the teamwork amongst midwives at all levels.
- The development of trust-wide governance had meant that senior staff based at the hospital attended a number of meetings at other locations and had less time to spend at the local hospital. There was some concern that this maternity unit's specific concerns were not addressed by wider management.
- We noted that on some occasions insufficient scrubs were available for staff in maternity to wear.
- We thought that the termination of pregnancy service was well run and had good administrative support.

### Culture

- Midwives we spoke with were keen to make improvements and said they were able to make suggestions – for example, of monitoring waiting times in triage.
- The trust's decision to reduce the banding level of some nurses and midwives had resulted in disharmony. Furthermore, the reduction in the number of midwifery managers had increased managers' workloads and had ultimately proved unsustainable. New managers had recently been appointed.
- Staff told us the maternity unit was a welcoming and friendly place to work.
- Medical trainees said their training was generally good, with deanery teaching monthly, peer-led teaching on Fridays, a journal club and foetal medicine and perinatal sessions. However, many trainees thought that the workload was heavy because there were insufficient staff at all levels. The withdrawal of funding for study leave had led some staff to look for jobs elsewhere.

### Public and staff engagement

- Mechanisms for communicating with staff included weekly newsletters and 'hot topics' (complaints and incidents), open meetings, and a summary of current issues being displayed on noticeboards and highlighted at handover meetings. However, staff thought that communication was top down rather than two way. The maternity unit produced a site-specific monthly newsletter.
- Receiving regular feedback from women and their partners about maternity services was part of the 'Great Expectations' programme. There was evidence that action was taken to respond to negative feedback and to monitor progress in improving the patient experience.

### Improvement, innovation and sustainability

- The 'Great Expectations' programme had produced positive results in women's perception of their care and treatment, and the information leaflets had improved the quality of information available to them.
- The initiatives to increase normal births were becoming embedded and there was optimism about the improvements this would bring to the service.
- The early pregnancy assessment unit provided a comprehensive, well-run service with easy and timely access.

# Services for children and young people

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

## Information about the service

The children and young people's service at Newham University Hospital is provided on the neonatal unit and the paediatric ward (Rainbow Ward).The neonatal unit has been assessed as level 2 by the local children's network. This means it can accept neonates from 27 weeks or babies born weighing at least 800g.There are two intensive care cot spaces, three high dependency cots and 19 special care cots.

Babies requiring more than 24 hours of ventilation and babies born below 27 weeks' gestation are routinely transferred to a regional neonatal intensive care unit. The neonatal unit received approximately 300 admissions between April 2014 and January 2015, and has an occupancy level of between 80% and 85%.Rainbow Ward has 24 beds: 18 inpatient beds and six day-care beds. Of the 18 inpatient beds, two are high dependency; there are two six-bedded bays and four cubicles. This figure may change according to the time of year and the demand for beds.

The day-care beds are used throughout the week for: day surgery such as ear, nose and throat (ENT) and dental; care and treatment for children with sickle cell disease; oncology; and preassessment before surgery. Bed occupancy rates from April 2014 to December 2014 ranged between 34% and 86%.We visited all areas where children and young people were cared for, including inpatient areas, operating theatres and the recovery area, and the children's outpatient department.

We talked with 10 parents and their children, and 37 members of staff, including nurses, student nurses, matrons, play specialists, doctors, consultants and support staff. We observed care and treatment being provided.

# Services for children and young people

## Summary of findings

Incident reporting was satisfactory, but opportunities for sharing lessons learned were limited. The environment on Rainbow Ward was in need of refurbishment, and single-sex accommodation did not exist.

There was a shortage of equipment and some was not fit for purpose. As no one in the clinical academic group (CAG) had overall responsibility for the children's service, there was the potential for fragmentation and ineffective management.

None of the nursing staff in the resuscitation area of the ED had a children's qualification. Low staffing levels resulted in staff not being able to undertake their mandatory training. However, staff were passionate about the care they delivered and reported positively about their immediate leaders.

Patient outcomes were mixed, but one audit showed that the median HbA1c of children and young people with diabetes using the hospital was worse than the national average.

Care and treatment was based on evidence. The service took part in local and national audits in order to keep its practice at safe levels.

Systems for regular education of staff on the neonatal unit were excellent. Most staff were competent to deliver effective care, and children were looked after in a caring and compassionate manner.

Some consideration had been given to meeting the needs of young people aged between 16 and 19 years and a draft policy had been developed. However adolescents were often placed on an adult ward. Educational services had been removed from the hospital site, so a full-time teacher was not available.

Staff could access an interpreting service for families whose first language was not English via health advocates employed by the hospital.

## Are services for children and young people safe?

**Requires improvement**

Incident reporting was satisfactory, but because there were no multidisciplinary clinical governance meetings in paediatrics, opportunities for sharing lessons learned from all the incidents were limited. Expressed breast milk, prepared baby milks and ordinary milk were stored in the same fridge, which should not be done. Rainbow Ward was in need of refurbishment.

There were no children's facilities in the operating theatres, and the environment was not child friendly. There was a shortage of equipment, and some was not fit for purpose for children needing postoperative care.

None of the staff in the operating department had a children's qualification. Low staffing levels resulted in staff not being able to undertake their mandatory training. Two keys to the medicine cupboard had been mislaid recently, which was reported immediately; the estates staff had not yet replaced the keys.

### Incidents

- The children and young people's service reported two serious incidents requiring investigation to the Strategic Executive Information System (STEIS) between April 2014 and December 2014. Both were sudden unexpected deaths, one on the neonatal unit and one relating to the emergency department and Rainbow Ward. Both of these incidents were investigated, and there was evidence of learning as a result of the incidents.
- Between October 2014 and December 2014, 32 incidents were reported across the children and young people's services. Ten of these were attributed to the Rainbow Ward and 22 to the neonatal unit. Each of the incidents was investigated; each investigation, once complete, was closed.
- All incidents were reported through a centralised electronic system. Senior management staff described how they would review incidents to identify any trends. The 32 incidents reported for October 2014 to December 2014 did not demonstrate any trends.

- We were told about staff having the opportunity to tell their 'stories' at team meetings, which allowed staff to hear about incidents that occurred during a span of duty.
- Medical and nursing staff described how they would report an incident, and could describe some action taken after an incident.
- There were no multidisciplinary clinical governance meetings in paediatrics, so the opportunities for sharing lessons learned from all the incidents were limited.
- Action taken as a result of learning from incidents included: using a more holistic approach to child protection assessments and admitting a child as a place of safety until more information was received; being more familiar with national guidelines for management of encephalitis in children; and the increased use of interpreter services to improve communication for critically ill children.
- Incidents on the neonatal unit were discussed at monthly governance meetings, but attendance at these meetings was limited to senior staff. We could not identify a clear mechanism for sharing learning from incidents.
- During the inspection visit we were told about the inappropriate care of a baby being transferred from the emergency department to the neonatal ward. This was reported in the emergency department's core service report.

### Cleanliness, infection control and hygiene

- There were no MRSA or hospital-acquired infections on the children's ward and neonatal unit.
- We observed staff complying with the trust's policies for infection prevention and control. This included wearing the correct personal protective equipment, such as gloves and aprons.
- Staff washed their hands between each patient, and we noted good use of the hand sanitising gel.
- Rainbow Ward had isolation bays for children who presented with symptoms such as diarrhoea and vomiting.
- The ward was clean and tidy; however, we saw that the room used for preparing baby feeds was also used to store pre-packed baby milks. In the fridge, expressed breast milk, prepared baby milks and ordinary milk were stored together. This was not a suitable environment for preparing milk feeds, and expressed breast milk should not be stored in the same fridge as any other products. We were told the same situation occurred in the neonatal unit, but we did not see this area.
- We spoke with a cleaner on the neonatal unit while the cleaner was carrying out his daily cleaning schedule. He described his routine each day for cleaning the neonatal unit and told us how happy he was working on the unit.
- Infection control nurses visited the ward daily and carried our regular audits. We observed the cleaning records for the equipment and toys in the children's outpatient department. The nurse in charge completed these records daily. Stickers were placed on equipment once it had been cleaned.
- The take up of infection control training could be improved. Only 41% of nursing staff completed level 1 training and 36% completed levels 2 and 3. This may mean that the staff's knowledge on infection control was not up to date. However, we were told after the inspection that all three NNU consultants and both SpRs were compliant with infection control training.
- We saw the receptionist on the neonatal unit stopping visitors coming onto the unit until they had washed their hands, and asking them to remove clothing so they would comply with hand hygiene standards.

### Environment and equipment

- Security doors on both the neonatal unit and Rainbow Ward were used appropriately; however, fire precautions were in need of an upgrade on Rainbow Ward. Staff had been recognised this, and an action plan was in place to repair fire doors and organise training for staff.
- Nursing staff told us there was a shortage of blood pressure monitors and they spent a lot of time looking for them. We asked what they would do if they could not find one, and a nurse replied, "We do the best we can." However, a number of oxygen saturation monitors had been purchased, which had helped nurses to monitor children better.
- There was no suitable paediatric resuscitation equipment in the recovery bays and no paediatric handles for laryngoscopes. Endotracheal tubes for children were not easily available, and, when asked, staff did not know where any of this equipment could be found. Following a brief search, endotracheal tubes were found in the resuscitation trolley; however, there were only two, and these were not the right sizes for the age range of children seen.

- The cardiac monitor in the children's space was last checked in 2012 according to the notice placed on the equipment.

### Medicines

- We observed one medicines cupboard on Rainbow Ward that was unlocked, but the main door to the room was operated by swipe card. We were told that two keys to the medicine cupboard had been mislaid recently, which had been reported immediately. Estates staff had yet to replace the keys. Overall the room was safe, because only trained staff had a swipe card to enter.
- We checked eight prescription charts; all were fully completed, including the child's height and weight and details of any allergies. There were no missed doses.
- Medicine fridges were found to be locked and their temperatures were routinely checked daily.
- Controlled drugs were stored according to legal requirements. We looked at medication records on both the neonatal unit and rainbow unit, and noted they were accurate with no gaps.
- We saw chemotherapy being given to a child on the Rainbow Ward. This was undertaken by a member of the medical staff with a nurse accompanying them while the chemotherapy was given.
- Only intravenous chemotherapy (cytarabine and vincristine) was administered, to approximately four children each month. We saw copies of protocols used, and found guidelines for managing febrile neutropenia on the trust's intranet.
- We saw cytoxic spillage kits; these were in date.
- Three medication errors had been reported as incidents but caused no harm to the children. Investigations had been carried out on all three incidents.

### Records

- We reviewed the care plans of eight patients on Rainbow Ward and four on the neonatal unit. The care plans were comprehensive and person centred. We reviewed handover sheets, and these included risk assessments and evaluation records. Notes were legible, and it was clear what action needed to be taken.
- All entries in the neonatal notes were dated, timed and signed by the person writing the notes. Notes provided a clear narrative of the care of each neonate. There was evidence of communication with tertiary centres and there were clearly printed summaries.
- The World Health Organization (WHO) checklists that we reviewed for preoperative care for children were completed. However, the hospital did not audit these checklists for compliance, and as a result could not demonstrate that checklists were always completed.
- We noted that medical notes were stored correctly and securely throughout the areas we visited. Student nurses told us they do not access to health records unless supervised by a trained member of staff.

### Safeguarding

- The hospital had a safeguarding team made up of a named nurse and specialist nurse, named midwife and named doctor. Staff could name the members of this team and could give examples of when they contacted them, including for advice and to escalate concerns.
- There were weekly psychosocial meetings on both the Newham University Hospital and The Royal London Hospital sites, which were multi-agency as well as multidisciplinary. We saw evidence that minutes were taken of these meetings.
- A system was in place for referring children and adolescents to the local Child and Adolescent Mental Health Services (CAMHS). We spoke with staff who could name the person they would speak with.
- We observed records of a child who had been admitted to the ward who had self-harmed. Details of the admission was recorded on the IT system with safeguarding concerns. CAMHS had been notified of the child's admittance, and later saw them the ward.
- We were told that safeguarding advice was available 24 hours a day by an on-call rota of safeguarding nurses across the trust.
- Staff were trained in safeguarding children. Staff we spoke with on the neonatal unit and Rainbow Ward had all completed level 3 safeguarding children training.
- Some student nurses told us they had no induction in safeguarding on the ward, although they were aware of the process of flagging safeguarding issues and had attended lectures on child protection and safeguarding at university. They could describe how to report safeguarding concerns and who to report them to.
- The neonatal unit had three rooms where parents could stay with their baby while waiting to be discharged home. If a baby was identified as needing a child

protection plan, this was flagged in the baby's notes and the safeguarding lead was informed. A social worker, children's ward safeguarding leads and neonatal staff held weekly meetings.
- Safeguarding information was on display at the reception desk on the neonatal unit and the Rainbow Ward for staff to use when necessary.
- The hospital's abduction policy had not been ratified. We were told that a cross-site and cross-clinical academic group (CAG) meeting was arranged for the end of January 2015 to ratify the abduction policy which will cover maternity and children's services.

### Mandatory training

- Staff attendance at mandatory training was low and needed to improve. Attendance at fire training sessions for staff on the neonatal unit was low, and attendance at information governance training was 45% for trained nursing staff.
- Due to the high vacancy rate in the operating theatres, staff could not be released for training. As a result, paediatric training for staff was out of date. Staff in the recovery unit also did not have training, including paediatric resuscitation training. This posed a potential risk to the care of children undergoing surgical procedures.
- No medical staff on the neonatal unit had attended infection control training, and no operating theatre staff were trained in paediatric resuscitation.
- All staff had completed their nutrition and safeguarding training.

### Assessing and responding to patient risk

- The bedside Paediatric Early Warning Score (PEWS) system was used to help assess and monitor children on Rainbow Ward. This helped to determine whether a child's condition was deteriorating. We saw from patient records that the PEWS monitoring system was being used routinely. Staff were able to talk to us about how they would escalate any concerns about a child's condition.
- Audits of the PEWS monitoring by the practice development nurse demonstrated a high level of compliance. Both nursing and medical staff reported that they found this system, which had been in place for about six months, very beneficial.
- Babies requiring surgery were transferred out to a tertiary centre so that they could be cared for in a neonatal intensive care unit. These babies were then transferred back to Newham University Hospital once they no longer need to be cared for in a neonatal intensive care unit.

### Safety thermometer

- Safety thermometers were observed at the entrance of Rainbow Ward and the neonatal unit, demonstrating 100% compliance with the safety thermometer standards.

### Nursing staffing

- Nurse staffing levels on Rainbow Ward were 17.4 whole time equivalent (WTE) trained staff with a further 5 WTE healthcare assistants (HCA). There was also a high number of bank and agency staff used on the ward. We were told this was due to having six winter operational resilience beds open.
- Staff told us a number of nurses had recently left the hospital, mainly for promotion or personal reasons which had increased the need to use bank and agency staff. Ward staff could book their own bank and agency staff when needed.
- We were told nurses working in the operating theatres received 'on the job' training but due to the lack of staff this was difficult to complete. Due to the loss of Band 7 staff in the operating theatres, the matron still had to undertake clinical duties.
- At present the children's department was budgeted for 69 (WTE) nurses, but there were 14 vacancies, six on maternity leave and one on a career break. There was permanent use of five agency staff to cover anaesthetics and recovery.
- Nurse staffing levels on the Neonatal Unit were 35.6 WTE with a further 9.3 HCAs. This establishment complied with the British Association of Perinatal Medicine (BAPM) recommendations for safe staffing.

### Medical staffing

- Nine consultant paediatricians covered children's services at the hospital. This included a paediatric consultant of the week, who was responsible for all the patients on Rainbow Ward.
- Two consultants worked out of hours until 8pm in the evening from Monday to Friday and covered four hours on Saturdays and Sundays. This meant, however, that they covered a 1:4.5 rota.

- Nursing staff told us how proactive and supportive the consultants were, and that they would regularly and willingly come in as required when on call.
- There was close cooperation between the paediatric and emergency care doctors regarding the management of paediatric patients in the emergency department.
- The junior medical staff on Rainbow Ward included two registrars and three FY 2s in the daytime, and one registrar and one FY 2 at night. Overnight, a consultant on call for general paediatrics supported the on-call doctors.
- There were four paediatric consultant anaesthetists, and all anaesthetised fewer than 25 children per year. Medical staff had raised concerns relating to the lack of opportunities to care for children undergoing surgery. Due to the higher risks in anaesthetising children, middle grade doctors could only anaesthetise children when a consultant anaesthetist was present.
- All doctors had paediatric advanced life support training, although some were not up to date with this training.
- We observed a medical handover at 8.30am for the neonatal unit, and saw evidence of good multidisciplinary working. The handover was consultant led, and education for junior staff took place during this handover period. There was also a consultant-led ward round every evening.

### Major incident awareness and training

- The trust had a major incident plan which was available on the intranet. Senior staff were aware of the plan and were able to explain their roles.

## Are services for children and young people effective?

Requires improvement

Care and treatment were based on evidence, and the service took part in local and national audits in order to keep practice at safe levels. Systems for regular education of staff on the neonatal unit were excellent. Most staff were competent to deliver effective care, but none of the nursing staff in the resuscitation area of the ED had a children's qualification.

Postoperative pain management of children was less than good. A number of guidelines had no dates on them, so it was unclear how up-to-date they were. Parenteral nutrition was led by the medical and pharmacy staff, with no involvement by dieticians. Multidisciplinary meetings did not take place in paediatrics.

Patient outcomes were mixed, but one audit showed that the median HbA1c of children and young people with diabetes using the hospital was worse than the national average.

### Evidence-based care and treatment

- The children's services used the National Institute for Health and Care Excellence (NICE) and Royal College of Paediatric and Child Health (RCPCH) guidelines to define the treatment provided, such as the management of sickle cell acute pain episodes in children.
- There were pathways and protocols of management and care for various medical and surgical conditions. We looked at policies and procedures on the local intranet; many were out of date, for example oncology and haematology manuals were dated 2007 and 2010. Also a number of guidelines had no dates on them, so it was unclear how up-to-date these were.
- The neonatal unit took part in the National Neonatal Audit Programme (NNAP) in 2014, which audited the completeness of data reports when caring for neonates. This provided the neonatal staff with an opportunity to address any missing entries in their data and to help ensure that all data was complete for each episode of care.
- A number of audits of neonatal and children's care were carried out over the 2014/15 period, such as an audit of long line placement on the neonatal unit, a paediatric prescription audit, a nutritional screening tool audit, and a parental satisfaction audit in paediatric ear.
- An audit of parental nutrition following the British enteral/parental nutritional guidelines was undertaken, and a protocol was written following the results of the audit. All consultants agreed with the protocol, but it was never implemented because it had to be agreed across all sites. This was frustrating to staff on the hospital. This was a similar case for the use of vitamins, as consultants at one site would not agree with consultants at another site. As a result, no changes were implemented that would improve practice.

# Services for children and young people

### Pain relief

- Previously, a board covered children's services, chaired by the chief nurse and with representation from all services within the trust; due to changes in the clinical academic groups (CAGs), this board no longer exists. This board was responsible for overviewing all services for children and young people. For example, the children's board had aided the development of pain protocols and overseeing children going through for surgery.
- Senior managers recognised there was an inability to adequately manage postoperative for children, such as with patient-controlled analgesia and epidurals. Most children were transferred to The Royal London Hospital for pain management, but the pain-management teams supported staff at Newham University Hospital when necessary. However, ward staff still reported problems with pain relief for children undergoing surgery as well as with fluid management, particularly as the medical teams were based in adult services.
- An audit was carried out in November 2014 to identify whether children's pain was being assessed, documented and treated throughout their inpatient stay on Rainbow Ward. The results of this audit showed that nurses asked children about their pain, and that children thought nurses were caring, helpful and compassionate. Areas for improvement included reviewing pain-assessment practices and improving escalation strategies if pain was not adequately controlled. There was no evidence of an action plan to address these outcomes, although the notes from the audit mentioned that further discussions were to take place.
- Children admitted to Rainbow Ward underwent age-appropriate pain assessments; records demonstrated that staff routinely assessed children's pain thresholds.
- Three children told us they did not have EMLA cream (a local anaesthetic cream) applied to their arms before having blood taken for testing. This meant that these children may have experienced some pain unnecessarily.

### Nutrition and hydration

- Children or parents could decide what the child wanted to eat or drink. There was milk for babies but no baby food, so parents had to bring in their own food. Water was offered to children throughout the day.
- We observed a meal being served at tea time on the Rainbow Ward, which included hot and cold choices. We observed the temperature of the food being checked to make sure it was the correct. Staff serving the food wore aprons.
- We asked young people about the choice and quality of the meals. One person said there was not much choice, because the ward catered for younger children, and that they did not always want fish fingers. This person did tell us that they could, on occasion, request alternative meal choices.
- An audit in 2013 of the use of an intravenous sugar solution for neonates showed that parental nutrition should be started early. This was to be re-audited this year to see whether improvements have been made.
- We were told that some clinicians still used dextrose for a few days before starting parenteral nutrition. We also heard that parenteral nutrition was led by the medical and pharmacy staff, with no involvement by dieticians.

### Patient outcomes

- There was no evidence of risk indicating that the trust was an outlier regarding paediatric disorders and perinatal morbidity.
- Children's services submitted a range of data for national audit programmes such as the national neonatal audit programme, paediatric asthma audit, childhood epilepsy audit and national paediatric diabetes audit.
- Data from the National Paediatric Diabetes Audit in 2012/13 showed that the median HbA1c of children and young people with diabetes using Newham University Hospital was worse (79.0mmol/mol) than the national average (69.0mmol/mol). HbA1c test measures how much haemoglobin in the blood has become chemically bonded with glucose. It is recommended that people with diabetes aim for an HbA1c below 58 mmol/mol.
- Data from the Hospital Episode Statistics (HES) 2013/14, showed that there were emergency readmissions after elective admission at Newham University Hospital among patients in both the under 1 and 1 to 17 age groups between June 2013 and May 2014. However, no treatment speciality reported six or more readmissions.
- Data from the Hospital Episode Statistics (HES) 2013/14 showed that the rate of multiple (two or more) emergency admissions to Newham University Hospital within 12 months among children and young people for

asthma, diabetes and epilepsy (July 2013 to June 2014) were as follows- Asthma (under 1 age group) 0%, better than the England average of 11.1%; (1-17 age group) 16.1%, worse than the England average of 15.6%. Diabetes (under 1 age group) not recorded, England average 17.4%; (1-17 age group) 0%, better than the England average of 13.1%. Epilepsy (under 1 age group) 40%, worse than the England average of 37.5%; (1-17 age group) 35.4%, worse than the England average of 26.3%.

### Competent staff

- None of the nursing staff in the resuscitation unit had a children's qualification. This could have a negative impact on the care received by children in the resuscitation unit.
- The appraisal rate for staff across children's services was 67%. This meant that a third of staff did not have their performance appraised to ensure their competencies and skills were discussed and improvements and development opportunities agreed. However, we heard from junior nurses and student nurses how well supported they felt in the clinical area, by both other trained nurses and medical staff; two of the students had asked to return to the ward. Student nurses knew who their senior nurse was and how to make contact. They could also verbalise how they would contact the paediatric intensive care unit at The Royal London Hospital if they had concern.
- A practice development nurse led on preceptorship for newly qualified nurses. Newly qualified staff told us about the support they received from a mentor. However, sometimes it was difficult to get tasks signed off, because the mentor could be the nurse in charge and so did not always have the time to do this. We were also told how the practice development nurses had altered the adult-focused healthcare assistants' competencies to ensure the healthcare assistants in paediatrics met appropriate competencies.
- We spoke with doctors in training on the neonatal unit who told us they had good exposure to different cases and good support and supervision from their consultants and senior medical staff. We observed a handover session with the neonatal team which was led by a consultant, where individual cases were discussed and information shared so that more junior staff could improve their knowledge of caring for neonates.
- Education sessions for doctors on the neonatal unit occurred almost every day. Most had been carefully designed to capture maximum attendance by holding them immediately after the morning handover session. Trainees told us that doctors on the preceding night shift often stayed for these, because they deemed the sessions to be of value.
- Junior medical staff told us how they would recognise poor medical practice and how they could report this to a senior medical member of staff. One trainee told us how they felt well supported and confident to undertake the tasks they had been asked to do, and stated, "I have never felt out of my depth because of the support I get from consultants and registrars."
- Medical staff in training on the neonatal unit told us, "The unit is a great place to get experience", and that they had regular supervision.
- A proposal to expand the provision of clinical equipment training across all sites was submitted in September 2013, and although agreed by all clinical academic groups (CAGs), no funding had been found.
- Currently there were no medical device trainers at the hospital. A medical equipment training model was being implemented at some other sites, but not at the Newham University Hospital site as yet.

### Multidisciplinary working

- We were told by senior staff that multidisciplinary team meetings did not take place in paediatrics, but they did in the neonatal unit. It was clear from discussions that the teams worked well together, but it was difficult to assess how learning and proactive management plans could be taken forward without formal multidisciplinary team meetings.

### Seven-day services

- The neonatal unit was open and general paediatric services were provided over seven days, 24 hours a day.
- Patients had access to allied healthcare professionals such as physiotherapists outside normal working hours.

### Consent

- The staff we spoke with could explain how consent was sought. We noted verbal and written consent being obtained from patients' relatives on the ward. We spoke with four mothers, who told us they had been fully informed of the procedure their child was going to have and understood the possible complications of this procedure.

# Services for children and young people

- We saw consent forms being checked before a patent had a surgical intervention, and signatures being checked before administering an anaesthetic.

## Are services for children and young people caring?

Good

Children were looked after in a caring and compassionate manner. Parents and some children, when appropriate, were involved in planning their care. Information was shared with families, so they could be fully informed about the children's care and treatment.

### Compassionate care

- The trust was piloting a Friends and Family test questionnaire for children. Once this has been completed, children would be able to give their views on the hospital's services. The neonatal unit had carried out its own local satisfaction survey, but the results were yet to be analysed.
- We saw staff interacting with parents and children in a polite and friendly manner.
- Parents told us that staff at all levels were committed and caring.
- Parents told us there was a good team spirit among staff, and nurses generally seemed happy with their roles.
- Parents told us about the "great care" their children received, and how staff listened to children and gave them information in order to help them make informed decisions. We spoke with one young person and her mother, who told us how the patient was fast-tracked as a result of being a frequent attender on the ward. The young person and her mother said that communication with the consultant was excellent, and at times the consultant would ring from his holiday if he had heard they had been admitted.
- One parent told us how caring staff were with her five-month-old baby. Because the mother did not sleep well at night, she was allowed to take her baby home after 10pm and return at 8am the next morning. The baby's mother told us there was plenty of milk for her baby, although her husband had to bring food in for her (the mother) to eat.

### Emotional support

- If a child died unexpectedly, staff knew the protocol to follow. They reported how the safeguarding lead and lead consultant would always be called. The hospital had a chaplaincy service, which could be accessed easily.
- There was regular liaison with psychiatric nurses on Monday to Friday, from 9am to 5pm, when needed.

## Are services for children and young people responsive?

Requires improvement

There was no adolescent strategy, although we were told this was being developed. Arrangements were in place for the neonatal transfer service to transfer critically ill children to specialist centres. Staff could access an interpreting service for families whose first language was not English via health advocates employed by the hospital.

Single-sex accommodation did not exist on Rainbow Ward but we were told following the inspection that a refurbishment was planned for summer 2015 that will offer en suite accommodation and enhanced facilities.

Some consideration had been given to meeting the needs of young people aged between 16 and 19 years and a draft policy had been developed. However adolescents were often placed on an adult ward.

### Service planning and delivery to meet the needs of local people

- There was no adolescent strategy, although we were told this was being developed using the Department of Health's quality criteria for young people friendly health services, which are referred to as 'You're Welcome'.

### Access and flow

- Morning conference calls took place to check how many beds were available, whether staffing levels were appropriate, and imminent deliveries across the maternity unit, so that any capacity issues could be addressed in a timely manner.
- Arrangements were in place for the neonatal transfer service to transfer critically ill children to specialist centres. The unit transferred patients to any paediatric

intensive care unit across London that had beds available, such as Great Ormond Street and The Royal London Hospital. We were told by staff that these arrangements worked well.

- Paediatricians undertook a 'hot week', where they taught junior doctors, took calls from GPs on a GP hotline to give advice on serious cases, and alerted the emergency department if a sick baby was coming in. This ensured that children were admitted appropriately and treated in a timely manner.
- Nursing staff looking after children with sickle cell disease could explain the pathway of care for these children on Rainbow Ward. Children arriving at the hospital in crisis were fast-tracked through the emergency department by a paediatrician, and also had an access card to enable this fast track to take place.
- For serious illnesses, consultants arranged same-day appointments in the day centre and, if necessary, admitted a sick child from there via the emergency department.
- The nurse in charge was aware of what to do if children did not attend their appointments. The receptionist sent a message a day before the clinic appointment to reduce the likelihood of non-attendance.There were arrangements in place for the transfer of critically ill children to specialist centres by the neonatal transfer service.

### Meeting people's individual needs

- Rainbow Ward cared for children and young people between the ages of 0 and 19 years. Some consideration had been given to meeting the needs of young people aged between 16 and 19 years and a draft policy had been developed. However adolescents were often placed on an adult ward. While there was provision for adolescents on the ward, no 16- to 19-year-olds were on the Rainbow Ward at the time of the inspection.
- The Rainbow Ward had two six-bedded bays, but these were not same-sex bays, nor were they age limited, so a young girl of 15 could be in a bed next to a baby of 12 months. We were told following the inspection that a refurbishment was planned for summer 2015 that will offer en suite accommodation and enhanced facilities.
- The variety of the ages of the children and young people would not be a good experience for them. One young person told us how the baby in the cot next to her "cried and kept me awake at night".
- Within the neonatal unit, staff could access an interpreting service for families whose first language was not English via health advocates employed by the hospital. Health advocates were available for languages such as Bengali, Somali and Eastern European languages.
- Out of hours, the hospital used an external translation service that covered all services across the trust.
- We were told that one parent could stay overnight if necessary, while the second parent could stay until midnight. Folding beds were available next to the beds for parents to sleep on, if needed. There were two en-suite rooms for parents and a third which was used mainly as a 'quiet room' and for retinopathy screening.
- We were told and we observed that accommodation on the Rainbow Ward was in need of refurbishment.
- Despite the fact that children underwent ear, nose and throat and dental surgery every week, there were no children's facilities in the operating theatres and the environment was not child friendly. Senior staff were aware of this, but nothing had been done to improve the environment. We asked one senior member of staff in the operating theatre why there were no children's facilities; the response we received was, "No one has asked me to provide them".
- There was no dedicated child-friendly theatre, although one was generally used for children. No effort had been made to make this theatre look less daunting for children.
- We visited the children's outpatient department, which was a prefabricated building outside the Rainbow Ward. Staff told us the outpatient department was difficult to access in a clinical emergency, because of its location and it being behind a metal gate.
- We were told there were plans in place to refurbish Rainbow Ward and build a new children's outpatient department funded by charitable funds (£6.8 million) by March 2016. The business case for the outpatient building had yet to be approved by the Training and Development Agency.
- The outpatients department had four consulting rooms, a waiting area and a play area for the children. There were plenty of toys and books to keep children occupied while waiting to see a doctor or nurse. Although the building was isolated, CCTV was in place and the nurse who ran the clinic could access the Rainbow Ward via a rear door.

# Services for children and young people

- A number of clinics for children took place every day, including for epilepsy, diabetes and pain. A community dietician also ran approximately eight clinics a week and saw children who needed dietary advice, such as for tube feeding and children with special needs.
- We were told that children who attended the outpatient department with sickle cell disease are seen by the adult nurses when they are approaching the age of 16. This ensured continuity of care for these children when moving into adulthood.
- A number of leaflets were provided about specific procedures, and included information about the complications of surgery.

### Educational services

- Education services are provided by the London Borough of Newham.
- The play specialist worked weekdays between 7.30am and 3.30pm, and when not on duty left toys out for children and young people. There was access to Wi-Fi for older children, but this had to be paid for. For children with a long term illness who would be frequent attenders on the ward, teachers visited and provided home tuition, but this was usually organised by child's own school.
- We were told how the school room had been reduced to an office space, and, more recently, the education service had removed itself altogether from the hospital site. The hospital made a referral to the local authority for educational support if a child was in hospital for more than three weeks (however, the Education Act states that this should be after two weeks; we were told that it was the choice of the local authority to extend this to three weeks). One young person told that their mother brought coursework into hospital so they could keep up with their school work.
- We were told that children undergoing regular treatment for sickle cell disease were offered appointments later in the day, so they did not miss too much of their school work. This was a different experience to that of those children attending day care at The Royal London Hospital, who had a full-time teacher and a school room through term time.

### Learning from complaints and concerns

- There were five complaints in total within the children's services in the past year: one on the neonatal unit, three relating to the Rainbow Ward, and one to paediatric surgery. There had been a delay in responding to complaints across the service; this was being addressed.
- Nursing staff told us how complaints were fed back to them through their local team meetings in order to improve children's experiences.
- Information was available for patients and parents to access on how to make a complaint and how to access the Patient Advice and Liaison Service.
- We asked some parents whether they knew how to make a complaint; some said they would go to the receptionist, and others said they would talk with a nurse on duty. The neonatal unit, Rainbow Ward and children's outpatient clinic all had posters on the walls describing how to access the Patient Advice and Liaison Service.
- All concerns raised would be investigated, although there was still further work to do to ensure learning from complaints took place.

### Are services for children and young people well-led?

Inadequate 

There was no overall children's strategy in place, although there were plans to move children's emergency surgery to The Royal London Hospital by March 2015 and leave elective ear, nose and throat and dental surgery at Newham University Hospital. Because no single clinical academic group (CAG) had overall responsibility for the children's service, there was the potential for fragmentation and ineffective management.

There was no dedicated children's lead that covered all services for children from 0 to 18 years of age, which meant that some children did not have choices about where they were treated.

The CAGs were still developing their clinical governance systems, and dashboards were now being used although this was still in its infancy. There were no clinical governance meetings at ward level and no weekly multidisciplinary meetings on the Rainbow Ward.

# Services for children and young people

Staff were passionate about the care they delivered and reported positively about their immediate leaders.

### Vision and strategy for this service

- There was evidence of a range of developments to enhance the provision of services for neonates, children and young people, but this developments were compromised by the lack of one clinical academic group (CAG) overseeing them.
- No overall children's strategy was in place, although there were plans to move children's emergency surgery to The Royal London Hospital by March 2015 and leave elective ear, nose and throat and dental surgery at the Newham University Hospital.
- Medical staff had raised concerns about the transfer of service to The Royal London Hospital. At the time of this inspection, there were neither transfer protocols in place nor any information for people who would be bringing children into the emergency department. We were told that no public consultation had, to date, taken place about any potential changes.

### Governance, risk management and quality measurement

- Services for children and young people sat within multiple clinical academic groups (CAGs): surgery was led by the surgical CAG, emergency care was led by the emergency care and acute medicine CAG, and the women and children's CAG led the remainder of children's services. As no single CAG had overall responsibility for the children's service, there was the potential for fragmentation and ineffective management.
- The CAGs were still developing their clinical governance systems, and dashboards were being used, although this was still in its infancy. There were no clinical governance meetings at ward level and no weekly multidisciplinary meetings on the Rainbow Ward. However, multidisciplinary meetings did take place on the neonatal unit.
- CAG risk registers were being reviewed, although some risks should have been reviewed already and had not been.

### Leadership of service

- There was no dedicated children's lead that covered all services for children from 0 to 18 years of age, which meant that some children did not have choices about where they were treated.
- There was also no one lead for children transferring to adult care, but we were told that such a post would be filled soon.
- Each of the three areas for children's services (neonatal unit, Rainbow Ward and children outpatients) were individually well-led, but due to a lack of overarching leadership, plans to improve the services were compromised. Improvements had been made, but there was further work to do.
- The leadership of individual aspects of children's services was mainly good, with staff reporting positively about their immediate line managers.
- There was no clear leadership for all children and young people at the hospital from anyone with the authority to make change. This was highlighted in areas such as the operating theatres and the apparent lack of consultation about surgical services.

### Culture within the service

- Staff we spoke with were passionate about the care they delivered. All staff we spoke with in the clinical areas enjoyed coming to work and felt they worked as a team. Staff were open, friendly and motivated to provide high quality and safe care.
- The staff in the children's outpatient department were very happy, motivated and professional.
- Senior staff who we spoke with were positive about working at the hospital and spoke passionately about how they wanted to improve the care for children and young people.
- Staff reported that they felt like "second class citizens" to staff at The Royal London Hospital, and lack of motivation was evident in some areas. It did appear that children and young people were not understood to be unique and requiring different support and care within the whole of Newham University Hospital.
- Staff commented that the trust's directors were not visible on the hospital.
- We were told that approximately six to seven nursing staff were absent daily due to sickness and low morale.

### Public and staff engagement

- There was little evidence that members of the public were engaged in commenting on the service, and no evidence of young people or children making comments about the service.
- On the neonatal unit, we saw parent feedback forms which were very positive, and were told about engagement with the public at local events.

# Services for children and young people

### Innovation, improvement and sustainability

- There was little evidence of day-to-day innovation, because a lot of work appears to go unrecorded.
- There were plans to redevelop the children's ward and outpatients department, and the trust was piloting the children's Friends and Family Test.
- The Paediatric Early Warning Score (PEWS) had been very well implemented at the hospital.

# End of life care

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

## Information about the service

Newham University Hospital's palliative care team (HPCT) consisted of two full-time clinical nurse specialists, 0.5 of a whole-time-equivalent consultant post divided between two consultants, and 0.5 of a social work post. The hospital reported 283 patient deaths between April 2013 and March 2014. The HPCT had a caseload of 379 new patients between April 2013 and March 2014.

We visited a number of wards where care was being given to patients at the end of their lives. These included general surgery, orthopaedic, oncology, endocrinology and general medicine wards including care of the elderly. We spoke with patients and relatives whenever this was possible. We reviewed medical records and talked with staff from a variety of disciplines, including porters, chaplains, mortuary and bereavement staff, ward clerks, healthcare assistants, consultants, doctors, nurses and senior managers.

## Summary of findings

An end of life care strategy had only just been drafted and at the time of our inspection, and had not been ratified by the board. This draft strategy did not reference any published practice guidance and demonstrated no detailed planning of how the recommendations laid down in these guidance documents would be met through specific initiatives and service developments.

End of life care appeared to have been overlooked within the clinical academic group (CAG) structure and become a forgotten service. There was a lack of direction and a lack of leadership.

The do not attempt cardio-pulmonary resuscitation (DNA CPR) form was unclear, and we had concerns about the trust's new DNA CPR policy, which did not acknowledge a recent ruling.

New end of life care planning documentation and guidance to replace the Liverpool Care Pathway had been written but not yet implemented across the whole hospital. There had been no assessment of the current needs for service provision against major national documents.

Ward staff had not received any training in managing patients' end of life care needs or care plans for dying patients.

Clinical nurse specialists in the hospital palliative care team (HPCT) demonstrated an understanding of the

# End of life care

safeguarding reporting process and of recognising vulnerable adults at risk of harm. However, there was no policy or guideline on the consistent use of opioids, leaving scope for drug errors.

The limited number of nursing staff available to the HPCT and wards had a detrimental effect on the hospital's ability to meet patients' end of life care needs.

Conversations involving families and friends, in which they were updated on a patient's progress and about decisions such as preferred place of care, routinely took place. Relatives found staff very helpful, caring and compassionate.

Patients' individual needs were met by ward staff and HPCT staff. There was open access for relatives visiting patients who were dying and preferential car parking rates for those spending long periods visiting. Bereavement services were well organised and responsive to people's needs.

## Are end of life care services safe?

Requires Improvement

The hospital palliative care team (HPCT) clinical nurse specialists (CNSs) demonstrated an understanding of the safeguarding reporting process and of recognising vulnerable adults at risk of harm. There was appropriate access to syringe drivers, which had been standardised in response to a national patient safety alert, and drugs administered to patients in the last few weeks of life had been prescribed appropriately. However, there was no policy or guideline on the consistent use of opioids, leaving scope for drug errors.

Ward doctors and nurses told that they thought the HPCT responded promptly when called. Patient records documented multi-professional input and clear decision making. The HPCT worked well with ward teams to manage individual patient risk. However, there was no systematic way for themes relevant to patients receiving safe end of life care to be identified or analysed.

The limited number of nursing staff available to the HPCT and wards had a detrimental effect on the hospital's ability to meet patients' end of life care needs. HPCT CNSs were also asked to cover sickness and staff shortage at other hospitals within the trust, which placed further pressure on the nursing staff on the team.

### Incidents

- Ward and hospital palliative care team (HPCT) staff we spoke with were knowledgeable about the incident-reporting process. They confirmed that, to their knowledge, there been no Never Events or serious incidents relating to end of life care.
- There was no way of understanding whether reported incidents related to patients who were receiving end of life care and whether themes had arisen through the reporting process. For instance, we learned during our inspection that there had been an issue last year with faulty syringe drivers, which was resolved by purchasing new equipment in response to a National Patient Safety Agency (NPSA) alert. We also learned that on one ward (Plashett, medical ward), a patient receiving end of life care had fallen after standing to use a urine bottle.

# End of life care

- We asked HPCT staff what were the 'live issues' that were potential risks to patients receiving good end of life care. We were told that access to side rooms for end of life patients could be an issue because there was not enough and infection control took priority.

### Mandatory training

- A CNS from the HPCT told us that staff who had not completed their mandatory training would receive emails from a central database to remind them. We were told that the trust lead nurse for palliative care would also do this.
- We asked the trust lead nurse for palliative care whether the department collected training figures or was aware of HPCT staff training performance. We were told that an annual performance report for the palliative care team contained this detail and would be supplied. However, this annual report was not produced.

### Safeguarding

- HPCT CNSs demonstrated an understanding of the safeguarding reporting process and of recognising vulnerable adults at risk of harm. HPCT staff met and liaised with the trust's safeguarding team on specific safeguarding issues and reported having a good working relationship with team members.

### Medicines

- The hospital achieved its National Care of the Dying Audit of Hospitals (NCDAH) organisational key performance indicator for clinical protocols for the prescription of medicines for the five key symptoms at the end of life (score 5 out of 5).
- There was appropriate access to syringe drivers, used to administer regular continuous analgesia. These were available through the medical equipment library. Access to syringe drivers could be difficult at night, when staff told us they needed to ask other wards. The syringe drivers used had been standardised in response to a national patient safety alert. Ward staff gave us numerous reports that they did not have a problem with the supply of syringe drivers and that they had been trained to use them.
- We encountered patients in the last few weeks of life with multiple needs, where drugs had been prescribed appropriately. For instance, on a stroke ward, one patient had good regular contact with the HPCT CNSs, and 'as required' drugs had been administered to help a patient manage their condition in conjunction with the ward staff. A ward manager told us they had no problems getting doctors to prescribe medication for symptom control for end of life care. We were told that the ward pharmacist was present at board round meetings and could supply drugs quickly.
- There was no policy or guideline on the consistent use of opioids. This meant there was considerable scope for drug errors and misprescribing when doctors moved between wards and failed to appreciate that the drugs had different potencies when administered by different methods. There was no consistency in the use of opioids, with some wards using morphine and others diamorphine.
- The trust lead nurse and lead consultant for palliative care told us that guidelines for prescribing opioids had been 'buried'. Diamorphine was the drug of choice, but wards used morphine as well as oxycodone, and there were no restrictions on the prescribing of strong opioids for administration either orally or by syringe driver. There was no palliative care input to governance of controlled drugs and no policy for or monitoring of the prescribing of strong opioids for palliative care patients. Staff were not aware of any opioid prescribing incidents. There was not a pharmacist with special interest in palliative care.

### Records

- HPCT staff wrote details of contacts with patients in the ward medical notes. They also made an electronic record that they had seen a patient. This demonstrated that the HPCT had been involved with a patient.
- HPCT members completed referral forms to the HPCT following contact with ward staff or specialists.
- There was an informal set process for assessments rather than a proforma. HPCT assessments were written in the medical case notes.
- A 'communication form' was completed that travelled with patients when they moved to a different settings such as hospices and the community, and contained details of diagnosis, preferred place of care, family involvement, medical information and other organisations involved.
- We found that HPCT contact with patients was clearly documented in the case notes. We also found good examples of decision making being clearly documented. Discussions with relatives were clearly documented, as were details of progress with fast-track and continuing care referrals.

# End of life care

- We reviewed eight 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms in patients' files and found that half of them had not been fully or correctly completed, for instance not countersigned by the nurse in charge, and signed by only one doctor. On one ward, the DNA CPR form simply stated the reason as 'medical futility'. On another ward, there was no consultant validation and no record of who the decision had been discussed with. We also found a form that was not signed by the nurse in charge and stated there had been no consultation with a family member, although the patient's medical records stated there had been a discussion with the son.
- The DNA CPR form, due to its misleading layout and poor completion, made it unclear whether it meant 'stop all treatment' or what level of intervention there was meant to be regarding fluids. Half the forms we reviewed had not been fully or appropriately completed, which led to confusion about the validity of forms that were not fit for purpose in the first place.
- Some do not attempt DNA CPR forms we reviewed on the medical wards were not fully or appropriately completed, with some signed as in the patient's best interest when the patient's capacity had either not been assessed or the patient had been assessed as having capacity. Reasons for the DNACPR were not always filled out.

### Assessing and responding to risk

- An HPCT CNS told us they managed patient risk through symptom control and tried to see new admissions within 24 hours. They also assessed all urgent requests for patients to go home at short notice.
- On one ward (Stratford Ward), the manager told us that dying patients were identified by the whole multidisciplinary team at daily board rounds; the whole team was expected to attend these meetings. We were told that this helped the team to involve the HPCT at an early stage. On a stroke ward, we found a that after a multidisciplinary team meeting discussion it had been noted on the file that if a patient was dying on the ward, to refer the patient to the HPCT for symptom control and move the patient to a side room.
- On another ward (Plashett, medical ward), we found a resource folder which was generic but included some end of life care resources such as syringe driver chart, information on initial assessment of the dying patient, and interim guidance on end of life care in last hours/ days of life, although it was unclear whether staff referred to these. We also found a patient receiving end of life care who had received good regular contact from an HPCT CNS to manage the patient's condition in conjunction with the ward staff. We noted five contacts in six days from the HPCT, who had arranged 'as required' drugs and liaised with community palliative care teams.

### Nursing staffing

- There were currently two full-time CNSs in post. One currently had two days a week study leave. The level of input with patients included giving advice, providing pain management, monitoring outcomes of advice given to wards, monitoring syringe driver use and building relationships with relatives. No patient dependency scores were measured. In 2013/14, 379 new patients were referred to the hospital palliative care team (HPCT).
- On the wards, nursing staff told us low staffing rates and fears of further nursing down-banding had created low morale and job insecurity. This had an effect on caring for patients receiving end of life care. The atmosphere at the hospital was positive despite the evident pressures on nurses of workload, increasing levels of stress and being expected to take on extra workloads.
- We heard from a number of sources that the limited number of nursing staff available to the HPCT had a detrimental effect on the hospital's ability to meet patients' end of life care needs. More recently, the CNSs had been asked to also work between two other sites within Barts Health, to cover sickness and staff shortages, which had placed further pressure on the nursing staff in the team.
- An experienced CNS was soon to retire, and there was no plan in place to compensate for this, adding to already pressurised staffing levels. The experienced CNS had an excellent reputation around the hospital. Comments from staff included "excellent nurse" and "brilliant resource". This will leave only a new band 6 nurse who had not been allowed to transition to band 7.
- We were also told there were not always enough ward nurses to meet patients' end of life care needs, and a high proportion of bank and agency staff were used.

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### Medical staffing

- There was 0.5 whole-time-equivalent consultant, with the time split between two doctors; one was the trust's lead for palliative care (0.3 whole-time-equivalent) and 0.2 was provided by a doctor normally based at a local hospice. The two would only meet on a Friday.
- Job plans for consultants were repeatedly requested but were not provided.

### Major incident awareness and training

- There were 12 mortuary spaces at the hospital with more available within the trust if needed (these had never been needed so far).

## Are end of life care services effective?

Inadequate

Pain was generally managed well for patients receiving end of life care. Ward staff felt well supported by the hospital palliative care team (HPCT) in meeting patients' pain-management needs. We found good examples of multidisciplinary working.

New end of life care planning documentation and guidance to replace the Liverpool Care Pathway had been written but not yet implemented across the whole of Newham University Hospital. There had been no assessment of the current needs for service provision against major national documents. The new draft end of life strategy, due to go to the board for approval in February 2015, did not reference any published practice guidance and demonstrated no detailed planning of how the recommendations laid down in these documents would be met through specific initiatives and service developments. Ward staff had not received any training in managing patients' end of life care needs or in care plans for dying patients.

Generally, the nutrition and hydration needs of dying patients were being well managed.

### Evidence based care and treatment

- There had been no assessment of the current needs for service provision against major national documents such as National Institute for Health and Care Excellence (NICE) guidance, the Neuberger report, the Leadership Alliance for the Care of Dying People (LACDP) report One Chance to Get it Right, the national Transform Programme or the National Care of the Dying Audit. The draft end of life strategy document did not demonstrate any detailed planning of how the recommendations laid down in the published guidance will be met through specific initiatives and service developments. The draft end of life strategy, due to go to the board for approval in February 2015, also did not reference any published practice guidance. We asked the trust's lead consultant and lead nurse for palliative care what were the sources for the draft strategy. They were unable to name any sources, and we were left believing that none had been used.
- We asked the trust's lead nurse and lead consultant for palliative care what progress had been made with withdrawing the Liverpool Care Pathway. We were told that a decision had been taken in August 2013, in conjunction with the trust's medical director, to withdraw the Liverpool Care Pathway immediately. We were told that the lead nurse for palliative care and hospital palliative care team (HPCT) had, over a number of months, disseminated information about the removal of the Liverpool Care Pathway and removed copies of the Liverpool Care Pathway guidance from wards. We found some Liverpool Care Pathway guidance still on the wards, and were also told that staff could still locate it on the intranet and print copies off. This was not good practice.
- A daily nursing care plan for the dying patient was being piloted on three wards at Newham University Hospital. It was planned for this to be known as the 'compassionate care plan'. Ward staff had not been trained in its use, and we found examples of it being partially completed.
- Newham University Hospital contributed to the National Care of the Dying Audit for Hospitals (NCDAH). It had not developed an action plan in relation to this.

### Nutrition and hydration

- HPCT clinical nurse specialists felt there was good speech and language team support for end of life care. There was also a nutrition team. The HPCT saw patients with these teams. We were also given examples of joint visits and working with dieticians. Patients' files demonstrated that end of life patients' hydration and nutrition needs were being managed.
- The hospital's National Care of the Dying Audit for Hospitals (NCDAH) score for reviewing patients' nutritional requirements was 67%. This was better than the England average of 41%.

# End of life care

- The hospital's NCDAH score for reviewing patients' hydration requirements was 87%. This was better than the England average of 50%.

### Pain relief

- The HPCT saw its role as prompting symptom management, which included pain management. The HPCT gave advice to ward staff in relation to managing patients at the end of life. The ward staff also contacted the HPCT for advice on the management of pain symptoms.
- Ward staff told us they felt able to call the HPCT for support with pain management. We were told the HPCT was prompt to respond and was accessible and approachable.
- There was a pain team on site, and HPCT CNSs worked with the team to monitor patients and provide advice to wards.
- The hospital scored 43% in the National Care of the Dying Audit for Hospitals (NCDAH) for 'as required' prescribed medication for the five key symptoms that might develop during the dying phase. This was worse than the England average of 51%.

### Patient outcomes

- Patient outcomes with respect to pain management was not measured. The HPCT had talked about plans to do a trust-wide patient outcome scale, but at the time of our inspection this was off the agenda.

### Competent staff

- We were told that the HPCT's access to study days was not a problem. One HPCT CNS was currently doing 'clinical evaluation for nurses', which was two days a week off site for eight weeks. Ward staff, however, had been told that if they did any study, it had to be in their own time, due to nursing staff pressures. Oncology new starters had study seminars in palliative care.
- There were plans for the HPCT to provide sessions for band 5 nurses, but these had not yet been organised. We were told that due to the new long-shift arrangements, there was now no time to carry out nurse training during handovers.
- We noted that nurses had not been trained in the new end of life care planning documentation.
- We found examples, such as on a medical ward (Plashett ward), where a generic resource folder included some end of life care resources, for instance a syringe driver chart, initial assessment of dying patient, and interim guidance on end of life care in the last hours/days. All nurses had syringe driver training.
- The hospital did not achieve its National Care of the Dying Audit for Hospitals (NCDAH) organisational indicator for access to specialist support for care in the last hours or days of life (score 1 out of 5).
- The hospital did not achieve its NCDAH organisational indicator for continuing education, training and audit (score 0 out of 20).

### Multidisciplinary working

- The HPCT had links with a local hospice that was also the base for three boroughs' community palliative care teams. The HPCT took part in a six-monthly East London multi-professional audit group, run by a local hospice, whose function was to bring palliative care teams together to hear about audit and improvement, experiences, teaching and sharing-experience sessions.
- Within Newham University Hospital, we encountered good multidisciplinary working between the wards, the HPCT and specialist teams such as dieticians, nutritionists and the pain-management team.

### Seven day services

- No seven-day services were available from the HPCT, and there were no plans at the time of our inspection, because of the lack of staff resources. Outside weekday hours, there was a consultant-on-call system. Ward teams were aware of the consultant-on-call system and how to access it via the hospital switchboard.

### Access to information

- The HPCT kept all its records of contact with patients in ward files, along with any assessments it had completed, for ease of access by ward teams. On some wards such as the hyper-acute stroke unit, medical notes were held electronically on computers. Staff told us it took several attempts to access these, because of the slow running of the software.
- The HPCT lead nurse told us a generic 'communication form' was in use across north-east London. This form gave details of the specialist input by palliative care teams, and was sent to district nurses, GPs and community support services on patients' discharge.

# End of life care

- The hospital achieved its National Care of the Dying Audit for Hospitals (NCDAH) organisational indicator for access to information relating to death and dying (score 5 out of 5).

### Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Members of the hospital palliative care team (HPCT) told us they thought the hospital was good at taking a multidisciplinary approach to capacity issues, and that the advocacy service at the hospital was good. However, the HPCT was now asked to access advocacy by telephone. We were also told that the lead chaplain for the trust was a good source of information, because they had a solid understanding of aspects of Muslim's best interest issues, especially around eating and drinking up to death.
- The HPCT told us it had not had much input to Deprivation of Liberty Safeguards (DoLS) cases at Newham University Hospital. We did not come across any DoLS issues with end of life patients, either.
- The HPCT always sought consent from patients in order to work with them. Team members themselves often asked the patient for consent, because this ensured it was sought sensitively. HPCT nurses would work on capacity issues with ward teams as they arose. We were given some examples of recent work around capacity issues undertaken with patients receiving end of life care, which included working with learning disability and dementia. The HPCT clinical nurse specialists (CNSs) told us they also worked in conjunction with the hospital's dementia team and learning disability team, as well as an independent mental capacity advocate (IMCA), when it was appropriate for them to be involved.
- Some patients receiving end of life care had been identified as not for resuscitation – that is, 'do not attempt cardio-pulmonary resuscitation' (DNA CPR). They had the appropriate form in their file so that staff were aware of what action to take if their cardiac or respiratory function ceased.
- We had concerns regarding the adequacy of the trust's new DNA CPR form, which was not influenced by the June 2014 court ruling or the British Medical Association (BMA)/Resuscitation Council guidelines from October 2014. The form did not acknowledge the legal duty to consult the patient, where they had capacity, before imposing a DNA CPR order. There was no reference to the need for an assessment of capacity. The form also included a 'limitation of treatment' section, where decisions on treatments that were potentially life-prolonging, such as fluids and intravenous antibiotics – decisions that needed to be made individually – had been combined/conflated with DNA CPR; this could lead to confusion about what had actually been decided or agreed. We fed these concerns back to the chief executive and medical director during our inspection.

## Are end of life care services caring?

Good

Conversations involving families and friends, in which they were updated on a patient's progress and decisions such as preferred place of care, routinely took place. Chaplaincy and bereavement services demonstrated a caring and compassionate approach to working with people. Relatives found, and we observed staff to be, very helpful, caring and compassionate. We also found that relatives were included in their loved one's care.

### Compassionate

- A full-time imam coordinated chaplaincy services across both The Royal London Hospital and Newham University Hospital sites. Both bereavement officers spoke very highly of the imam, as did the HPCT CNSs. People thought that the imam supported his teams well, which instilled a culture of caring.
- On the stroke ward, we found a good example of how caring staff had been in looking after a patient receiving end of life care. The patient had been kept very comfortable and well positioned.
- We spoke to the relative of one patient receiving end of life care, who told us they found the staff "compassionate in comparison to other hospitals" and also kind, helpful, caring and patient.
- On the orthopaedic ward, we found the notes of one patient, which demonstrated the very caring side of the HPCT, in that team members were checking that the patient was comfortable, and they were explaining treatment to the family and offering emotional support.
- On another ward, we found an example of a patient receiving end of life care who was kept comfortable, with symptoms well controlled. Mouth care, pressure care and positioning all demonstrated that the ward

and the HPCT offered a caring service. A ward band 5 nurse discussed very passionately how they wanted to make sure end of life care was given as well as possible for their patients.
- The hospital did not achieve its National Care of the Dying Audit in Hospitals (NCDAH) organisational key performance indicator for clinical provision/protocols promoting patient privacy, dignity and respect, up to and including the death of the patient (score 5 out of 9).

### Patient understanding and involvement of those close to them

- The HPCT saw part of its role as engaging with patients and relatives and updating them on the progress of treatments and any discharge plans. Understanding the patient's preferred place of care was seen as central to this.
- On a stroke ward, we found an example where the HPCT clinical nurse specialist (CNS) had made contact with the patient five times in six days, maintained contact with the family and ascertained the preferred place of care. We also found an example where the grandson of one patient told us that his mother and aunts had discussed the plan of care for their relative with nurses.
- We spoke to the relative of one patient receiving end of life care, who told us they found the staff always willing to help and explain things.
- The bereavement coordinator met relatives after a death to talk through aspects of the next steps, and provided information to relatives on this.
- The hospital scored 72% in the NCDAH for the indicator for health professionals' discussions with both a patient and their relatives or friends about their awareness that the patient was dying. This was better than the England average.
- The hospital failed to achieve its National Care of the Dying Audit in Hospitals (NCDAH) organisational indicator for a formal feedback process regarding bereaved relatives' or friends' views of care delivery (score 1 out of 4).

### Emotional support

- The HPCT offered emotional support to patients and their relatives. This was confirmed through conversations we had with relatives and through what had been documented in patients' notes. The support the HPCT offered included speaking to people sensitively about the progress of treatment.
- The hospital's score in the National Care of the Dying Audit in Hospitals (NCDAH) for assessment of the spiritual needs of a patient and their nominated relatives or friends was 25%. This was worse than the England average of 37%.
- The HPCT thought that the 0.5 whole-time-equivalent social-work post was a good resource to help provide patients with emotional support.

## Are end of life care services responsive?

Good

The HPCT had a flexible referral process. Ward staff told us that the HPCT responded promptly to referrals, usually on the same day. Patients' individual needs were being met by ward staff and HPCT staff.

There was open access for relatives visiting patients who were dying, and preferential car parking rates for those spending long periods visiting. However, access to side rooms was limited. Facilities to meet the multi-faith needs of people were adequate; however, it was reported to us that chaplaincy was under-resourced, and the chaplaincy staff told us they felt like the chaplaincy was an underused resource. Bereavement services were well organised and responsive to people's needs.

### Service planning and delivery to meet the needs of local people

- The role of a bereavement coordinator CNS within the trust was to work alongside mortuary services, the chaplaincy, the coroner's office and the registrars to see that arrangements were in place after a death. They were also responsible for providing information to relatives, providing booklets around services available at the hospital and coordinating arrangements to view the deceased person's body. The bereavement coordinator CNS gave information packs to families when they came to collect the death certificate. The CNS told us that their main tasks were to get the bereavement policy implemented and chair the trust's bereavement committee. The CNS told us that they also had a link with families and carers to help answer questions in relation to their relative's last days of life, and helped families through the grieving process.

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### Meeting people's individual needs

- The HPCT was responsible for meeting the individual end of life care needs of patients by prioritising and managing a workload. Once a particular HPCT clinical nurse specialist (CNS) had seen a patient, they would invariably continue with this patient, for the continuity of the relationship. Recently, there had been a lot of working between multiple sites within the trust to cover sickness and staff shortages, sometimes at short notice. This had implications for meeting patients' individual needs and for continuity of care. A variety of people from within the HPCT thought that the service could not cope with senior CNSs being moved around sites.
- Ward staff told us there was easy access to interpreters, who were available face to face or over the phone. Face-to-face interpreters were available the same day or next day. We found one example where a ward sister told us that the family of one patient receiving end of life care tended to stay often and would translate. In one set of notes, we found that a translator for a mandarin speaker had attended a ward round.
- We generally found that families had been included in the planning and delivery of care for dying patients. Ward teams were aware of the need to address family issues. Junior doctors told us they often spoke with families. We found appropriate discussions with families documented in patients' notes. HPCT members also did a lot of liaising with families, and ward staff told us they felt well supported by the HPCT nurses when dealing with complex family issues.
- On a stroke ward, we found an example where one patient had their individual needs met through regular contact from a HPCT CNS in conjunction with the ward staff. The HPCT had made five contacts with the patient in six days, maintained contact with the family, ascertained the preferred place of care, arranged medications and liaised with community palliative care teams.
- We also found an example where a multidisciplinary meeting discussion noted on file the preferred place of care for one patient receiving end of life care, and to arrange a care package/continuing care for them. It noted to refer to the HPCT for symptom control and move the patient to side room.
- On one ward, a stroke ward, we found a patient receiving end of life care being well cared for. The patient was very comfortable and well positioned.
- Ward staff told us they provided a bereavement leaflet to bereaved relatives on the ward. Ward staff thought that porters and the bereavement office provided them with good support when patients died. They also felt able to accommodate requests for burial within 24 hours whenever needed.
- Ward staff told us there was easy access to interpreters, who were available face to face or over the phone. We found one example where translation was needed for a patient and this was provided by a member of the family.
- The chaplaincy team members spoke about the chaplaincy being underused and no longer having a place at the trust induction for staff.
- Newham University Hospital had 12 mortuary spaces, with more available within the trust if needed. Additional spaces had never been needed so far. Bins of 'product' had been moved since our previous inspection, and arrangements were in place to have these removed regularly by a contractor. However, there was still an odour in the mortuary. The mortuary fridges were old, and we were told that the odour might be because the seals needed replacing; however, we did not get a copy of the daily fridge temperature records. The smell did not permeate into the viewing area or the quiet spaces.
- The passage to the viewing area gave privacy to relatives, because it was directly off the main corridor. The entrance, however, was directly opposite the coffee shop. For the purposes of maintaining people's dignity, and to restrict the view of the entrance, frosted and patterned glass had been placed on the large windows of the coffee shop.
- Due to the layout of Newham University Hospital, deceased people's bodies had to be transferred to the mortuary via the main hospital corridor, and in front of the public. In order to appropriately manage this, porters had been trained to move deceased people's bodies with dignity in public areas, in concealed trolleys.
- There was a quiet space for bereaved relatives to sit next to the mortuary viewing area. This was a pleasant space to sit in and contained information for the bereaved. It offered a peaceful space and had been planned with sensitivity.
- The cost of car parking was reduced for families and friends visiting patients receiving end of life care at the hospital for prolonged periods: £7.50 a week for two cars, instead of £7.50 a day for one. To be eligible for this

discount, people had to complete a form that was available on the wards. HPCT nurses saw their role as bringing this form to people's attention and reminding wards to do the same. We spoke to the grandson of one patient, who told us that at weekends and peak times car parking space was a problem.

- The HPCT also advocated for patients receiving end of life care to be moved to side rooms for privacy and dignity. We were told that access to side rooms for end of life patients could be an issue, because caring for infected patients took priority. The newer medical wards had better access to side rooms. For instance, on Stratford Ward, the manager told us it was not always possible to accommodate patients in side rooms; however, relatives could stay overnight if the patient was in a side room. There was no private/day room in which to have sensitive conversations best held in private, so the nurses' office was used.
- Wards were encouraged to include families who were visiting for prolonged periods in tea rounds, of which there were four a day. Ward staff had access to kitchens to which visitors did not, so visitors relied on ward staff making them drinks outside of tea rounds. HPCT CNSs told us they encouraged wards to give drinks to visitors. No food preparation facilities were available to visitors, but the hospital canteen offered three meals a day.
- No specific sleeping facilities were available on the wards for visitors. There were, however, comfortable chairs available, and HPCT CNSs told us they made sure visitors were comfortable and had enough suitable chairs in the room to allow them to sleep if necessary.
- Chaplains visited wards across the hospital to link up with people. However, chaplains we spoke with did not think their service was well utilised by wards and medical staff, and did not think their profile was as high as it could be, because ward staff did not generally refer people to them. This left chaplains feeling they could be providing a better service to people.
- The HPCT told us that the chaplaincy did "sweeps" of the wards, and that chaplains in the borough provided an on-call service out of hours. It was generally felt that the head chaplain provided a good service to his congregation, arranging death certificates out of hours and within 24 hours, which was culturally important.
- HPCT staff thought there was a gap in the level of input from Christian chaplaincy. A trainee Christian chaplain covered the whole of Newham University Hospital four days a week, which the HPCT felt was not adequate to meet the needs of the people. The hospital also had some links to Russian Orthodox chaplaincy, but this resource was somewhat limited.
- There were two quiet multi-faith rooms. The room in the main hospital looked tired, faded and old, and was in need of refurbishment. The other, at the Gateway Surgical Centre, was a lovely, bright, well-maintained space. Information was available in both rooms on multi-faith chaplaincy services.

### Access and flow

- On one ward (on Plashett Ward, a medical ward) staff told us that the HPCT responded to referrals promptly: usually they would visit the same day.
- We found an example (on Plashett Ward, a medical ward) where a discharge had been slowed down after preferred place of care had been decided, referrals had been made and discharge had been planned. This was due to the patient being formally transferred to another hospital within the trust for some treatment; the patient had to take medicines for the intra-trust transfer but later returned to the ward.
- The HPCT told us that Newham University Hospital had a discharge team. However, the team did not do fast-track discharges, which were formally the ward staff's responsibility; however, ward staff often did not have the time to do this. The HPCT assisted and supported the discharge process.
- The HPCT felt well supported by the continuing care team at the local authority, who would process referrals for an assessment within a few hours. However, assessments for nursing home placements were not processed as fast continuing care assessment.
- There was a social worker post which was employed through social services and commissioned fast track care packages.

### Learning from complaints and concerns

- We were told that the HPCT had not had to respond to a complaint in between 18 months and two years. It did, however, respond to relatives' concerns on a daily basis.
- There was no way to extract complaints that related to end of life care from hospital data in order to improve learning. The HPCT lead nurse told us there were plans to address this through the end of life care board.

## Are end of life care services well-led?

# End of life care

Inadequate

An end of life care strategy had only just been drafted and, at the time of our inspection, had not been ratified by the board. The draft strategy outlined action on a number of things that could only be described as remedial, due to the trust still working to implement a number of issues, such as replacing the Liverpool Care Pathway, providing staff with training in end of life care, and identifying a non-executive director to provide a board lead for this area. End of life care appeared to have been overlooked within the clinical academic group (CAG) structure and become a forgotten service. There was a lack of direction and a lack of leadership.

## Vision and strategy for this service

- The draft end of life care strategy was due to go to the board for approval on 4 February 2015. The executive summary stated that the strategy needed to be redefined following the cessation of the Liverpool Care Pathway. Implementing the compassionate care plan for the dying, including end of life care in mandatory training, and identifying a non-executive director to provide a board link were key to the strategy; however, none of these were currently in place.
- The medical director and associate medical director with responsibility for end of life care spoke to us about their vision for the service. They spoke about developing a strategy group and trying to build up collaboration with local commissioners and local hospices using the Gold Standards Framework, and developing care planning, metrics and 'Coordinate my Care'. Coordinate My Care is a clinical service sharing information between healthcare providers, coordinating care, and recording patients' wishes for how they would like to be cared for. Coordinate My Care had been running for some years in London. Money was available to develop the software and for a huge pan-London initiative including training and support staff to set it up. It was not clear why the trust had taken so long to use the service.
- We were told that the nursing care plan for the dying patient would be launched one month after the strategy had gone to the board; however, there were no clear plans of how this was to be achieved within the strategy we were shown.
- The medical director had handed over the chair of the end of life strategy group to the associate medical director who had an interest in palliative care. The end of life strategy group was working with four different commissioning groups across the structure of Barts Health to develop a single strategy, but had found it a challenge to agree priorities.

## Governance, risk management and quality measurement

- No end of life care audits were carried out, because no strategy or resources were available to support this.
- A Commissioning for Quality and Innovation (CQUIN) payment framework, worth £300,000, was planned for benchmarking and developing a dashboard to include a notes audit recording numbers of deaths and a do not attempt cardio-pulmonary resuscitation (DNA CPR) audit, and measuring length of stay in hospital. The medical director and associate medical director told us about this CQUIN, but the trust's nursing and medical leads did not appear to be aware of it when asked whether there were any relevant CQUINs.
- The bereavement coordinator chaired the trust's bereavement committee, which met monthly and included chaplaincy and mortuary staff.
- There was not a meeting for joint hospital and community palliative care leads, but we were told that lots of contact took place at clinician to clinician level.
- The trust wide specialist palliative care business meeting occurred approximately every two months with the general manager and clinical director for haematology oncology and palliative care. It had no executive representation. But the end of life care group is chaired by the associate medical director with responsibility of end of life.
- No action plan was developed as a result of the National Care of the Dying Audit in Hospitals (NCDAH).

## Leadership

- The medical director handed over the chair of the end of life strategy group to the associate medical director, who was able to spend more time on this. We were told the group had lost some momentum due to staff sickness, but was now on track. However, the associate medical director was about to leave and a replacement had not been identified. No non-executive member of the trust's board attended this strategy group.

# End of life care

- Leadership of the service was unclear. The lead nurse for palliative care in the trust attended meetings but was not otherwise present because of the broad workload of other duties within the cancer and surgery clinical academic group (CAG).
- The trust's nursing and medical leads gave the impression that governance of and accountability for end of life care had to be fed up through the convoluted and unwieldy CAG structure. Because end of life care was such a small part of the business of the hospital – even of the cancer services – the trust's nursing and medical leads thought it got lost in the trust's management system.
- We were told that, on the ground, the HPCT did a good job, but that higher up within the trust, palliative care and end of life care was paid "lip service", for instance when it came to resources and strategy. We asked the trust's lead nurse for palliative care about the business-planning processes and were told the CAG prioritised other bids over end of life care. The lack of importance placed on replacing the Liverpool Care Pathway was given as another example.
- Palliative care and end of life care were not identified clearly on the organisational chart and appeared to have been 'lost' within the organisational structure. The trust's lead nurse for palliative care also held a large management portfolio that encompassed oncology and other duties. One member of the HPCT referred to the lead nurse for palliative care as the "oncology lead", and the lead nurse's input into the HPCT was described to us as "low".
- Chaplaincy services were well-led in that they were thought-out and organised. Lead chaplains had regular three-monthly meetings with the chief nurse to discuss chaplaincy issues and staff issues across the trust.
- Chaplaincy services across both The Royal London Hospital and Newham University Hospital sites were coordinated by a full-time imam. Both bereavement officers spoke very highly of the imam, as did the HPCT clinical nurse specialists (CNSs). People thought the imam supported his teams well, which instilled a culture of caring.

### Culture within the service

- The medical director and associate medical director told us that it was "noticeable the strain the trust is under". They told us there was a huge need for education and staff support. We were told of fewer and fewer opportunities for and less interest in training and implementation of new initiatives in end of life care.
- Staff across the hospital told us that morale was low within palliative care and more broadly across the trust. We were told there was uncertainty about job security.
- Staff felt that, as a team, the HPCT remained open and cohesive, despite all the challenges it faced, but that palliative care in the trust had become fragmented. If one acute hospital within the Barts Health structure had difficulty delivering on its end of life care commitments, or its quality of care more generally was challenged, it could now easily have an impact on the other hospitals in the trust. It was hard to see what action came from strategy meetings, and the service was struggling to sort out matters such as staffing. Staffing represented a real challenge, leaving no time to address other things. However, patients took priority for the HPCT .
- The medical director and associate medical director with responsibility for end of life care said the priorities were the face-to-face availability of specialist nurses and education in end of life care. Services were overstretched, and HPCT staff felt unable to give what was needed because of this. They felt quality was compromised and that end of life care needs within the hospital were not met.

### Public and staff engagement

- The HPCT did not carry out any public or staff engagement initiatives. This was put down to low staffing levels. Dealing with patients had become the team's priority.
- The bereavement officer gave out information packs to families when they came in to pick up death certificates The packs also contained a bereavement questionnaire. The bereavement coordinator was compiling the outcomes for 2014 at the time of our inspection. These were being broken down by hospital. Relatives graded the care they experienced from 'excellent' to 'very poor'. There were 42 respondents trust wide, with only one from Newham University Hospital. The process relied on families feeling able to respond soon after bereavement and hospital bereavement offices giving out the information packs post bereavement.

# Outpatients and diagnostic imaging

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

## Information about the service

Barts Health NHS Trust provided outpatient services of approximately 1.4 million attendances for first and follow-up appointments over 2013/14. Approximately 281,300 of these appointments were seen at the Newham University Hospital site. Most clinics at Newham University Hospital are provided from the health centre (the hospital's main outpatient clinic area), West Wing, the children's outpatients department and the newly built Gateway Surgical Centre. The outpatient department caters for a number of different specialties; clinics include breast, fracture, ear, nose and throat, ophthalmology, general medicine, cardiology, oncology, gastroenterology, general surgery and other clinics.

During our inspection, we visited the outpatients and diagnostic imaging department and spoke with 15 members of staff including nurses, healthcare assistants, receptionists, the head of operations and medical staff. We spoke with 42 patients and relatives attending the hospital for a variety of outpatients and diagnostic imaging procedures.

Before the inspection, we reviewed information about the trust's performance, sent to us by the trust, and information from the listening event. We observed interactions between patients and staff and inspected the environment where services were provided.

## Summary of findings

Many patients complained about the waiting times in the outpatient clinics. They said they had very little information and staff were not always open with them about waiting times.

There was a lack of shared objectives and strategy to achieve an improved outpatient service. Local managers were not well supported by the trust-wide senior managers and there were no clear lines of accountability. Not all staff were aware of the electronic incident-reporting process.

Medicines were stored and administered safely. The department held its own training records, which were up to date and demonstrated that most staff had attended mandatory training.

All the patients we spoke with told us they had been treated with dignity and their privacy had been respected and protected. Patients found staff polite, supportive and caring. They spoke highly of the staff in the outpatients and diagnostic imaging department.

Patients were appropriately asked for their consent to procedures. Medical records were available on most occasions for patients' clinic appointments. Translation services were available for people who did not speak English.

# Outpatients and diagnostic imaging

## Are outpatient and diagnostic imaging services safe?

Good

We found that the environment was safe and the required safety checks were being completed and recorded. The outpatient waiting areas and clinic rooms were clean; however, no cleaning rotas were available to show when the department/area was last cleaned. There were no hand gel dispensers on entrances to the outpatient department.

Although the clinics were busy, nursing staff provided good and safe care to patients. Treatment records were informative and showed a clear pathway of the care and treatment patients received at the hospital.

Some staff stated that they reported incidents through the electronic incident-reporting system called DATIX. Feedback from these incidents was not always given to staff in order that services could improve.

### Incidents

- The trust had an electronic incident-reporting system (DATIX) in place. Not all members of staff we spoke with had access to the electronic system. Some staff said that they could access the system and understood their responsibilities with regard to incident reporting. However, some staff told us they did not report incidents, because they did not have time. Agency staff were not able to report incidents, because they did not have access to Newham University Hospital's computer system.
- Three serious incidents had been reported in the outpatient department in 2013/14, but no Never Events.
- Staff we spoke with in the diagnostic imaging department understood their responsibility to raise concerns and record safety incidents, and they understood the process for doing this. All diagnostic imaging department staff confirmed that they were trained in the use of the DATIX incident-reporting system.
- There were differences in whether staff received feedback after reporting incidents. Some staff said they received prompt feedback and guidance relating to reported incidents. However, others told us they had completed incident forms and received no feedback.

### Cleanliness, infection control and hygiene

- Mandatory training records showed that not all staff had received infection prevention and control training within the last year. However, staff we spoke with demonstrated knowledge and understanding of the importance of cleanliness and control of infection.
- The environment was visibly clean. Nursing staff told us that they cleaned the clinic rooms at the start of a clinic and changed couch rolls after each patient.
- Staff were aware of infection-control processes such as the use of personal protective equipment and hand hygiene. Staff observed the hand hygiene and 'bare below the elbows' policies of the hospital. However, hand gel sanitisers were not readily available at the outpatient clinic.
- We saw that equipment that had been cleaned had a green label to indicate that it was clean; this system made the date when equipment had been cleaned clear for staff to see.

### Environment and equipment

- Equipment was maintained, checked regularly and given a portable appliance test (PAT) in line with the trust's policy. Labels on equipment stated when the equipment was last checked. All equipment we saw had been checked within the last year.
- Resuscitation equipment was available for use throughout the outpatients department. Other equipment was visibly clean, regularly checked and ready for use.
- The outpatient department at the Gateway Surgical Centre was a purpose-built department with its own dedicated main entrance.

### Medicines

- Staff we spoke with were aware of medicines management policies for reference purposes. Medicines administration records we checked were completed appropriately.
- Medicines were stored in locked cupboards in the outpatients department. Nursing staff ordered all medicines through the hospital pharmacy. Two nurses checked controlled drugs taken from the locked medicines cupboards for administration. A lockable medicines fridge was in place, and daily temperature checks were recorded.

# Outpatients and diagnostic imaging

- We found that controlled drugs and fridge temperatures were regularly checked by staff working in the outpatients and diagnostic imaging department. The nurse in charge carried the keys to the controlled drugs cupboard at all times.

## Records

- Staff told us that medical notes were provided efficiently and were appropriately tracked and prepared for clinics.
- Medical records storage was outsourced to a third-party company. We saw there was secure storage for medical records in the department awaiting collection by the outsourced company.
- Staff told us it was unusual for them not to have medical records available when patients were in clinic for their appointments. However, Newham University Hospital had not carried out medical records audits within the outpatient department to assess whether medical records were always available for clinics.
- Patients we spoke with confirmed that they experienced no problems with their medical records not being available for clinics. Staff confirmed that in the event of medical records not being available, temporary record were created with information available electronically on the computers; these arrangements ensured that patients were always seen, even if their medical records were not available.

## Safeguarding

- Staff told us they had received training in safeguarding. We saw evidence of training undertaken by staff for level 1 safeguarding.
- Staff demonstrated knowledge and understanding of safeguarding and of the trust's process for reporting concerns. They understood their role in protecting children and vulnerable adults.

## Mandatory training

- The completion of mandatory training varied between different departments, but completion rates were all above 90%. Staff knew how their training was monitored and confirmed that managers reminded them when training was overdue and needed to be completed.
- We saw examples of staff training records showing completed training. We also saw examples of the monitoring that showed that staff had undertaken all mandatory training, such as health and safety, infection prevention and control, moving and handling, safeguarding and basic life support.

## Assessing and responding to patient risk

- The hospital had systems and processes in place for responding to patient risk.
- Staff were not present in all the waiting areas for clinics. For example, no staff were manning the 'sub-waits' (mini reception areas), so they would not notice patients who appeared unwell and needed assistance.
- In the diagnostic imaging department, staff we spoke with knew who their radiation protection advisor and radiation protection supervisor were for their clinical area. Staff explained how they would report any concerns about safety to their line manager. We saw local rules and copies of the Ionising Radiation (Medical Exposure) Regulations 2000 in place.
- Staff we spoke with demonstrated knowledge and understanding of patient risk, particularly for people living with dementia or learning disability, and elderly or frail patients with more than one medical condition.

## Nursing staffing

- A mix of registered nurses and healthcare assistants staffed the outpatient department. Registered nurses and healthcare assistants generally ran the clinics. Some staff told us that some clinics could be very busy and understaffed.
- There had been staffing shortages due to long-term sickness and compassionate leave. These shifts were either being covered by internal staff from different locations, or by bank or agency staff.
- Nursing staff told us that although they were busy, they thought they provided good and safe patient care. They thought that staffing was generally insufficient. The outpatients department relied on bank and agency staff to cover staffing shortages. Staff also said that staff vacancies sometimes went unfilled.
- We were told when staff were absent, an escalation process was triggered that enabled other staff to be reallocated. However, this was not always effective, and sometimes staff could not be found to cover the shortages.

## Medical staffing

- Medical staffing was provided by the relevant specialty running the clinics in the outpatient department. Medical staff were of mixed grades, from consultants to junior doctors. There was always a consultant to oversee the clinics, and junior doctors felt supported by the consultants.

# Outpatients and diagnostic imaging

- Doctors we spoke with thought they had a good relationship with outpatient nursing and clerical staff. They said they felt well supported and could discuss issues with them.

### Major incident awareness and training

- Information was in place about major incident preparedness at the outpatients and diagnostic imaging department. The trust's plan for managing major incidents included utilising parts of the outpatient treatment area of the clinic.
- Staff we spoke with were aware of the procedure for managing major incidents such as winter pressure and fire safety incidents. Senior staff had completed major incident training and were able to describe the outpatient's department role in the event of a major incident.
- Business continuity plans were in place to maintain the delivery of services in the event of a major incident.

## Are outpatient and diagnostic imaging services effective?

We observed patients received effective care and treatment. Patients were provided with sufficient information about their treatments and had the opportunity to discuss any concerns.

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

### Evidence-based care and treatment

- National Institute for Health and Care Excellence (NICE) guidance and the trust's treatment protocols and guidelines were available on the trust's intranet. Staff told us that guidance was easy to access and was comprehensive and clear.
- We saw that the outpatients department was operating to NICE guidance and local protocols and procedures. Staff we spoke with were aware of how this guidance had an impact on the care they delivered.
- The trust adhered to NICE guidelines for the treatment of patients. We were told that the clinical academic group (CAG) had an effective process to monitor the implementation of NICE guidelines at Newham University Hospital.
- We noted that NICE guidelines were in use in most clinics. Staff we spoke with described how they ensured that the care they provided was in line with best practice and national guidance. Adherence with NICE guidelines was monitored by the relevant directorates' clinical governance committees.
- Nursing staff told us how new practice guidance were cascaded through the specialist areas they were working in.
- A morning meeting was held every day for outpatient staff, and any new guidance or procedures were highlighted during these meetings.
- We observed the outpatients department had several specialty clinics such as cardiology and breast surgery.

### Pain relief

- Patients at the outpatients department had access to pain relief when it was needed. Patients reported that their pain was well managed, monitored and recorded to ensure they received the appropriate amount of pain relief when in clinic.

### Patient outcomes

- We observed that none of the clinics had any safety performance improvement data displayed about the performance of the outpatients department.
- Information we received before the inspection indicated that the trust had a high ratio of follow-up patients to new patients.
- Newham University Hospital did not have dermatology clinic on site; this meant patients were always referred to other hospitals within the trust for dermatological treatment.

### Competent staff

- Specialist clinics, including pain, heart failure and breast clinics, were run by a clinical nurse specialist. Nurse protocols and competencies were in place for staff working in the outpatients department. Nursing staff we spoke with were positive about the training they had been supported to complete.

# Outpatients and diagnostic imaging

- Patients who attended outpatient clinics and the diagnostic and imaging department were very positive about the nursing staff and the care and treatment they had been given.
- In the diagnostic imaging department, protocols, policies and procedures for the use of equipment were in place, and these acted as a reference manual for staff. All staff underwent local training in the use of all equipment in the diagnostic imaging department.
- All staff we spoke with confirmed they received annual appraisals from their line manager. However, we did not receive records of staff appraisal to confirm whether all staff had received their appraisals. While some staff said they had formal supervision meetings with their managers, most staff we spoke with did not. The staff we spoke with were not aware of a process that required staff to have regular formal supervision meetings with their line manager. Nevertheless, all staff we spoke with told us they were well supported by colleagues and by their managers.

### Multidisciplinary working

- There was evidence of multidisciplinary working in the outpatients department. We were told about a number of examples of where joint clinics were provided.
- Specialist nurses ran clinics for some specialties, such as a pain clinic, breast clinic, heart failure clinic and diabetic clinic, among others. We spoke with some of the specialist nurses, who described how their clinics fitted into patient treatment pathways.
- We saw that patients were regularly referred to community-based services such as community nursing services and GP services.
- Nursing staff and healthcare assistants we spoke with in clinics such as orthopaedic and gynaecology clinics told us that teamwork and multidisciplinary working were effective and professional.

### Seven-day services

- The outpatient department ran from Monday to Friday, from 8.30am to 5pm. There were no evening or weekend clinics.
- The diagnostic and imaging department offered seven-days-a-week services for patients who attended the emergency department.

### Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients we spoke with said that they completed consent forms before their treatment, when this had been appropriate. We were told that clinicians asked for consent before commencing any examination and explained the procedure that was to take place. Staff undertaking procedures were aware of the need to obtain patients' consent and completed appropriate consent documentation.
- We saw evidence from staff training records that clinical staff had completed training on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff we spoke with confirmed they had completed training and undertaken regular updates.

## Are outpatient and diagnostic imaging services caring?

Good

We found that the outpatient and diagnostic imaging services at Newham University Hospital were focused on the patients. We observed staff interacting with patients in a caring and friendly manner. Patients told us they felt their privacy and dignity were respected.

Patients told us they felt involved in their care and treatment, and they thought that staff supported them in making difficult decisions. Patients told us they were given sufficient information about their care and treatment and were fully involved in making any decisions about their care and treatment at Newham University Hospital. We found that treatment was provided in a caring and compassionate manner. We observed throughout the outpatients department that staff treated patients, relatives and visitors in a respectful manner. All the patients we spoke with told us the staff were caring and polite.

Patients we spoke with were satisfied with the services provided and stated that doctors and nurses had time to discuss with them their care and treatment.

We observed staff interacting with patients in a respectful and attentive manner. Staff knew how to maintain patients' privacy and dignity – we observed staff ensuring that patients' privacy and dignity were maintained during their

time at the outpatients department. Feedback from patients was very positive about the services at the Newham University Hospital outpatient department. They told us this was always done in a way that they understood.

### Compassionate care

- Throughout our inspection, we observed patients being treated with dignity and respect. We saw staff spending time with patients, and explaining care pathways and treatment plans to them. We noticed that staff sat next to patients and spoke with them in a friendly and respectful manner.
- Patients we spoke with were positive about the clinics and the staff they were seeing; they told us they were satisfied with the professional approach of the staff.
- Staff listened to patients and responded positively to their questions and requests for information. We observed staff assisting patients around different outpatient areas, guiding them to the appropriate clinic. Staff approached patients rather than waiting for patients to request assistance, asking them if they needed assistance.
- We observed nurses, healthcare assistants and receptionist staff interacting in a positive and caring manner with patients. We saw that enquiries made at the reception desks were responded to in a polite and helpful manner. We saw patients being redirected to other clinic locations in a clear and reassuring manner.

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

- Most of the patients we spoke with told us they felt involved in their care and were fully consulted about their treatment options. They told us they were given sufficient information to help them make any decisions they needed to make.
- Staff told us that treatment options were clearly explained to patients and their consent to treatment was sought.
- Patients told us how they were able to ask questions during their consultations and also by speaking with nursing staff running the clinics. We were told that the nursing staff were patient and listened to the concerns raised. Most patients we spoke with told us staff had explained their care and treatment to them, and thought that staff were friendly and polite.
- The Friends and Family test was carried at the outpatient department in October 2014. The total number of respondents was 44. Sixteen respondents said they were extremely likely to recommend the hospital, 22 said they were likely, three were neutral and two respondents said no, they would not recommend the hospital to their friends and family.
- Patients told us their doctors had explained their diagnosis, and they were aware of what was happening with their care and treatment. None of the patients we spoke with had any concerns about how staff had spoken to them. All the patients we spoke with were very complimentary about the way in which staff had dealt with them.

### Emotional support

- Staff explained how they would ensure that patients were in a suitably private room before breaking bad news or discussing any distressing news with them. We were told that it was always possible to find a suitable room for these conversations.
- Patients we spoke with were positive about the support they received from staff throughout the outpatient department.
- Macmillan staff provided emotional support to cancer patients and their families.
- The staff we spoke with were sensitive to patients who required emotional support while attending the outpatient department, and knew of the areas within the hospital where that support might be provided.
- Staff were observed to be sensitive to the needs of patients who were anxious or distressed about their procedure at the imaging department. Staff worked hard to allay patients' fears and anxieties about proposed procedures, and they explained the procedure carefully and stayed with the patient to provide support.

## Are outpatient and diagnostic imaging services responsive?

Requires improvement

The outpatient service was not responsive to patients' individual needs. Overall, patients were not seen within the national waiting time target for waiting to be seen in a clinic, and we observed consistent delays in patients being seen at their appointed time throughout the two days we

were onsite at the hospital. Delays in clinics were not always explained to patients. The information board displaying wait times was not prominently displayed where all patients would see it.

The trust had higher than the national average cancellation rates for appointments, both by patients and the hospital. Action was being taken to improve these rates. We found that the trust had implemented changes to respond to increased demand in some clinic services. Changes included coordinated action by the booking centre, the various clinics' specialties and the management teams of the different divisions to reduce the referral-to-treatment times.

Plenty of written information was available to patients; however, this information was only in English, and the hospital does have a very diverse population, who speak many different languages. There were however, arrangements to have relevant information translated if necessary. Limited poster information was displayed in the reception areas and consulting rooms.

### Service planning and delivery to meet the needs of local people

- Patients told us they were allocated enough time with the doctors when they attended their appointments, and that their appointments were not rushed. Doctors were well informed about patients' medical history, and patients' medical records were available to doctors.
- We found that patient waiting times varied in different clinics, from a few minutes to over an hour and we observed consistent delays in patients being seen at their appointed time. Information about waiting times was not displayed for patients, although we were told that this facility was available on the noticeboard behind the 'sub-wait station' in the health central clinics.
- Some reception and nursing staff told us they would inform patients if clinics were running late. However, several patients we spoke with expressed frustration at the lack of information about waiting times.
- Appointment-booking systems did not consider the variable needs of patients. This was particularly evident in the ophthalmology department, where patients might require a longer appointment. This also contributed to appointments overrunning.
- There was a single reception desk for the outpatient clinic, which all patients reported to on arrival. Patients then sat in the main waiting area until they were called into a consulting room to be seen by the clinician.
- Within the radiology department, we saw separate changing facilities for men and women. Separate cubicles were screened with curtains to help preserve patients' privacy and dignity.
- Patients who attended the outpatient department for blood tests were directed to take a ticket and wait until their number was called to be seen by the phlebotomist.
- The radiology waiting area catered for patients referred from inpatient wards and outpatient clinics and those referred directly by their GPs. The radiology department operated from Monday to Sunday. The only dissatisfaction expressed by patients we spoke with was about long waits in the department.

### Access and flow

- The trust consistently failed to meet national referral to treatment waiting time targets. The trust suspended reporting 18-week referral-to-treatment waits in September 2014. It was not know when the trust was expected to resume reporting.
- Limited information was displayed in some clinics about patient support groups; however we saw that some clinics made information leaflets available for patients about health conditions and patient support. This literature was only in English.
- Hospital Episode Statistics for 2013/14 showed that 281,300 outpatient appointments were made during 2013/14. We noted that 82% of patients attended either their or first follow appointments. The data showed that the hospital's ratio of follow-up to new appointments was better than the England average.
- Hospital Episode Statistics for Newham University Hospital for 2013/14 showed that 13% of patients did not attend their outpatients' appointment which was higher (worse) than the national average of 7%. Of the total outpatient appointments for 2013/14, 2% had been cancelled by patients and 3% by the hospital. Both these figures were lower (better) than the national average of 6% respectively.We were told that the 'did not attend' figure was continuously monitored by the

trust to enable changes and adaptations to be made to minimise wasted resources. For example, text messages and phone calls had been used to remind patients of their appointment dates and times.

- Cancer waiting times were better than the England average for all the three measures at the trust level for 2013/14. The percentage of diagnostic patients waiting more than six weeks for appointments was 1% compared with the national average of 2%.
- The trust's target for admitted closed pathways was 90%; however the average score for the trust was 76%. For non-admitted pathways, the trust's target was 95% and the average score was 86%. The trust set an incomplete-pathway target of 92% and its average score for October, November and December 2014 was 78%.
- Even though waiting times for patients to be seen were long, we observed good patient flow in the main waiting areas. The patient non-attendance rate was 10% across the trust, which was worse than the national average. Newham University Hospital's non-attendance rate was 13%. Measuring the non-attendance rate is important, because non-attendances mean that resources are not being used well and can have negative impact on patients receiving services at the hospital.
- The trust was consistently not meeting the national waiting time target of 18 weeks for non-admitted pathways (95% referral to treatment target) – i.e. the waiting times for patients whose treatment started during the month and did not involve admission to hospital. The trust performed worse than the England average between September 2013 and September 2014. It achieved an average of 91% between March 2014 and October 2014. Some of the worst-performing specialties in August 2014 were neurosurgery (76%), gastroenterology (77%), neurology and general surgery (82% each).
- The trust was consistently not meeting the national waiting time target of 18 weeks for incomplete pathways. Incomplete pathways are waiting times for patients waiting to start treatment at the end of the month (referral to treatment target of 92%). The trust achieved an average of 81% between March and October 2014. Trauma and orthopaedics (69% of all patients treated within 18 weeks), general surgery (81%) and urology (83%) were among the worst-performing specialties across the trust in August 2014.

### Meeting people's individual needs

- A system in was place to meet the communication needs of patients whose first language was not English. A translating system could be accessed over the phone at any time.
- The outpatient clinic used Language Line as its interpretation service, when such a service was required. Staff we spoke with told us that they also made use of staff who spoke other languages, with the patient's consent.
- Patients we spoke with were positive about the outpatients services. Patients and relatives we spoke with told us they were satisfied with the treatment and the approach of staff. Patients made positive comments about nursing staff, healthcare assistants, receptionists and consultants.
- Some nursing staff running clinics told us they provided chaperones if either the patient or the consultant requested this. However, no information was displayed about this facility or its availability at the outpatients department. Some of the medical staff we spoke with were concerned about the lack of training around chaperoning services and staff responsibilities.
- There were generally enough seating places in most areas of the outpatients department we visited; however, the gynaecology clinic appeared overcrowded and had an inadequate number of chairs for the number of patients waiting for appointments. This clinic (West Wing) was cramped and was not ideal for a busy clinic. Staff and patients we spoke with thought that the overcrowding affected the experience of care; staff had to work in close physical contact with each other.
- The reception area of the West Wing clinic did not provide privacy for patients, and the waiting area appeared overcrowded and congested. We observed patients standing throughout their visit to the clinic; some of the patients we spoke with described their experience as very uncomfortable. Most of the patients we spoke with complained that the clinic was running late and they had to stand while waiting for their appointment.
- Arrangements were in place to provide patients with a chaperone during appointments that required an intimate examination, or when requested. Nursing staff and healthcare assistants acted as chaperones. However, due to a shortage of staff, chaperones were

not always provided. We noticed each member of nursing staff worked with two to four doctors at a time, and this made it difficult to provide effective chaperone services.
- There was a Macmillan Information station, stocked with books and information leaflets, on the ground floor of the hospital near the main entrance reception area. Macmillan information boards displayed in departments gave advice and directed patients to services.

### Learning from complaints and concerns

- Complaints were handled in line with the trust's complaints policy. Staff explained the complaints procedure to us. Initial complaints were dealt with by senior staff in charge of each clinic. We observed that staff tried to resolve patients' issues/concerns immediately.
- If staff were not able to resolve complaints or issues locally, patients were referred to the Patient Advice and Liaison Service. If the Patient Advice and Liaison Service was not able to address the patient's concerns, they were advised to make a formal complaint. We found that information about the Patient Advice and Liaison Service was displayed on posters across Newham University Hospital.
- Staff told us that details of complaints were shared with them, in order that lessons could be learned. Staff also told us that compliments were shared so they knew what they had done well.
- Patients we spoke with told us they would be prepared to make a complaint, but were unaware of the formal process to follow. Patients told us that the reception staff responded politely and sympathetically when they had expressed their concerns.
- Staff told us complaints and incidents were discussed at the monthly clinical governance meetings. We were told that most complaints were about delays in clinics. There were small numbers of complaints about the service. Staff responded positively when patients raised concerns, and they used complaints to make improvements in the outpatients department.

## Are outpatient and diagnostic imaging services well-led?

**Requires improvement**

None of the junior managers or their staff at department level had any idea about the vision and strategy for the service. There was a lack of shared objectives and strategy to achieve an improved service.

Local managers were not well supported by the trust-wide senior managers within their division. There were no clear lines of accountability, and most senior managers were not based on the hospital site.

No consistent process was in place to monitor the performance of services and identify risks and ongoing concerns, especially with staffing shortages. The leadership of the outpatients department required improvement to ensure that information on performance was available to staff, and to ensure that the outpatients department learned and improved following complaints and incidents.

Information for local staff on performance of the service in respect of cancelled clinics, waiting time and delays for patients was limited and some staff did not feel empowered to raise issues with the wider trust leadership.

Governance meetings were held on a monthly basis with representatives from all departments. Complaints, incidents, audits and quality improvement projects were discussed at these monthly meetings. There was a positive culture in the outpatients department and staff were committed and proud of their work.

### Vision and strategy for this service

- Each senior manager told us what their vision for the service at local level was, yet none of the junior managers nor their staff at department level had any idea about these visions and strategy for the service.
- There was a lack of shared objectives and strategy to achieve an improved service.

# Outpatients and diagnostic imaging

### Governance, risk management and quality measurement

- Information for local staff on performance of the service in respect of cancelled clinics, waiting time and delays for patients was limited. Because local staff were not aware of these issues, they could not lead to improvements in the service.
- Morning meetings were held at the outpatients department to discuss issues and plan the day's work. Governance meetings were also held on a monthly basis with representatives from all departments. Complaints, incidents, audits and quality improvement projects were discussed at these monthly meetings.
- However, there were no consistent process in place to monitor service performance, identify ongoing risks and concerns and staffing shortages. For example, whilst we saw performance monitoring in some areas, some nursing staff in the Health Central Gateway and West Wing clinics were not aware of the hospital's initiatives for dealing with the above concerns. They told us that even though governance meetings were held, they seldom had the time to attend these due to staffing shortages; and minutes of the meetings were not always shared with them.
- We noted that the trust had not ensured that policy and governance decisions about all outpatient services had had a positive impact on the services delivered at the hospital.
- There were no outpatients department specific risks on the hospital's risk register dated December 2014.

### Leadership of service

- The outpatients service's manager worked predominantly at The Royal London Hospital but visited Newham University Hospital occasionally. Not all the junior nursing and administration staff felt supported by the visiting manager and by other senior managers of the team.
- We spoke with a variety of healthcare assistants, told us they felt generally well supported by the nursing staff and their managers.

### Culture within the service

- There was a positive culture in the outpatients department; staff were committed and proud of their work. Quality and patient experience were seen as a priority and everyone's responsibility.
- Imaging staff and radiologists felt well supported, and opportunities for their professional development were good.
- Staff supported each other, and there was good team working within the clinics. The outpatient department had morning meetings where all staff were invited to bring innovative ideas.
- Medical staff we spoke with told us the communication between different professionals was good and that it helped to promote a positive culture within the outpatients department .

### Public and staff engagement

- We noted that staff were keen to engage patients and the public to improve the patient experience. Staff we spoke with were positive about the quality of care they provided, and the future of the service, and spoke very highly of the team they worked in. However, some staff did not feel empowered to raise issues with the wider trust leadership.
- At the time of our inspection, the gynaecology outpatient clinic had not completed a patient survey, and the staff from the clinic could not tell us when the last patient survey was done. There was no record of Friends and Family Test at the imaging department either.

### Innovation, improvement and sustainability

- Due to the merger that created Barts Health NHS Trust and shortage of staff across the nursing workforce, there had been few opportunities to implement innovative activities. Staff were more concerned about maintaining the service and keeping patients safe.
- The nurse manager for outpatients told us that the service had introduced clinical assistant practitioner posts working at band 4 at the outpatient department. However, outside these posts, most staff reported that opportunities for professional development were very limited.

# Outstanding practice and areas for improvement

## Outstanding practice

The Gateway Surgical Centre's design, layout, forward planning, engaged staff and integrated care with members of the multidisciplinary team were outstanding.

## Areas for improvement

### Action the hospital MUST take to improve

**The trust must:**

- Ensure governance and risk management processes are robust and embedded throughout the hospital.
- Ensure, where appropriate, that intensive care and hospital risk registers reflect any risks in relation to the safety of patients and/or quality of care.
- Make sure that staff are aware of and adhere to local and national guidelines, to ensure patients receive safe care.
- Improve the leadership and direction of the end of life care service.
- Ensure that staffing establishments meet the acuity and dependency levels of areas such as the coronary care unit.
- Address the significant shortages of medical and midwifery staff which sometimes compromised the care and treatment delivered to women.
- Ensure nurse staffing levels and the skill mix on some surgical areas are always appropriate to meet the needs of patients, to ensure safe, effective, caring and responsive care is provided.
- Provide a minimum of 14 hours a day consultant cover in the emergency department, in line with the College of Emergency Medicine recommendation.
- Recruit band 5 nurses to the full establishment of the critical care unit, so that patient care is not adversely affected.
- Comply with The Misuse of Drugs Regulations 2001 in relation to the security of the keys for the controlled drugs cabinet on the medical wards and the condition of the controlled drugs record book on the surgical areas.
- Ensure arrangements are in place for the safe storage of intravenous fluids in line with best practice guidance.
- Ensure that nurses record the date and time they commence intravenous fluids for central venous lines and arterial lines.
- Make sure staff are aware of their responsibilities under the Mental Capacity Act and have suitable arrangements in place for obtaining and acting accordance with the consent of service users, or acting in accordance with the best interest principles of the Act.
- Ensure nursing records are completed fully and accurately to ensure patient safety.
- Ensure the do not attempt cardio-pulmonary resuscitation (DNA CPR) form and the new DNA CPR policy are clear and in keeping with any recent ruling or guidance.
- Make sure all nursing staff on the medical wards are competent to care for the patients they are caring for.
- Ensure that all relevant ward staff receive training specific to managing patients at the end of their lives.
- Improve processes/referrals for safeguarding children in the emergency department.
- Improve multidisciplinary working in the emergency department and paediatrics.
- Listen to staff concerns regarding bullying and harassment and take action to improve the culture of the organisation.
- Ensure national guidance for the care and treatment of surgical patients is always followed.
- Support staff must to obtain the necessary qualifications to meet the core standards for intensive care units.
- Make sure all staff have appraisals as required.
- Ensure reasonable adjustments are made for people with disabilities who access surgical services.
- Share the hospital's vision with all staff.
- Reduce patient waiting times in outpatient clinics.

# Outstanding practice and areas for improvement

### Action the hospital SHOULD take to improve

**The trust should:**

- Use the modified early warning score consistently to assess patients whose health may be deteriorating and update the electronic patient record with modified early warning score and PEWS scores.
- Provide leaflets in other languages for the local population.
- Improve feedback on and learning from incidents, so that staff are aware of incidents that have occurred and so that appropriate recommendations are put in place to learn from them.
- Ensure cleanliness and infection control standards are adhered to consistently across the whole hospital.
- Keep up to date with equipment checks.
- Keep policies and procedures up to date.
- Consistently obtain feedback from patients and take action to improve the service based on this feedback.
- Meet the particular needs of vulnerable patients, particularly those living with dementia.
- Ensure complaints are responded to in a timely fashion and improvements are made following these complaints.
- Reduce the gap between recommended staffing levels in relation to the number of births and the current establishment in maternity. This relates both to midwives and obstetricians, and also to the availability of theatre staff to support obstetric surgery.
- Manage the risk to timely care and treatment of women in the maternity service that results from current staff deployment, particularly out of hours.
- Improve the environment for children in the operating department, as it is not child-friendly.
- Consider providing up-to-date training in children's resuscitation, as none of the staff in the operating theatre are trained in this.
- Review the level of resuscitation equipment for children undergoing surgery.
- Review pain relief for children, as the systems to ensure that children have adequate pain relief are not comprehensive.
- Review how the children's service is led, as the service is disjointed with no overall direction or strategy.
- Review its plans to move non-elective children's surgery to The Royal London Hospital, as some medical staff are not convinced that this move is the best option for the service.
- Provide patients with clear and up-to-date information on waiting times in outpatient clinics.
- Ensure the adequate availability of hand-gel sanitiser in outpatient clinics.
- Have a coordinated outpatient booking system.
- Monitor performance targets in the outpatient department and reduce the overbooking of clinics to avoid clinics overrunning, especially the West Wing clinic.
- Make sure administration staff are regularly supervised and thus better supported.
- Share performance data with staff to increase awareness and improve practice.
- Develop mechanisms to obtain feedback from patients and relatives about their experience on the unit and improving the unit.
- Continue to recruit nursing and medical staff on the critical care unit.
- Look for ways to improve the facilities for relatives and friends on the critical care unit.

This section is primarily information for the provider

# Compliance actions

## Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing<br>People who use services were not protected against the risks of care or treatment that was inappropriate or unsafe because:<br>1. Nurse staffing levels were not always appropriate to the acuity and dependency levels of patients being cared for on the coronary care unit.<br>2. There were significant shortages of medical and midwifery staff which sometimes compromised the care and treatment delivered to women.<br>3. The nurse staffing levels and the skill mix on some surgical areas were not always appropriate to meet the needs of patients to ensure safe, effective, caring and responsive care was provided.<br>4. There was not a minimum of 14 hours a day consultant cover in the emergency department, in line with the College of Emergency Medicine recommendation.<br>5. There were not sufficient band 5 nurses on the critical care unit to ensure patient care was not adversely affected.<br>Regulation 22 |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment<br>People who use services were not protected against the risks of care or treatment that was inappropriate or unsafe because: |

This section is primarily information for the provider

# Compliance actions

1. The obtaining of patients' consent and acting in their best interest in accordance with the Code of Practice of the Mental Capacity Act (2005) was not well understood by staff on the critical care unit.

2. There were not suitable arrangements in place for obtaining and acting accordance with the consent of service users, or acting in accordance with the best interest principles of the Mental Capacity Act (2005), on the critical care unit and medical wards.

Regulation 18 (a)

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services<br>People who use services were not protected against the risks of care or treatment that was inappropriate or unsafe because:<br>1. Not all nursing staff on the medical wards were competent to care for the patients they were responsible for.<br>2. Staff were not all aware of and did not always adhere to local and national guidelines to ensure patients received safe care.<br>Regulation 9 (1) (b) (i) (iii) |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records<br>People who use services and others were not protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them because: |

This section is primarily information for the provider

# Compliance actions

1. Patient records on the medical wards were not complete and up to date, particularly nursing assessments, Multinutritional Universal Screening Test charts and early warning scores, and the appropriate actions were not always recorded in relation to these assessments.

Regulation 20 (1) (a)

| Regulated activity | Regulation |
| --- | --- |
| Diagnostic and screening procedures<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines<br>People who use services were not protected against the risks associated with the unsafe use and management of medicines because:<br>1. Suitable arrangements were not in place for the safe storage of intravenous fluids in line with best practice guidance.<br>2. Nurses did not always record the date and time they commenced intravenous fluids for central venous lines and arterial lines.<br>Regulation 13 |

This section is primarily information for the provider

# Enforcement actions

## Action we have told the provider to take

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