TOWER HAMLETS

HEALTH SCRUTINY SUB-COMMITTEE

Tuesday, 17 January 2017 at 6.30 p.m.

MP701, 7th Floor, Town Hall, Mulberry Place, 5 Clove Crescent, London, E14 2BG

This meeting is open to the public to attend.

Members:
Chair: Councillor Clare Harrisson
Vice-Chair**:** Councillor Sabina Akhtar

Councillor Dave Chesterton, Councillor Peter Golds, Councillor Abdul Mukit MBE, Councillor Muhammad Ansar Mustaquim and Councillor Md. Maium Miah

Substitues:
Councillor Danny Hassell, Councillor Amina Ali, Councillor Rajib Ahmed, Councillor Chris Chapman, Councillor Mahbub Alam and Councillor Aminur Khan

Co-opted Members:

David Burbidge	Healthwatch Tower Hamlets Representative
Tim Oliver	Healthwatch Tower Hamlets

[The quorum for this body is 3 voting Members]

Contact for further enquiries:
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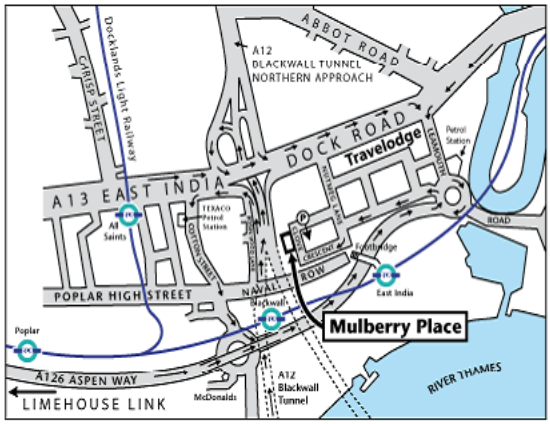

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PAGE NUMBER(S)

APOLOGIES FOR ABSENCE

1. DECLARATIONS OF DISCLOSABLE PECUNIARY INTERESTS — 1 - 4

To note any declarations of interest made by Members, including those restricting Members from voting on the questions detailed in Section 106 of the Local Government Finance Act, 1992. See attached note from the Monitoring Officer.

2. MINUTES OF THE PREVIOUS MEETING(S) — 5 - 12

To confirm as a correct record the minutes of the meeting of the Health Scrutiny Panel held on ……..

3. REPORTS FOR CONSIDERATION

3 .1 Unpaid Carers - Scrutiny Review Action Plan Update — 13 - 32

3 .2 Early Years and access to care: Early Interventions improving outcomes for 0-5 year olds To Follow

3 .3 Royal London Hospital CQC Inspection Results — 33 - 262

4. ANY OTHER BUSINESS WHICH THE CHAIR CONSIDERS TO BE URGENT

Next Meeting of the Panel

The next meeting of the Health Scrutiny Panel will be held on Tuesday, 14 March 2017 at 6.30 p.m. in MP701, 7th Floor, Town Hall, Mulberry Place, 5 Clove Crescent, London, E14 2BG

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DECLARATIONS OF INTERESTS - NOTE FROM THE MONITORING OFFICER

This note is for guidance only. For further details please consult the Members' Code of Conduct at Part 5.1 of the Council's Constitution.

Please note that the question of whether a Member has an interest in any matter, and whether or not that interest is a Disclosable Pecuniary Interest, is for that Member to decide. Advice is available from officers as listed below but they cannot make the decision for the Member. If in doubt as to the nature of an interest it is advisable to seek advice **prior** to attending a meeting.

Interests and Disclosable Pecuniary Interests (DPIs)

You have an interest in any business of the authority where that business relates to or is likely to affect any of the persons, bodies or matters listed in section 4.1 (a) of the Code of Conduct; and might reasonably be regarded as affecting the well-being or financial position of yourself, a member of your family or a person with whom you have a close association, to a greater extent than the majority of other council tax payers, ratepayers or inhabitants of the ward affected.

You must notify the Monitoring Officer in writing of any such interest, for inclusion in the Register of Members' Interests which is available for public inspection and on the Council's Website.

Once you have recorded an interest in the Register, you are not then required to declare that interest at each meeting where the business is discussed, unless the interest is a Disclosable Pecuniary Interest (DPI).

A DPI is defined in Regulations as a pecuniary interest of any of the descriptions listed at **Appendix A** overleaf. Please note that a Member's DPIs include his/her own relevant interests and also those of his/her spouse or civil partner; or a person with whom the Member is living as husband and wife; or a person with whom the Member is living as if they were civil partners; if the Member is aware that that other person has the interest.

Effect of a Disclosable Pecuniary Interest on participation at meetings

Where you have a DPI in any business of the Council you must, unless you have obtained a dispensation from the authority's Monitoring Officer following consideration by the Dispensations Sub-Committee of the Standards Advisory Committee:-

- not seek to improperly influence a decision about that business; and
- not exercise executive functions in relation to that business.

If you are present at a meeting where that business is discussed, you must:-

- Disclose to the meeting the existence and nature of the interest at the start of the meeting or when the interest becomes apparent, if later; and
- Leave the room (including any public viewing area) for the duration of consideration and decision on the item and not seek to influence the debate or decision

When declaring a DPI, Members should specify the nature of the interest and the agenda item to which the interest relates. This procedure is designed to assist the public's understanding of the meeting and to enable a full record to be made in the minutes of the meeting.

Where you have a DPI in any business of the authority which is not included in the Member's register of interests and you attend a meeting of the authority at which the business is considered, in addition to disclosing the interest to that meeting, you must also within 28 days notify the Monitoring Officer of the interest for inclusion in the Register.

Further advice

For further advice please contact:

Graham White, Acting Corporate Director of Law, Probity & Governance & Monitoring Officer, Telephone Number: 020 7364 4800

APPENDIX A: Definition of a Disclosable Pecuniary Interest

(Relevant Authorities (Disclosable Pecuniary Interests) Regulations 2012, Reg 2 and Schedule)

Subject	Prescribed description
Employment, office, trade, profession or vacation	Any employment, office, trade, profession or vocation carried on for profit or gain.
Sponsorship	Any payment or provision of any other financial benefit (other than from the relevant authority) made or provided within the relevant period in respect of any expenses incurred by the Member in carrying out duties as a member, or towards the election expenses of the Member. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.
Contracts	Any contract which is made between the relevant person (or a body in which the relevant person has a beneficial interest) and the relevant authority— (a) under which goods or services are to be provided or works are to be executed; and (b) which has not been fully discharged.
Land	Any beneficial interest in land which is within the area of the relevant authority.
Licences	Any licence (alone or jointly with others) to occupy land in the area of the relevant authority for a month or longer.
Corporate tenancies	Any tenancy where (to the Member's knowledge)— (a) the landlord is the relevant authority; and (b) the tenant is a body in which the relevant person has a beneficial interest.
Securities	Any beneficial interest in securities of a body where— (a) that body (to the Member's knowledge) has a place of business or land in the area of the relevant authority; and (b) either— (i) the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body; or (ii) if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which the relevant person has a beneficial interest exceeds one hundredth of the total issued share capital of that class.

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LONDON BOROUGH OF TOWER HAMLETS

MINUTES OF THE HEALTH SCRUTINY SUB-COMMITTEE

HELD AT 6.35 P.M. ON WEDNESDAY, 2 NOVEMBER 2016

MP702, 7TH FLOOR, TOWN HALL, MULBERRY PLACE, 5 CLOVE CRESCENT, LONDON, E14 2BG

Members Present:

Councillor Clare Harrisson (Chair)
Councillor Dave Chesterton
Councillor Abdul Mukit MBE

Co-opted Members Present:

David Burbidge	Healthwatch Tower Hamlets Representative

Other Councillors Present:

Councillor Amina Ali
Councillor Rachel Blake
Councillor Amy Whitelock Gibbs

Apologies:

Councillor Sabina Akhtar

Others Present:

Chris Banks	CEO GP Care Group
Jenny Cooke	Deputy Director for Primary and Urgent Care, Tower Hamlets Clinical Commissioning Group
Josh Potter	Deputy Director Of Commissioning And Transformation, NHS Tower Hamlets Clinical Commissioning Group
Tracey Connell	GP Care Group
Edwin Ndlovu	Director of Adult Mental Health, East London Foundation Trust

Officers Present:

Daniel Kerr	Strategy, Policy & Performance Officer
Dr Somen Banerjee	Director of Public Health
Janet Fasan	Head of Legal (Operations)
Joseph Lacey-Holland	Senior Strategy, Policy &Performance Officer
Tim Madelin	Senior Public Health Strategist, Adults' Services
Farhana Zia	Committee Services Officer

1. DECLARATIONS OF DISCLOSABLE PECUNIARY INTERESTS

The Chair, Councillor Clare Harrisson welcomed everybody to the Health Scrutiny Sub-Committee meeting and asked everyone to introduce themselves.

She stated the Sub-Committee would be considering a report relating to how the Local Authority and its Health partners planned for healthcare infrastructure in light of population growth, consider the challenges facing General Practice plus how the housing needs for the elderly was being addressed.

She said the Sub-Committee would also consider a report which outlined the Clinical Commissioning Groups commissioning intentions in order to gain an understanding of their key priorities plus a report on ELFT and their Care Quality Commission inspection and rating.

Apologies for absence were received from the vice-chair Councillor Sabina Akhtar and Simon Hall, Acting Chief Officer of Tower Hamlets Clinical Commissioning Group.

Councillor Clare Harrison declared she was a member of UNISON.

2. MINUTES OF THE PREVIOUS MEETING(S)

The Chair referred members of the Sub-Committee to the minutes of the previous meeting held on the 15th September 2016. She asked members to approve these minutes as an accurate record of the meeting.

No points were raised and the minutes were approved.

3. REPORTS FOR CONSIDERATION

3.1 Planning and Primary Health Care Infrastructure

Jenny Cooke, Deputy Director for Primary and Urgent Care at Tower Hamlets Clinical Commissioning Group (CCG) jointly presented her report with Chris Banks and Tracey Connell from Tower Hamlets GP Care Group as well as Tim Madelin, Senior Public Health Strategist at Tower Hamlets Council.

The presentation gave an in-depth analysis of the issues facing the health economy in Tower Hamlets due to increased demand and population growth, coupled with funding restraints Commissioners was experiencing. In light of this the CCG was working with General Practices to improve access, streamline procedures using technology in innovative ways to ensure patients are signposted correctly.

Jenny acknowledged recruitment and retention of staff in primary care faced an unprecedented challenge however the CCG was working with GP practices to ensure change was occurring. She said the CCG had piloted their GP support programme over eight months and had seen impressive results. For example it had assisted one surgery to improve their telephone access with a drop in complaints by 40-60% and helped to reduce Did Not Attend (DNA) rates. The CCG was helping GP practices to think through their processes and to be more customer focussed, in order to help embed learning from the pilot.

Tracey Connell and Chris Banks informed Members about the GP Care Group. Chris explained how the GP Care Group came into existence with GP practices being grouped together and working in a network. It is a not-for-profit 'Community Interest Company' (CIC) which aims to support GP's and their patients. This has allowed Tower Hamlets to be 'ahead of the curve' in terms of consolidating the primary care offer.

The GP Care Group had successfully tendered for the Prime Ministers Access Fund (known as the GP Access fund), which exists to support provision outside of core hours and has created four hubs in Tower Hamlets where patients can access 350 appointments p/w in primary care out of normal hour's.

Evening and weekend appointments were available to patients and the hubs were staffed with a range of professionals – GP's, pharmacists, nurses and healthcare assistants. Patient footfall during the week and Saturday showed demand for an extended service (although Sunday take-up has been low) with an average of 290 appointments p/w. For example, the hubs had assisted with the BCG vaccinations by offering new parents additional appointments.

The GP Care group had built good relations with pharmacies and with additional funding next year hoped it could align services with the Urgent Care and Walk in centres.

Jenny added patient feedback indicated satisfaction with the standard of clinical care, but there was frustration with the process of getting an appointment. She also added that the GP workforce was also changing. In the past the profession was male dominated and GP practices were stand-alone businesses however more GPs are salaried staff and more are female. Hence with this change GP's are looking to work in federations and networks and there needs to be a strong local offer to attract GPs and retain them in Tower Hamlets. The CCG has developed their 'open doors' and 'physician associates' scheme in order to support career development and the skill mix of practitioners.

Tim Madelin, Senior Public Health Strategist stated the Public Health Team worked closely with Health professionals and the Local Plan set out the 15 year planning policy, subsequent design, scale and location of development. The Plan had identified and safeguarded potential sites for infrastructure development and considered how infrastructure could be funded.

Tim explained the difference between S106 agreements which were replaced with the Community Infrastructure Levy (CIL) in April 2015. He said that whereas the S106 agreements could specify what the monies should be used for – e.g. health centre, the CIL was a collective tax and the priority of allocating CIL monies were decisions made by the Mayor and Cabinet. CIL money is only likely to meet up to 20% of the cost required for infrastructure.

Tim informed Members the 'Ageing Well' Strategy was being developed with a view to ensure older people could live independently in their own homes for longer. Cllr Whitelock-Gibbs clarified the local authority was considering to build more extra-care sheltered housing in addition to supporting residents who require residential care or those with complex needs.

This was followed by questions and comments from Members, who stated:

- Impressed with the plans in place to analyse population increases and demand on health infrastructure however it's also about physical space in a given locality. Some parts of the borough have been over developed and there may not be the physical space for infrastructure buildings.

- What is being done to tackle overcrowding and can CIL monies be used to improve existing homes?

- What support is provided to vulnerable tenants in their own homes?

- S106 specified the project to be developed but how can we ensure CIL money is spent on health priorities?

- Will there be nurse-led surgeries similar to midwife led birthing centres?

- Improvement of Primary care focusses on GP's however attention should also be given to Dental Care and access to Dental practices.

- Would welcome the centralisation of processes – such as online registrations and appointments, telephone systems.

- Recruitment and retention has been highlighted as an issue; what is being done to link up with the councils objective of providing homes for key workers and how can we integrate health and housing need especially for those with Mental Health issues?

The Chair thanked everyone for their input.

The Sub-Committee **RESOLVED** to **NOTE**:

The contents of the presentation to help gain a greater understanding of:

- The challenges facing general practice and the plans in place to address them.
- Planning of healthcare infrastructure to account for population increases,
- The links between planning and health infrastructure and how this is implemented in LBTH.
- How the housing needs of elderly residents will be addressed.

3.2 TH Clinical Commissioning Groups Commissioning Intentions 2017/18

Josh Potter, Deputy Director of Commissioning and Transformation, for the Clinical Commissioning Group presented his report which outlined the Commissioning intentions of the CCG.

He referred members to points 1.1 and 1.2 of his report and said the local health economy needed to identify £10m of system savings per year over the next five years, in addition to the productivity savings set by NHS England. However due to the additional pressures within the health economy the requirement for 2017/18 have been revised to £15m.

In order to deliver the saving required the CCG was working together with other CCG's in East London and there were currently three major programmes underway;

- Transforming Services Together (TST) which is a sub-regional programme involving Tower Hamlets, Newham and Waltham Forest;

- North East London Sustainability and Transformation Plan (NEL STP) and

- Tower Hamlets Together – a new model of care Vanguard.

Josh referred members to the table on page 30-31 and explained the process involved in identifying savings. He said data analysis and review of current schemes and services plus public engagement informed their decision making. The Tower Hamlets Together programme builds on integrated care and Providers and Commissioners are working to identify areas they can deliver on.

Members raised the following questions and comments:

- The Tower Hamlets Together Board has the Director of Adults and the Director of Children's on its Board.

- There are several different plans running together. How will you ensure they are joined up and will help to deliver the transformational change you are seeking?

- The diagram on Page 29 does not show how public engagement will take place – how will the Patient Voice link between the different organisations and the THT Board?

- NHS has complex structures and finances. How can councillors engage in the debate?

The Chair thanked the Officer for his report and said that it was difficult for members to scrutinise the paper but would welcome the opportunity for it to come back to the Sub-Committee. She asked for a fuller briefing to be provided on the Tower Hamlets Together programme.

The CCG agreed to provide a diagram on how the NHS works and the organisation structures within it.

The Sub-Committee **RESOLVED** to **NOTE** the recommendations within the report, namely:

1. To develop an understanding of the CCGs key priorities and commissioning activities;
2. Consider how CCG commissioning at borough-level fits in with the Transforming Services Together (TST) programme across the sub-region (Tower Hamlets, Newham and Waltham Forest), and the North East London Sustainability and Transformation Plan (NEL STP)
3. Develop an understanding of Tower Hamlets Together: a 'New Models of Care' Vanguard.

3.3 East London Foundation Trust Care Quality Commission Inspection Response

Edwin Ndlovu Director of Adult Mental Health from East London Foundation Trust presented his report and stated that the Care Quality Commission visited in June 2016. The inspection included a visit of 86 services and discussions with over 300 patients, 52 carers and over 700 members of staff.

The CQC rated ELFT as 'Outstanding' and the table on slide 3, showed how the organisation has performed under various categories. Edwin stated ELFT were particularly proud of its achievement under the 3rd column labelled 'Caring' because it had worked hard with patients and carers to ensure service models delivered the expectations of the users.

Members made the following comments and questions:

- Members congratulated ELFT on their achievement and their outstanding rating.

- What is being done to ensure patients receive care in the community rather than locked wards?

- The Governing Body of the Foundation Trust should have user representation.

- Could ELFT lead on improving the physical health of patients with mental health? - i.e. making links with Primary care.

Edwin invited members of the Health Scrutiny Sub-Committee in visit services provided by ELFT and said he would be happy to arrange this for members.

Cllr Clare Harrisson informed Members she was visiting the CAMHs unit on the 21st November.

The Sub-Committee **RESOVLED** to

1. Note the outcome of the inspection;
2. Develop an understanding of the performance of East London Foundation Trust (ELFT)

4. ANY OTHER BUSINESS WHICH THE CHAIR CONSIDERS TO BE URGENT

Dr Somen Banerjee informed the Sub-Committee the Health and Wellbeing Board's strategy was out for consultation next week and once the consultation was complete the draft Strategy would come to the Sub-Committee for scrutiny.

He also informed members there was a workshop planned for the end of November, which members of the Health Scrutiny Sub-Committee may find useful which was looking at the shared outcomes stakeholders wanted to achieve across the health economy.

The meeting ended at 8.45 p.m.

Chair, Councillor Clare Harrisson
Health Scrutiny Sub-Committee

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Non-Executive Report of the: **Health Scrutiny Subcommittee** 17th January 2017	
Report of: Denise Radley – Director Adults' Services	**Classification:** Unrestricted
Health Scrutiny Challenge: Progress on Action Plan – Carers	

Originating Officer(s)	Barbara Disney, Service Manager, Strategic Commissioning
Wards affected	All wards

Summary

This paper outlines the background to the Health Scrutiny Subcommittee's *Unpaid Carers' Scrutiny Challenge Session* and provides an update on progress against the recommendations contained in the Action Plan.

Recommendations:

The Health Scrutiny Subcommittee is recommended to:

1. Note the contents of this report and the Action Plan (Appendix Two)

1. DETAILS OF REPORT

1.1 As part of its work programme for the municipal year 2014-15, the Health Scrutiny Panel was keen to see how the Care Act 2014 was being implemented locally with a specific focus on the council's statutory duty to assess unpaid carers (a carer is someone of any age who provides unpaid support to family or friends who could not manage without this help. This could be caring for a relative, partner or friend who is ill, frail, disabled or has mental health or substance misuse problems). .

1.2 A scrutiny challenge session held that the Carers' Centre, on 13th May 2015, focused on a number of key questions, which resulted in a series of recommendations. The key questions were:

- What are the council's proposals for supporting carers in the light of the Care Act 2014?
- How has the council supported service users previously, is there going to be any reduction or access to services and what new measures is the council proposing to put in place?
- Is the carer's plan being refreshed or reviewed and how will it change in line with the new regulations?
- Which partners are providing carers' services currently and will there be a new commissioning strategy for carers' services in light of changes?
- What feedback do we have from carers to understand how support services enable them to continue with their caring role (this should include details of things that work and areas for improvement)?
- How are carers engaged and involved in the design, delivery and scrutiny of services to carers?
- What will the council and its partners do to raise the voice of the carers and ensure their involvement in the decision-making process?

1.3 The challenge session was attended by a range of stakeholders, who included Councillors, officers from Adult Social Care, providers of carers' support services and local carers. The discussions focused on how the council and its partners could improve services for carers to enable them to continue with their caring role and maintain their health and wellbeing.

1.4 Seven recommendations were developed and presented to the Health Scrutiny Panel on 9th September 2016.

1.5 At this meeting, the Health Scrutiny Panel identified two critical areas missing from the original challenge session report. Firstly, there are many carers who do not recognise themselves as a carer because they see the support they provide as a duty or are supporting their family or a friend. This lack of self-recognition means that carers do not always access appropriate support, which may put their health and wellbeing at risk. It was felt that the CCG should look at how GPs might increase the identification and recording of carers. Additionally, as many carers were not aware of the benefits they can access, it was noted that additional financial stress of the caring role can have

an adverse impact on their health and wellbeing. Two further recommendations were added in relation to these points.

1.6 The Health Scrutiny Panel (9th September 2016) recommendations are attached as Appendix One. Progress against each recommendation is recorded in the accompanying Action Plan Update (Appendix Two).

2. COMMENTS OF THE CHIEF FINANCE OFFICER

The Census of 2011 identified 19,356 unpaid carers in Tower Hamlets. Without their services the local authority would have to provide additional resources to meet their clients' needs. Therefore this Carer's Action Plan is important to ensure their services are maintained and supported.

Any increase in carers' support will have a financial implication. The Current cost on carers services is shown below:

Services	Expenditure (£)
Care Act Services	330,700
Commissioned Carer services	664,413
Direct Payments	10,602
Respite in Care packages	187,000
Carers Assessments Costs	636,930
Carers Package Costs	434,449
Other Carers Provision Costs	21,600
Total spent on Carers	2,285,694

There has not been a significant increase in the number of carers or their costs since the implementation of the Care Act 2014 and this is expected to remain the same going forward.

3. LEGAL COMMENTS

3.1. The Care Act 2014 (the 2014 Act) aims to bring about a greater emphasis on individuals, their families and networks to be in control over their situations and the legislation attempts to rebalance the role of the state in the process. One important change the 2014 Act brings about is placing the right to an assessment for carers, and consideration of their wellbeing, on an equal statutory footing as those being cared for.

3.2. S.10(3) of the 2014 Act defines a carer as 'an adult who provides or intends to provide care for another adult'. S 10 (11) clarifies that providing care includes 'providing practical or emotional support'. S.63(6) of the 2014 Act defines a young carers as 'a person who is under 18 who provides or intends to provide care for an adult'. Both definitions exclude situations where the carer is providing care under or by virtue of a contract or as voluntary work.

3.3. The duty to assess applies irrespective of the level of expected need. The duty to provide support for an identified need is determined by the eligibility criteria in regulation 3 of the Care and Support (Eligibility Criteria) Regulations 2014. This criterion reflects the approach applied to the eligibility of individual's with care and support needs. The focus of the eligibility is on the impact of a carer's need for support on their own wellbeing.

3.4. Section 17ZA-ZC of the Children Act 1989 (as amended by the Children and Families Act 2014) imposes a duty on the Council to assess any young person under the age of 18 if it appears that they are providing support, or if they request an assessment. This is known as a 'young carer's needs assessment'. The assessment must consider whether the young person wishes to take on a carer's role, whether this is appropriate, what impact it has on the young person's ability to participate in education, training, recreation or employment. The assessment must also consider whether the young person requires support, and if so, whether that support can be met through the Council's powers to provide services to a child in need under section 17 of the 1989 Act.

3.5. In respect of adult carers it is important to note that the duty of the Council to carers is determined by the ordinary residence of the person cared for rather than that of the carer. For example, if a carer lives in Norwich but the cared for person lives within the Borough, the legal duty to assess and determine eligible needs will rest upon the Council. Equally, it is important to direct those who live within the Borough but are caring for others who are not ordinarily resident within Tower Hamlets to the appropriate authority.

3.6. When undertaking young carers or parent carers needs assessments, the responsibility to assess will be with the local authority in which the young carer or parent carer is 'within their area' (s 17ZA and s 17ZD). In a number of s17 Children Act 1989 cases, the court has found that 'within their area' refers to whether a child is physically present in the authority's area.

3.7. Where a duty to meet eligible needs does not arise, the Council retains the power to meet a need where it judges there is a reason to do so.

3.8. In relation to charging carers to provide support to them, s.14(1) of the Act provides a power for the Council to charge. The Care and Support Statutory Guidance (2014) recognises that *'Local Authorities are not required to charge a carer for support and indeed in many cases it would be a false economy to do so'*, para 8.50. In the event that the Council does take a decision to charge a carer it must do so in accordance with the non-residential charging rules set out in the Care and Support (Charging and Assessment of Resources) Regulations 2014.

3.9. In developing its approach to the assessment and eligibility of carers the Council must have due regard to the need to eliminate unlawful conduct under the Equality Act 2010 (e.g. discrimination), the need to advance equality of opportunity and the need to foster good relations between persons who share a protected characteristic and those who don't (the public sector equality

duty). The level of equality analysis required is that which is proportionate to the function in question and its potential impacts.

4. ONE TOWER HAMLETS CONSIDERATIONS

4.1 Services for carers are being developed to ensure that they are appropriate to meet identified needs across all Tower Hamlets diverse communities.

5. BEST VALUE (BV) IMPLICATIONS

5.1 It is envisaged that the involvement and the co-production work with carers, particularly around service specifications for new contracts, will enable much better targeted solutions to meet needs. All new procurement will meet Best Value requirements.

6. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

6.1 There are no direct environmental implications arising from the report or review of the recommendations.

7. RISK MANAGEMENT IMPLICATIONS

7.1 There are no direct risk management implications arising from the report or review of the recommendations. Carers provide significant levels of support to vulnerable people and there are risks if carers are not identified and supported appropriately. Promoting the identification and support of carers is part of a holistic approach to prevention and early intervention which reduces risk for individuals, their families and the Council.

8. CRIME AND DISORDER REDUCTION IMPLICATIONS

8.1 There are no direct implications for crime and disorder as a result of the review of the recommendations.

Linked Reports, Appendices and Background Documents

Linked Report

- NONE.

Appendices

- Appendix One: The Health Scrutiny Panel (9th September 2016)
- Appendix Two: Scrutiny Challenge Session Action Plan Update: Unpaid Carers.

Local Government Act, 1972 Section 100D (As amended)

List of "Background Papers" used in the preparation of this report

- NONE

Officer contact details for documents:

- Barbara Disney – Barbara.disney@towerhamlets.gov.uk

HEALTH SCRUTINY PANEL RECOMMENDATIONS – Appendix One

Recommendation 1:
That the Carers Plan be developed in partnership with local carer service providers, carers' forum and in consultation with local carers.

Recommendation 2:
That carers assessments are completed in a timely manner to ensure carers are supported to continue in their caring role.

Recommendation 3:
That the council's social care staff are trained to support carers effectively by being aware of various services available in the borough to support carers including information, advice and guidance. This should also include managing expectations of carers.

Recommendation 4:
That carers are provided clear and substantive feedback when they are not eligible for services and appropriately signposted to universal and preventative services they can access.

Recommendation 5:
The range of carers services available are publicised on the internet. We will review our investment in those services in response to feedback from carers through the assessment process and ensure that any new provision is appropriately publicised and that carers and relevant organisations are made aware of such changes.

Recommendation 6:
That the council in partnership with Tower Hamlets CCG develop a manual handling training course for local carers to prevent long term harm and injuries to carers.

Recommendation 7:
That consultation and engagement be undertaken with carers to better understand need for respite services and ensure these are designed to meet local needs.

The additional recommendations were:

Recommendation 8:
That work is undertaken by primary health care service and the council to help carers that do not recognise their role as carer to better support them to enable them to continue with their caring role.

Recommendation 9:
That welfare benefit support to carers is strengthened to ensure carers are accessing all available benefits that they are entitled to and do not have additional financial stress.

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- To be presented by Luke Addams & Barbara Disney at Health Scrutiny on 17th January 2017

Comment	Action	Responsibility	Date
Recommendation 1: **That the Carers Plan be developed in partnership with local carer service providers, carers' forum and in consultation with local carers.**			
An updated carers' plan was produced to consolidate our approach to carers. However, there needs to be a review of the carers' offer in the context of carers' new status under the Care Act 2014, and how we are investing across partners to support carers better.	Pilot a one-year Carers' Strategy role to give the carers agenda additional focus.	Karen Sugars, Acting Service Head Commissioning & Health	Jan 2016
	Co-produce, by working with the Care Centre, carers' groups and carers in developing a new Carers' Strategy.	Karen Sugars, Acting Service Head Commissioning & Health	Summer 2016
	Map existing offer and needs, via an updated JSNA.		
	Create five 'user statements' to underpin the way we work to support carers.		
	Develop strategy action plans and commissioning plans		Autumn 2016
UPDATES: ▪ Strategic Commissioning Manager, with a lead role on carers, has been recruited to and started on 26 September 2016. Since coming into post this work has progressed at an increased pace. ▪ Extensive engagement work with Carers' Centre carers and Sonali Gardens carers took place during Summer/Autumn 2016. This identified and prioritised areas about which carers had concerns. These issues are being incorporated into the new Carers' Strategy which will be presented to Cabinet on 7 March 2017. The vision for this strategy, although based on the National Carers' Strategy, has been developed with and agreed by a group of local carers, through Tower Hamlets Carers Strategy Group. This vision illustrates our commitment to carers going forward.			

Carers will be universally recognised and valued as being fundamental to strong families and stable communities. Support will be tailored to meet individuals' needs, enabling carers to maintain a balance between their caring responsibilities and a life outside of caring, while enabling the person they support to be a full and equal citizen.

- An updated Joint Strategic Needs Assessment (JSNA) has been published on the Tower Hamlets Council internet and can be found at:

  http://www.towerhamlets.gov.uk/lgnl/health__social_care/joint_strategic_needs_assessme/joint_strategic_needs_assessme.aspx

- The Council's Adult Services Directorate has developed a Quality Assurance Framework which lays out the structure through which the quality of adult social care will be defined, measured and improved. It contains five core quality standards which apply equally to carers and the people they care for:

  - We treat everyone with dignity and respect
  - We provide honest information that is easy to understand
  - We support people to be as resilient and independent as possible
  - We are "person centred" and treat everyone like an individual
  - We listen to people's views and act on them where possible

  We intend to support carers to develop additional/enhanced standards as a series of "I" statements which will be published as a Carers' Dignity Charter. A series of focus groups for carers took place in December 2016 across the borough to draft these.

- The Carers' Strategy will be presented to Cabinet on 7th March 2017.

- A detailed Action Plan will be developed to take forward the issues identified through the Strategy. Carers will be involved in developing the Action Plan through a co-production model, and we propose that service users are fully involved in the development of service specifications for any future commissioning of services. Tower Hamlets Together (THT) is engaged in this work which will include a cohesive range of actions to support our carers.

Recommendation 2: **That carers assessments are completed in a timely manner to ensure carers are supported to continue in their caring role.**			
Since the Care Act came into force on 1 April 2015, there has been a new practice framework in place to ensure equal rights and quality of assessment for carers	Embed carer needs into service user assessments to ensure continuity of care and carer supported.	Cath Scholefield, Service Head Adult Social Care	1 April 2015
	Regular training of council and carer organisation' staff on self-assessments.		
	To explore and develop feedback standards and timescales as part of recommendation 1 above.		Summer 2016
	Monitor timeliness of assessments.	Cath Scholefield, Service Head Adult Social Care	1 April 2015
	The needs of carers to be highlighted in practice learning, in order to improve approach in supporting carers.		

UPDATES:

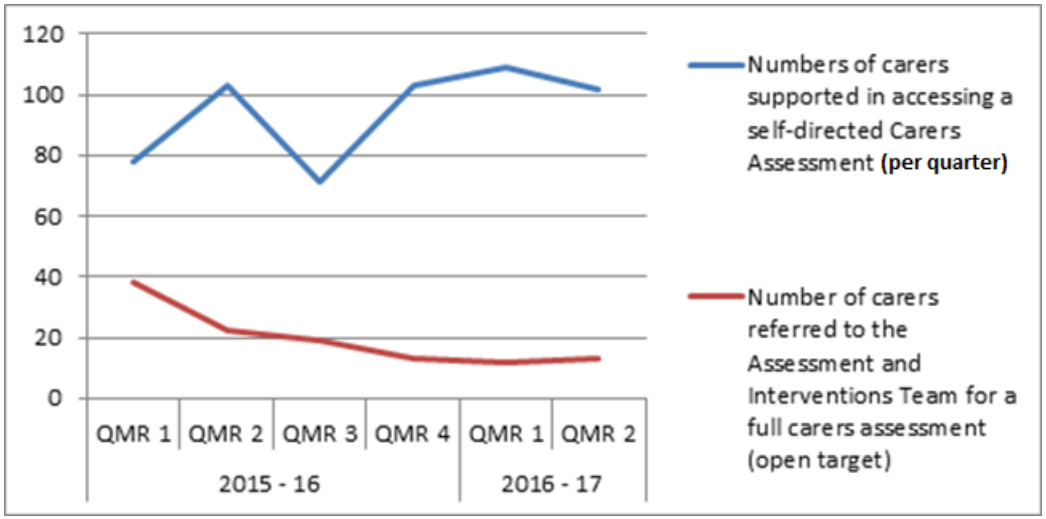
- Our revised Practice Framework adopts a 'whole family' approach to the assessment of needs, encouraging greater identification of carers and the wider support networks around vulnerable individuals. This means that all carers who may need support are able to get it at an early stage. It also means we have a holistic view of the care being provided to a person (for example, a service user may have a carer living far away who is still able to organise online shopping and visits).

- The Carers' Self-Assessment and Guidance has been revised in association with the Carers Centre, which is due to "go live" in January 2017.

- This new approach to social care assessments in Tower Hamlets is now focused on outcomes rather than service provision. Individuals will be asked specifically what outcomes they would like to achieve. One example of such an outcome could be the carer's ability to take up training or education. In such a case, support might include giving time off through respite, paying for and supporting carers to enrol on training courses, or signposting carers to the types of educational programmes carers they are interested in. The council must also consider other important issues, such as whether the carer is able, or willing, to carry on caring. If both the carer and the person they care for agree, a combined assessment of both their needs may be

considered.

- We have worked with the Carers' Centre to support carers to undertake Self Directed Assessments. The number of carers who have been supported to access a self-directed assessment averages 95 per quarter (over an 18-month period) with an average of 19 per quarter being referred to the Assessment and Intervention Team for a full Carer's Assessment. In line with carers' feedback the term self-directed assessment will change to "Carers' Needs Assessment" in January 2017.



- Following feedback from providers we plan to develop service standards, including response timescales, and feed back to referrers as a matter of good practice.

- Since the beginning of 2016, 100 providers have registered on the Community Catalogue, with services increasing from 80 to 185. This provides greater options for people who may need services, including respite.

- To enable non-commissioned providers to access the Community Catalogue, we have introduced the Ensuring Quality (EQ) award. This is awarded to providers that have gone through the EQ process. Providers that do not have a contract with the

council and who are not registered with the Care Quality Commission are required to go through this process before we list them on the Community Catalogue. We are one of six east London boroughs (Barking and Dagenham, Havering, Newham, Redbridge, and Waltham Forest) that use the EQ scheme. Once a provider has gone through approval in one of the six boroughs there is no need for them to apply again within these boroughs. Awards are for two years, after which the provider is required to demonstrate that it is still eligible for the award. There are 13 providers on the system, including nine payroll services to support people who are in receipt of a cash personal budget.

- Information and advice and the Community Catalogue (e-marketplace) are promoted to all staff on a regular basis, with information and links being included in the User Guide to the Practice Framework for assessment and during team based training.

  All new staff in Adult Social Care, including students on placement and locums, are required to attend generic Care Act 2014 training within two months of joining the council. Information on where to access information about local services is included within the session, with direct reference being made to the Community Catalogue.

Recommendation 3: That the council's social care staff are trained to support carers effectively by being aware of various services available in the borough to support carers, including information, advice and guidance. This should also include managing expectations of carers.

Information and advice consolidated and improved since 1 April 2015 including use of the Idea Store website platform and council E-market Place (Community Catalogue)	To recruit a permanent Information Strategy Officer, who will oversee the quality and effectiveness of information and advice.	Barbara Disney, Service Manager Strategic Commissioning	Jan 2016
	Set up an alert ICS System for staff to receive notifications on new services going onto e-marketplace.	Barbara Disney, Service Manager Strategic Commissioning	1 April 2016
	Practice framework reinforces resilience and family networking maximises informal resources to better support main carers	Cath Scholefield, Service Head Adult Social Care	1 April 2015

	Information and advice and e-market place regularly promoted at induction and relevant training.	Sue Hanna, Children and Adults Professional Development Manager	1 April 2015
	Quarterly visits to the Carer Centre by the operational Service Head for social care	Cath Scholefield, Service Head Adult Social Care	Dec 2015

UPDATES:

- The Information Strategy Manager post has been recruited to and the post holder commenced on 21 November 2016
- ICS system alert – further discussion indicates that a short, monthly update bulletin for staff would be a more effective and efficient use of resources. The Market Infrastructure Officer will also update the intra/internet regularly to ensure that information is fresh and up to date.
- The focus of the Care Act 2014 is on prevention and delaying dependency on formal resources, and delivering person-centred, strength based assessments. This includes supporting the person and their carer to fully utilise their own abilities, strengths and local community assets to meet identified outcomes and eligible needs. Our Idea Stores provide an on-line directory of generic services across the borough, including national organisations, to support a comprehensive range of universal provision.
- As noted above, information and advice and the Community Catalogue (e-marketplace) are promoted to all staff on a regular basis, with information and links being included in the User Guide to the Practice Framework for assessment and during team based training. Information on where to access information about local services, with direct reference being made to the Community Catalogue, is included in the generic Care Act training for all new staff.
- The Service Head, Adult Social Care, has met regularly with the manager of the Carers' Centre. The agenda has included specific casework enquiries, Safeguarding concerns, the review of the Practice Framework and wider service and community engagement, including Tower Hamlets Together.
- The Idea Store Friend and Carer Membership scheme links together two types of person:

- ✓ Someone who finds it difficult to get to their nearest Idea Store or library (the home reader)
- ✓ A 'Friend and Carer' – who could be a family member, a friend, a neighbour or a volunteer – who can go to the Idea Store or library on their behalf and choose books and other items for them.

This scheme recognises informal relationships, and gives the 'Friend and Carer' some additional benefits, including: vouchers for tea or coffee at Idea Store cafes, VIP access to exhibitions, a free place when accompanying the 'home reader' on an Idea Store Learning course and exemption from all charges for items returned late.

The intention is to promote the scheme widely so that more people are able to take advantage of Idea Store services – and to encourage others to help a friend or neighbour. We hope that the 'Friend and Carer' will be in regular contact with the 'home reader', breaking down social isolation – and will also be able to bring the home reader into Idea Stores to take part in courses or regular activities, such as the weekly 'Prime Time' clubs for older people. Currently, the scheme is in a "test and learn" phase and the official launch is likely to be April 2017.

Recommendation 4: That carers are provided clear and substantive feedback when they are not eligible for services and appropriately signposted to universal and preventative services they can access.			
This is a key aspect of the Care Act and is reinforced through the Practice Framework	Audit process to evidence that this feedback is happening and is legally compliant for both eligible and non-eligible Carers	Cath Scholefield Service Head Adult Social Care	November 2015

UPDATES:

One way that social work practice can be measured in relation to carers is through auditing activity. Prior to the new Practice Framework, 69% of audited assessments between January and March 2015 found that "the role and function of carers had been fully explored and their expertise respected" (a further 20% found this to be "non-applicable"). Auditing in relation to carers has since been expanded through the introduction of a "Senior Practitioner Checklist" audit tool. Although based on a small number of around 50 assessments, these reveal that over August and September 2016:

- ✓ 71% of audited assessments fully set out that all family and friends who can contribute are doing so to a level that is reasonable and appropriate
- ✓ 64% of audited assessments fully set out that all family and friends who could contribute are doing so

- ✓ 57% of audited assessments fully set out the views of a service user's significant others about the needs and service requirements of the person, and set out the extent of their influence on the service user's views.
- ✓ 23.5% of audited assessments fully identified the needs of carers, including through a carer's needs assessment, where appropriate. This was non-applicable to 50% of audited cases

- The promotion of the Community Catalogue (See Recommendation 3) and the proposed development of an analysis mechanism for reviewing unmet need will contribute to this recommendation.

Recommendation 5: The range of carers' services available is publicised on the internet. We will review our investment in those services in response to feedback from carers through the assessment process and ensure that any new provision is appropriately publicised and that carers and relevant organisations are made aware of such changes. This will link to Recommendation 1.

We continue to add services to our Community Catalogue. Some services are commissioned and others who may wish to advertise through the Community Catalogue will go through the ELS Ensuring Quality process.	Updating services to the Community Catalogue continues, and will be ongoing as more providers recognise its value.	Barbara Disney, Service Manager Strategic Commissioning	Ongoing
	The Ensuring Quality process will ensure that a vibrant range of options is available to meet the needs of our residents	Barbara Disney Service Manager Strategic Commissioning	Ongoing
	The Community Catalogue and Ensuring Quality process will be promoted at a range of fora, including the Pan-Provider Forum, internal team meetings with social workers, with brokers and through Partnership Boards and Carers' Groups.	Barbara Disney Service Manager Strategic Commissioning	Ongoing

UPDATES:

- See Recommendation 3

Recommendation 6: That the council in partnership with Tower Hamlets CCG develop a manual handling training course for local carers to prevent long term harm and injuries to carers.			
The proposed Carers' Strategy Officer will take forward the current Carers' Plan at the same time as leading development of the new strategy with Carers. One such action is delivery of a Carers' College	Deliver the Carers' College to include manual handling and other training relevant to supporting Carers in their caring role.	Karen Sugars, Acting Service Head Commissioning & Health	
	TH CCG will share the manual handling policies of our main providers	Sandra Moore, Senior Manager, Quality, Performance and Planning, TH CCG	Dec 2015
	TH CCG will support the council in finding/identifying an accredited provider of manual handling training	Sue Hanna	
	TH CCG will circulate information to our commissioned providers on manual handling training for carers	Sandra Moore	

UPDATE:

- Development of Carers' Academy/College: This work has been slow to progress. However, we have now identified good practice and are in the process of developing an options paper for a Carers' Academy for Tower Hamlets, supported through both social and health care economies

- It is envisaged that the training will provide more than general advice and information or awareness, such as more in-depth knowledge of specific conditions, such as cardiovascular disease, diabetes, dementia and end of life support, and practical training on basic caring tasks, such as washing and dressing. This training may be delivered in various formats, including face to face, online and peer support. It will also link with existing projects, such as the Smarter Care Project, which focuses on single carers rather than "double ups".

- It is intended that the Carers' Academy will also support carers to have life outside of their caring role, by signposting/linking to opportunities for special interest groups, IT training and volunteering opportunities through existing provision, such as LinkAge Plus, Public Health and the Idea Stores' offers.

Recommendation 7: That consultation and engagement be undertaken with carers to better understand the need for respite services and ensure these are designed to meet local needs.			
This will be looked at as part of Recommendation 1.	Specific analysis and research into respite from caring by working with carers as part of Recommendation 1 and piloting alternative approaches to respite, including specific groups such as Transitions.	Karen Sugars, Acting Service Head Commissioning & Health	1 April 2016
	Flexibility of home care to meet carers' needs for respite designed into the new tender process to take place in early 2016	Karen Sugars, Acting Service Head Commissioning & Health	Early 2016

UPDATE:
The Domiciliary Care tender process, which included a specific element around carers, will be mobilised during early January 2017. This is a service for informal carers who have been assessed as requiring assistance with caring for an individual who is in receipt of Community Care services provided by the council. The new services will be expected to meet the needs of Tower Hamlets' diverse communities in a sensitive and appropriate way. Services may include:

- ✓ undertaking domestic tasks, such as cleaning, shopping and laundry to provide some respite for the carer;
- ✓ spending time with the cared-for person, in order to give the carer an opportunity to go out;
- ✓ enabling the cared-for person to access community facilities or similar, in order to provide the carer with a break;

The service will also operate in conjunction with the council's Carers' Emergency Card scheme, and prospective providers will need to have the capacity to provide an immediate response as and when required.

The London Borough of Tower Hamlets has a diverse population and prospective providers will have to offer, through the procurement process, a high degree of certainty that they will be able to deliver sensitive and appropriate services to all communities across the Borough.

Recommendation 8: That work is undertaken by primary health care services and the council to help carers who do not recognise their role as a carer to access better support to enable them to continue with their caring role.			
	Identification of carers through assessment of people with support needs	Cath Scholefield Service Head Adult Social Care	1 April 2015
	Working with the CCG to develop joint approaches to upskill staff working with carers in GP practices		1 April 2016
	TH CCG will work with Public Health colleagues to look at how we encourage the identification of carers through new patient checks as part of our NIS contracts.	Chima Olugh, TH CCG	On-going

UPDATE:

- Identification – statutory returns around carers' data. It is recognised locally that more needs to be done to identify and work with carers in the borough. The 2011 Census identified 19,356 carers in Tower Hamlets, of which 4,917 provide fifty or more hours of care per week. However in 2015/16 only 1,407 adult carers' accessed support services for carers in Tower Hamlets.

  General Practices are likely to be the first point of contact for somebody who is struggling to cope with their caring role and may present with physical and emotional symptoms associated with this, such as stress and anxiety. GPs are in an ideal position routinely to identify and signpost carers to support services in the borough, although this hasn't happened as much as it should. The CCG has, since April 2016, included a requirement in the Network Improvement Service (NIS) for the recording of patients to establish their carer status. The NIS was offered and taken up by all 36 practices. From 1 April to 31 October 2016, 8,316 people attended for a Health Check and 7,182 (86%) were identified as having an unpaid carer. The NHS Health Check service is delivered to all eligible people between the ages of 40 and 74. When carers are identified they are given information and details of the Tower Hamlets Carers' Centre, this has yet to and this has been translated into increased referrals to the service.

Recommendation 9: That welfare benefit support to carers is strengthened to ensure that carers access all the available benefits that they are entitled to and do not experience additional financial stress.			
Information and advice services and financial assessment	Ensure Carers' Hubs are aware of carer'' rights to welfare benefits and are supporting them to make claims.	Barbara Disney Service Manager	1 April 2015

process are in place to support people.		Strategic Commissioning	
	Ensure carers' needs for welfare benefits are picked up as part of financial assessments for care contributions.	Cath Scholefield Service Head Adult Social Care	1 April 2015
	Ensure that welfare reform changes are specifically understood in relation to their impact on carers and vulnerable adults, and that they are prominent in any analysis.	Cllr Amy Whitelock Gibbs Cllr Asma K Begum	Ongoing
UPDATE: ▪ The Tower Hamlets Carers' Centre continues to offer welfare benefits advice to carers. ▪ Local Link, a partnership of local organisations with a broad range of specialist knowledge, provides our information, advice and advocacy service. ▪ There is the potential for carers to be identified and their needs for welfare benefits advice to be picked up as part of the implementation of charging for social care from 1 April 2017.			

Non-Executive Report of the: **Health Scrutiny Sub-Committee** 17th January 2017	TOWER HAMLETS
Report of: Jackie Sullivan, Managing Director Royal London Hospital	**Classification:** Unrestricted
Royal London Hospital, CQC Inspection Update	

Originating Officer(s)	Jackie Sullivan Managing Director Royal London Hospital
Wards affected	All

Summary

1.1 The Care Quality Commission (CQC) undertook an inspection of the Royal London Hospital in July 2016 and published its findings in December 2016.

1.2 The inspectors reviewed eight core services: Urgent and Emergency Care, Medicine (including older people's services), Surgery, Critical Care, Maternity and Gynaecology, End of Life Care, Services for Children and Young People and Outpatients and Diagnostics.

1.3 Overall the Royal London Hospital improved from a rating of 'Inadequate' in 2015 to 'Requires Improvement'.

Recommendations:

The Health Scrutiny Sub-Committee is recommended to:

1. Note the outcome of the inspection;

2. Develop an understanding of the performance of the Royal London Hospital (RLH) across all areas inspected and where improvements are required.

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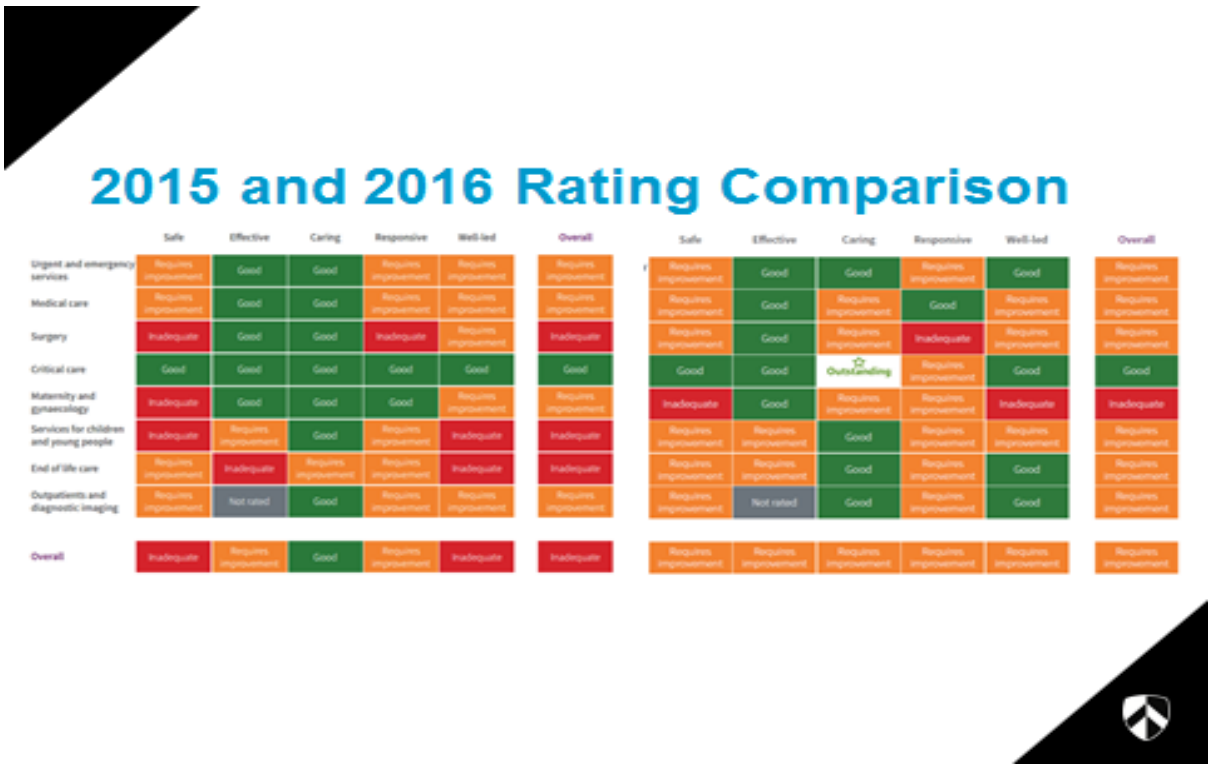
Barts Health Royal London Hospital CQC Report December 2016

Initial briefing for the Health Scrutiny Panel – January 2017

The CQC inspected the Royal London Hospital in July 2016. The inspectors reviewed eight core services: Urgent and Emergency Care, Medicine (including older people's services), Surgery, Critical Care, Maternity and Gynaecology, End of Life Care, Services for Children and Young People and Outpatients and Diagnostics.

Overall the Royal London Hospital has improved from a rating of Inadequate in 2015 to Requires Improvement in 2016

The full report is attached but the table below shows a very high level comparison between the 2015 and 2016 inspections.



Areas of improvement include:

- Outstanding in Caring in Adult Critical Care. The service had also developed a programme of learning to ensure best practice and improve patient care for a frequently changing workforce.
- Acknowledgement of the positive changes in the management structure
- Outstanding practice identified relating to innovation in trauma services, excellent sexual health services, code black protocol for patients with head injuries

- A change from inadequate to good for caring in end of life care and a move from requires improvement to good for well led in the same specialty
- Inadequate ratings reduced from seven to three

The Trust recognises that there is more work to be done and areas of specific focus include:

- Maternity services where the hospital was rated inadequate
- Particular focus on security and baby wrist bands
- High levels of agency staff. Concerns were raised that maternity services were not meeting the 1:28 ratio
- Flow throughout the hospital needs to be improved
- Caring has moved from Good to Requires Improvement in three specialties

The site leadership team is now working on a detailed action plan to address all of the CQCs concerns and a detailed plan will be fully discussed at the CQC Summit to be held at the end of January. There have been many specific areas of improvement since the inspection in July 2016 including

- a revision of the abduction policy within maternity which is now formally tested on a monthly basis along the lines of major incident testing protocol
- New baby wrist bands have been developed with the supplier and these are now in use throughout the maternity unit. Daily audit of use of wrist bands in place.
- Baby tagging system being sourced by PFI provider
- Staffing into permanent posts across the RLH has increased by 4%
- Agency usage on site has reduced by 31%
- The hospital has achieved a 40% response rate in the staff survey and early indications are positive. This level of response rate will facilitate a meaningful plan to improve areas of concern.

The RLH Leadership Team and Executive will be pleased to attend a Health Scrutiny panel at a later date to share the detailed action plan if requested.

Jackie Sullivan

Executive Managing Director, Royal London, Mile End Hospital & Community Health Services

4th January 2017

Barts Health NHS Trust

The Royal London Hospital

Quality Report

The Royal London Hospital
80 Newark Street
London
E1 1BB
Tel:020 7377 7000
Website:http://www.bartshealth.nhs.uk/our-hospital/the-royal-london-hospital/

Date of inspection visit: 26 - 29 July 2016
Date of publication: 15/12/2016

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

Ratings

Overall rating for this hospital	**Requires improvement**
Urgent and emergency services	Requires improvement
Medical care (including older people's care)	Requires improvement
Surgery	Requires improvement
Critical care	Good
Maternity and gynaecology	Inadequate
Services for children and young people	Requires improvement
End of life care	Requires improvement
Outpatients and diagnostic imaging	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

The Royal London Hospital in Whitechapel, East London is part of Barts Health NHS Trust, the largest NHS trust in the country, serving 2.5 million people across Tower Hamlets and surrounding areas of the City of London and East London.

The Royal London Hospital is a major teaching hospital. It offers a range of local and specialist services, which includes one of the largest children's hospitals in the UK and one of London's busiest paediatric Accident and Emergency departments. It is home to London's air ambulance, and is one of the capital's leading trauma and emergency care centres and hyper-acute stroke centres. Tower Hamlets is in the most deprived quintile of the 326 local authority districts, with about 37.9% (19,800) children living in poverty. The population includes 55.0% Black, Asian and Minority Ethnic (BAME) residents.

We returned to inspect this location (and the Whipps Cross Hospital location) to follow up on our previous inspection of Barts Health NHS Trust in 2014 and 2015 where we found a number of concerns around patient safety and the quality of care. Following the last inspection, significant changes were made to the leadership of the organisation at both an executive and site based level.

We inspected eight core services: Urgent & Emergency Care, Medicine (including older people's care), Surgery, Critical Care, Maternity & Gynaecology, End of Life Care, Services for Children, and Outpatients & diagnostic services. Overall, we rated this hospital as requires improvement. The critical care service was rated as good; maternity services as inadequate and the remaining core services as requires improvement.

Our key findings were as follows:

Safe:

- Nursing staff vacancies across the hospital and theatre staff vacancies impacted on staff morale and in some case the quality of patient care.
- A shortage of midwives meant that maternity wards were at times inadequately covered. There was also a low level of maternity consultant cover.
- Baby security was not robust, with poor compliance to the wearing of baby name bands.
- The infant abduction policy had not been promulgated to staff. However, the policy assumed the use of an electronic baby tagging system which was not in use in the hospital.
- At the time of our inspection reception staff were inappropriately involved in the streaming of patients coming in to the emergency department.
- At the time of the inspection and during the unannounced we found the medications cupboards on critical care were left open. All staff who had swipe card access to the unit including non-clinical staff such as domestic staff could access the medications room
- There were frequent problems with insufficient availability of sterile equipment in theatres.
- There was insufficient numbers of recovery staff with high dependency or advanced life support competencies to safely care for high acuity, high risk patients.
- Medicines management was on the whole safe. But there were observed incidents where medicines were unsecured.
- Infection prevention and control procedures were adhered to and monitored in most areas.
- We generally saw good evidence of learning from incidents.

Summary of findings

Effective:

- We found poor understanding of the Mental Capacity Act 2015 and Deprivation of Liberty Safeguards (DoLS) amongst staff in services for children and young people, and how it applied to their roles.
- Overall pain relief was well managed, however staff access to syringe drivers that delivered pain relief for end of life care patients was complicated by low stock levels.
- Evidenced based care and treatment was provided.
- We found good examples of local auditing as well as participation in national research that facilitated quality care.
- Established multi-disciplinary working and seven day working was in progress across all services, except for end of life care where a weekend face-to-face service was not provided.
- The use of paper based and electronic information in some departments meant that there were communication errors with patients, where appointments were duplicated or referral information was misplaced.

Caring:

- Most staff were caring and compassionate in their delivery of care. We found the delivery of care on critical care outstanding.
- Most patients and relatives were satisfied with the care and support they received and felt that staff took the time to include them in decisions about their care. Inconsistencies related to high workload, short staffing and the presence of agency staff.
- Patients had their dignity and privacy respected. However, there was not a robust policy in place to protect children from sharing rooms with others of the same sex.
- The compassionate care plan had been introduced in response to the withdrawal of the Liverpool Care Pathway

Responsive:

- We found that surgery services were inadequate in their response to patient's needs. The flow within the surgery system from admission, through theatres, wards and discharge was not managed effectively. There were consistent problems with bed management and bed availability, which caused late theatre start times and short notice cancellations of surgical procedures.
- The average bed occupancy was consistently equal to or above 95%.
- The average length of stay for elective and non-elective patients was worse than the England average.
- The average length of stay for medical inpatients was higher than the England average.
- The trust was not meeting national waiting time targets and had stopped reporting. However, the trust had implemented a full referral to treatment (RTT) recovery programme to address this, which included collaborative working with stakeholders to resolve the issue.
- The percentage of patients with suspected cancer being seen by a specialist within two weeks of urgent GP referral was worse than the England average.
- There was a two week backlog of outpatient appointments waiting to be booked. Some patients waited for over a year for follow up appointments.
- The nutrition and hydration needs of patients were met, though this was enabled by the support of relatives in some busy departments.

Summary of findings

- Sexual health and HIV services demonstrated a detailed understanding of the needs of the local population and formed community partnerships, developed research and adapted services to address these.
- Outcomes for mothers and babies in maternity services were better than the national average.

Well led:

- There were a number of innovations, particularly in trauma, where the hospital remains a world leader.
- Changes to the leadership structure of the trust, including at site level, were beginning to make a positive impact. Most staff spoke optimistically of the new leadership structure.
- Governance and risk management was better managed.
- In some services there was a lack of understanding of the vision and strategy of the organisation.
- Despite a general improvement in morale, a perceived negative culture of bullying and inequality was still prevalent in some services.

We saw several areas of outstanding practice including:

- There was a very strong record of innovation in the hospital's trauma service and the trust was internationally recognised as an innovator and leader in research in this field.
- The emergency department was the only centre in the country and one of only two in Europe to offer the Resuscitative Endovascular Balloon Occlusion of the Aorta (REBOA) treatment for patients.
- The emergency department had introduced a 'Code Black' protocol for patients who had severe head injuries. This was the first of its kind in the country and meant that appropriate patients had care led by neurological surgeon from the first time that they arrived in the department.
- Staff in sexual health and HIV services were highly research active and used findings from in-house research and collaborative partnerships to drive improvements in care and patient outcomes.
- We found the Adult Critical Care Unit delivered outstanding care. The service had also developed a programme of learning to ensure best practice and improve patient care for a frequently changing medical workforce.

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

Importantly, the trust must:

- Urgently improve security in the maternity services.
- Ensure that there are enough midwives on the delivery suite to provide safe care for all women.
- Ensure that the level of consultant cover on the delivery suite meets the recommendations made by The Royal College of Obstetricians and Gynaecologists.
- Ensure the proper and safe management of medicines on the critical care.
- Ensure sufficient numbers of suitably qualified, competent and skilled staff are effectively deployed to meet the needs of patients in all clinical settings.
- Ensure sufficient availability of sterile surgical equipment in theatres at all times to ensure the safety of service users and to meet their needs.
- Ensure there are enough recovery staff suitably trained in high dependency support and advanced life support to safely care for post-operative patients at all times.
- Improve bed management, theatre management and discharge arrangements to facilitate more effective flow of patients from theatres onto wards to ensure patients are not held in recovery for inappropriate lengths of time.
- Ensure there are sufficient numbers of suitably qualified, skilled and experienced staff to meet the needs of patients across all core services.

Summary of findings

In addition the trust should:

- Ensure that patients arriving in the emergency department are assessed within 15 minutes of arrival, and that all staff involved in the streaming of patients coming in to the emergency department are appropriately trained.
- Ensure that patients are admitted, transferred or discharged within four hours of arrival in the emergency department.
- Ensure that consultant cover on critical care during nights and weekends meets the Faculty of Intensive Care Medicine Core Standards consultant to patient ratio.
- Make arrangements to ensure staff in critical care side rooms have easy access to a call alarm should they require assistance when looking after patients.
- Consider ways to increase multidisciplinary ward rounds on critical care so they are happening on a daily basis.
- Review trust incident governance processes to ensure learning from incidents is shared systematically across all trust sites.
- Improve trust recruitment processes to facilitate more rapid employment of new members of staff and reduce staff vacancies on wards and theatres.
- Improve compliance and awareness of trust infection prevention and control policies and processes to ensure all staff understand how to label and dispose of clinical waste safely.
- Improve awareness of major incident plans, policies and protocols for all staff groups and grades.
- Ensure all staff have completed mandatory training and understand the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS).
- Ensure that staff appraisal rates are improved and all staff have timely clinical supervision.
- Take further action to improve and address the perceived culture of bullying and harassment.
- Ensure that equal opportunities for BAME staff are addressed.
- Ensure that all staff who wish to undertake additional qualifications relevant to their role are supported to do so.
- Ensure learning outcomes from incident reporting are effectively disseminated to staff.
- Ensure nurse to patient ratios are managed in relation to the individual needs of patients.
- Ensure that temporary staff, including agency nurses and volunteers, are suitably qualified.
- Ensure that pain scores are consistently recorded and there is always access to syringe drivers for the delivery of pain relief in end of life care patients.
- Take further steps to improve the patient experience of nursing care on wards
- Improve systems to ensure the nutrition and hydration needs of all patients are met.
- Ensure a hospital palliative care lead nurse is available 7 days a week to meet the hospital palliative care team's managerial and supervisory needs
- Investigate the introduction of enhanced recovery after surgery protocols to help patients achieve early recovery after surgical procedures.
- Ensure that documentation, such as pressure ulcer risk tools, are consistently used across all services.
- Ensure robust and consistent infection prevention and control measures are in place across all services.
- Ensure the removal of all potential ligature risks throughout children's services that would be a safety concern for young people at risk of self-harm.
- Ensure the development of a learning disability pathway in children's services, as well as ensure that staff have consistent access to input from specialist learning disabilities support.
- Ensure that a robust policy is in place to protect children and young people from sharing rooms with others of the same sex..
- Continue to reduce Referral to Treatment backlogs.
- Ensure improvements to diagnostic waiting times.
- Improve provision of patient literature in community languages.

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	Requires improvement 	At the time of our inspection, we found that reception staff were involved in the streaming of patients coming in to the emergency department. Patients arriving by ambulance did not consistently receive an assessment within 15 minutes of arrival, and the department had been consistently below the national target of seeing and treating 95% of patients within four hours of arrival. Nursing staff vacancies within the department remained high. However, we found good multidisciplinary team working and a culture of mutual respect and trust. A continuous programme of clinical and professional development was demonstrated. The environment was clean and 24 hours a day, seven days a week working was in place. Pressure ulcer risk tools were not in use and patients at risk of developing pressure ulcers were nursed on trolleys due to a lack of hospital beds. Pain scores were not consistently recorded. However, tools to monitor the deteriorating patient were in use across the department. Staff treated patients with dignity and respect. Patients we spoke with were positive about the care they received. Patients and their relatives told us that they felt informed and involved in their treatment plans. Staff also commented that they were supported by their peers and management. Patients received evidence-based care and treatment. The service was involved in a number of research projects that it recruited patients to. The service undertook a large number of clinical audits throughout the year and could show evidence of learning and improvement. Clinical incidents were appropriately investigated and learning was fed back to the staff.
Medical care (including older people's care)	Requires improvement 	Although notable improvements had been made in clinical care, leadership and governance, not all of the safety issues raised at our last inspection had been addressed. A rolling programme of staff recruitment was in place, but overall numbers of

registered nurses had decreased with high levels of agency nurses in some areas. The availability of specialist medical staff at weekends was inconsistent.
Patients were mostly treated with kindness and compassion. However this was inconsistent across the service and related to high workload and short staffing. Standards of infection prevention and control were variable and in some areas fell below standards. Auditing processes were in place but there was limited evidence of sustained improvement. Incident reporting took place, though learning outcomes were not consistently communicated to staff.
We found that multidisciplinary working contributed positively to patient assessment, safety and outcomes. Collaborative working between departments led to improved working relationships. Service planning was developed by staff who understood the changing needs of the local population. Several services offered 24 hours a day, seven days a week cover. Sexual health and HIV services demonstrated a detailed understanding of the needs of the local population and formed community partnerships, developed research and adapted services to address these.
Staff were inconsistent in their opinion as to how supportive the hospital's senior team was, and a number of staff across the service told us they felt the trust behaved in a biased manner when considering promotions and complaints
There were a number of areas of innovation in staff development, research, service expansion and quality improvement and sustainability.

Surgery **Requires improvement**

There was some evidence of progress since the previous CQC inspection. However, there remained a number of serious, cross-cutting risks and issues that were longstanding and unresolved and the service had not adequately addressed some concerns.
There were high levels of nursing and theatre staff vacancies across the service that impacted on the quality of care patients received. Patients told us some agency staff demonstrated a less caring approach. There were not enough recovery staff suitably trained in high dependency support and

advanced life support to safely care for patients in theatre at all times. Patients frequently remained in recovery after surgery for unacceptable lengths of time. Most patients we spoke to said that they had been well informed about their treatment.
We found that surgery services were inadequate in their response to patient's needs. The flow within the surgery system from admission, through theatres, wards and discharge was not managed effectively. There were consistent problems with bed management and bed availability, which caused late theatre start times and short notice cancellations of surgical procedures. There were inefficiencies and under usage of operating theatres and the service was not meeting all of its targets. Staff in theatres consistently reported problems with the timely supply of complete sterile surgical sets from the trust's external contractor. Surgeons told us that lack of instrumentation was impacting on their ability to treat patients effectively and was leading to cancellations and inefficient running of theatre lists. For example, surgeons reported a recent example where they did not have access to sets for major trauma, orthopaedic, vascular, arterial or neurosurgery for over 12 hours. ODPs told us they did not feel confident the service would be able to respond if there was a major incident. The average length of stay for elective and non-elective patients was worse than the England average. Ineffective discharge arrangements across surgery wards impacted on bed availability. However, the trust had focused on reducing 'Referral to Treatment' times which were steadily decreasing. There were also appropriate arrangements in place to support those with learning difficulties and those living with dementia. Barts Health was internationally recognised as a world leader in research and development of trauma care. The Royal London Hospital remains the busiest Major Trauma Centre in the UK, and there was a well embedded multidisciplinary multispecialty workforce.

Critical care

Good

Patient and relative feedback was positive about the care provided. Staff were frequently described as caring and professional. Patient privacy and dignity was maintained. Staff provided emotional

support to patients and relatives and could signpost to services within the organisations as well as external organisations for additional support. Flexible visiting was available on request.
We saw good evidence of learning from incidents. Patients received evidence based care. Suitable processes and development opportunities were in place to ensure nursing staff were competent.
The environment was clean and staff complied with infection prevention and control guidelines. However, medicines were not stored safely and securely. Drug cupboards were left unlocked and access to the medications room was not adequately secure.
Multidisciplinary working was effective, albeit that there were not sufficient numbers of allied health professionals, including physiotherapists and occupational therapists, to meet recommended standards.
Patient flow was hindered by a lack of bed availability elsewhere in the hospital. There was a significant number of delayed and out of hours discharges.
Staff spoke positively of the leadership and this was reflected in the culture across the service.

Maternity and gynaecology — **Inadequate**

There were not enough midwives on wards, day or night. Numbers of clinical midwives were significantly below establishment. This slowed down processes on the delivery suite and the postnatal ward and prevented some women from getting timely care. Only 92% of women had one to one care in labour, far short of national guidelines. The level of consultant cover on the delivery suite was 71.5 hours a week which falls far short of the Royal College of Obstetricians and Gynaecologist recommendations.
Processes for ensuring baby security were weak. Not all mothers or babies were wearing name bands and there was no local or central guidance on making appropriate checks when baby labels were missing. The infant abduction policy had not been effectively circulated to staff. However the policy itself was deficient as it assumed the use of an electronic baby tagging system not in use in the hospital.

Summary of findings

Women had inconsistent experiences, some very poor, of the maternity services, and some women and partners reported a lack of respect from midwives.
There was unwillingness among some midwives to adopt new processes: the morning safety briefing and the use of a second person to review fetal heart rate patterns at regular intervals were examples.
Record keeping was not consistent and accurate, particularly of handover of care from the delivery suite to the postnatal ward.
The maternity service did not demonstrate care for its own staff, rosters were late, approval of annual leave was slow, midwives felt their concerns were not listened to and morale was low.
However, improvements had been made in assessing and monitoring the quality of the service.
Staff planned and managed care in line with current evidence-based guidance, standards and best practice. Additional capacity for midwife led birthing was due to open in autumn 2016, and more space for postnatal women.
Secure archiving for ultrasound scans was being rolled out and already used in some areas. It would be available throughout maternity and gynaecology service in autumn 2016.Incidents were being investigated and closed in a timely way
Gynaecology services were well managed and provided a responsive service to women.

Services for children and young people

Requires improvement

We found potential ligature risks throughout children's services which would be a safety concern for young people at risk of self-harm. We also found examples of where safe guarding concerns were not appropriately acted upon.
There lacked a robust policy to protect children and young people from sharing rooms with others of the same sex.
The service did not have a specific area for the care of young people aged between 16 and 18 years who were generally cared for on adult wards.
There were high levels of nursing staff vacancies across the service. Staff did not receive regular clinical supervision and most staff had not been appraised in the last 12 months.

Summary of findings

Children's services did not have a specific learning disabilities pathway. Wards did not have access to input from specialist learning disabilities support, and the needs of patients with learning disabilities were not always being met.
Staff were encouraged to formally record concerns, and there was a good culture of learning from incidents. We also found effective multidisciplinary working across the service.
Children had access to a number of large, well-resourced playrooms, and age appropriate toys. Each ward had a play specialist available to work with children and provide exercises and playgroup sessions during their stay in hospital.
Patients and family members we spoke with were positive about the staff that were caring for them. Across all children's and neonatal services we saw patients and family members treated with dignity and respect. However, we found information was not provided in languages other than English.
Children's services and the neonatal unit did not have formalised plans in place for the future strategy and vision for the division. However, we identified good examples of local leadership, both on the wards and within the new organisational structure for the division. Most of the staff we spoke with stated that the culture of the children's services had improved since the last inspection.

End of life care **Requires improvement**

A face to face end of life care service was provided by the hospital palliative care team 9am to 5pm Monday to Friday. However, this was not in accordance with national guidelines, which recommends that palliative care services should provide such services 7 days a week between the same hours.
Staff access to syringe drivers that delivered pain relief was complicated by low stock levels. There was inconsistent completion of pain scoring tools on one ward. There was also inconsistency in the completion of patients' nutrition and fluid records.
The trust had introduced the compassionate care plan in response to the withdrawal of the Liverpool Care Pathway. Patients received care and treatment

			that was evidenced based. Although there were no formalised patient outcomes measure in place, work was in progress to introduce the integrated palliative care outcome scale. Staff were aware of how to report incidents and learning from incidents was shared. Most patients were positive about the way staff treated them. Most patients told us that their care met their expectations There was an open and honest culture within the service and morale had improved. Clinical leads were visible, approachable and supportive.
Outpatients and diagnostic imaging	**Requires improvement**		The trust was not meeting national waiting time targets and had stopped reporting. However, the trust had implemented a full referral to treatment recovery programme to address this, which included collaborative working with stakeholders to resolve the issue. There was a 2 week backlog of appointments waiting to be booked. Some patients waited for over a year for follow up appointments. A recent waiting times audit within clinics showed that over a third of patients experienced delays of more than 30 minutes. However, some clinical staff ensured services prioritised some individual's needs, such as those living with dementia or physical disability. The percentage of patients with suspected cancer being seen by a specialist within two weeks of urgent GP referral was worse than the England average. There had been 5 incidents where patients had suffered harm due to wrong site surgery in dental outpatients. There was lack of evidence to demonstrate feedback and shared learning with other outpatient services within the hospital. In the ophthalmology clinic we found medicines left unsecured. There were good staffing levels and skill mix was appropriate across the service. Patients were positive about the care they received and the information provided to them. Patients were treated with kindness, dignity and respect and told us they felt involved in their care and treatment.

Summary of findings

The environment was clean. Staff adhered well to infection prevention and control policies, and ensured equipment was clean and well maintained.
Diagnostic imaging provided services for inpatients 24 hours a day, seven days a week.
The leadership and culture of the senior management reflected the vision and values of the trust, delivering safe and compassionate care.
There were clear lines of management accountability and most staff worked well as a team.

The Royal London Hospital

Detailed findings

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

Detailed findings

Contents

Background to The Royal London Hospital

The Royal London Hospital in Whitechapel, East London is part of Barts Health NHS Trust, the largest NHS trust in the country, serving 2.5 million people across Tower Hamlets and surrounding areas of the City of London and East London.

The Royal London Hospital is a major teaching hospital. It offers a range of local and specialist services, which includes one of the largest children's hospitals in the UK and one of London's busiest paediatric Accident and Emergency departments. It is home to London's air ambulance, and is one of the capital's leading trauma and emergency care centres and hyper-acute stroke centres. Tower Hamlets is in the most deprived quintile of the 326 local authority districts, with about 37.9% (19,800) children living in poverty. The population includes 55.0% Black, Asian and Minority Ethnic (BAME) residents.

Barts Health NHS Trust has an annual turnover of over £1.5 billion. The trust employs over 14,000 staff. The private finance initiative (PFI) Royal London Hospital opened on 1 March 2012. The hospital has 647 beds across 32 wards. The trust comprises 14 registered locations, including 5 hospital sites in east and north-east London (The Royal London Hospital, Whipps Cross Hospital, Newham University Hospital, St Bartholomew's Hospital and Mile End Hospital).

Our inspection team

Our inspection team was led by:

Chair: Ellen Armistead, Deputy Chief Inspector, Care Quality Commission (CQC)

Head of Hospital Inspections: Nick Mulholland, CQC

Inspection Manager: Max Geraghty, CQC

The team included CQC inspectors and a variety of specialist advisors; such as consultants and doctors of different grades; nurses, midwives and allied health professionals, as well as experts by experience. We were also joined by specialists in child and adult safeguarding, clinical governance, executive leadership and work force race equality. An analyst team and an inspection planner also supported the inspection.

Detailed findings

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?

Before our inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included the clinical commissioning groups (CCGs), NHS Improvement (NHSI), Health Education England (HEE), General Medical Council (GMC), Nursing and Midwifery Council (NMC), Royal College of Nursing (RCN), NHS Litigation Authority and local branches of Healthwatch.

We held focus groups with a range of staff in the hospital, including doctors, nurses, midwives, allied health professionals, and non-clinical staff. We interviewed senior members of staff at the hospital and at the trust. A number of staff attended our 'drop in' sessions to talk with a member of the inspection team.

Facts and data about The Royal London Hospital

1. Context.

- The site is the largest standalone acute hospital building in Europe. It is one of 5 hospitals run by Barts Health NHS Trust, the largest trust in the country.
- The main commissioner of the acute services is Tower Hamlets clinical commissioning group (CCG).
- The hospital serves a local population of more than 2.5million. The population of Tower Hamlets is statistically worse than the national average for deprivation, under 16s in poverty, statutory homelessness, violent crime, long term unemployment, obese children (year 6), drug misuse, recorded diabetes, incidence of tuberculosis (TB), acute sexually transmitted infections, life expectancy at birth (males), smoking related deaths, killed and seriously injured on roads, and under 75 mortality rate for cardiovascular and cancer diagnosis.
- The population of Tower Hamlets is statistically close to the national average for alcohol-specific hospital stays (for under 18s), smoking prevalence, percentage of physically active adults hip fractures in people aged 65 and over, life expectancy at birth (females), and infant mortality.
- The population of Tower Hamlets is statistically better than the national average for GCSE achieved 5 A*-C, smoking status at time of delivery for women, under 18 conceptions, obese adults, excess weight in adults, hospital stays for self-harm, and hospital stays for alcohol related harm.
- The hospital has a total of 647 beds – 45 maternity beds and 44 critical care beds.
- The hospital employs 1898 WTE nursing and midwifery staff.

2. Activity

- Inpatient admissions: 327,012 (June 2014- July 2015)
- Outpatient admissions: 540,806 (June 2014 – July 2015)
- Emergency attendances: 456,149 trust wide, with 155,567 at The Royal London Hospital (May 2015 – April 2016, excluding MIU attendances)
- MIU attendances: 14,915 (May 2015 – April 2016)
- Births: 4,645 (April 2015 – March 2016)
- Deaths in hospital:1005 (April 2015 – March 2016)

3. Bed occupancy

- Equal and above 95% (2015/16).

4. Incidents

- Trust wide there were 14 never events and 337 serious incidents (August 2015 – July 2016) The Royal London Hospital reported 9 never events (June 2015 - May 2016). Eight were in surgery and cancer. One was in medicine. The Royal London Hospital reported 142 serious incidents.

5. CQC Inspection history

- CQC has inspected the Royal London Hospital four times since 1 April 2012.
- The hospital was last inspected as part of the Bart's Health NHS Trust inspection in January and February 2015 under the CQC's new methodology. The Royal London Hospital was rated overall as:

Safe – inadequate

Effective – Requires Improvement

Caring – Good

Responsive – Requires Improvement

Well-led - Inadequate

6. Key Intelligence Indicators

Safe?

- 9 never events were reported at the Royal London Hospital between August 2015 and July 2016. Overall, the trust reported 14 never events in the same period.
- Between June 2015 and May 2016, the trust reported 337 serious incidents (SI).
- The rate of midwifery staff to births ratio was below 1:30 due to staff turnover
- Clostridium difficile: 13 cases reported in medical care between April 2015 and March 2016
- MRSA: The trust has had 14 cases of MRSA between May 2015 and April 2016. It has also had a higher number of MRSA cases per 10,000 bed than the England average since September 2015.
- (Data not available specific to the hospital?)

Effective?

- Summary Hospital-level Mortality Indicator (SHMI) - no evidence of risk for the trust as a whole.

Caring?

- At trust level the NHS Friends and Family Test response rate was below the national average with 21% against 30%. Response rates at the Royal London Hospital were 23%. The average Friends and Family score across some core services was difficult to determine due to inconsistent recording of the data.
- NHS Friends and Family test (May 15 – June 16) - the score for urgent and emergency care was between 80% and 90%, almost consistent with the national average in the same period.
- The average Friends and Family score for maternity at The Royal London Hospital was difficult to determine due to inconsistent recording of the data.
- Cancer Patient Experience Survey 2015 – Asked to rate their care on a scale of zero (very poor) to 10 (very good), respondents at the Royal London Hospital gave an average rating of 8.4.

Responsive?

- A&E, four-hour target – Between June 2015 and May 2016 the hospital performed worse than the England average for the percentage of patients being seen within four hours, also failing to meet the 95% national standard for the whole of the reporting period.
- Referral-to-treatment times – the trust stopped providing this data beyond August 2014, so no up to date reliable data is available.

Well led?

- Staff survey 2015 overall engagement score (trust as a whole): 3.68. Slightly worse than the England average of 3.79
- Across the 32 Key Findings, the trust scored better compared to the national average in 3 key areas and was within expectations in 3 key areas. However, the trust scored below average in 26 key areas.
- The trust's sickness absence rate has been below the England average since February 2015
- Workforce Race Equality Standard (WRES): Key indicators in 2015 staff survey showed that 80% of white staff against 59% of BAME staff believed that the organisation provides equal opportunities for career progression.

Detailed findings

- The NHS staff survey indicated there was a higher proportion of staff reporting the experience of harassment, bullying or abuse in the last 12 months compared to the national average.

Our ratings for this hospital

Our ratings for this hospital are:

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

Urgent and emergency services

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

Information about the service

The emergency department (ED) provides a 24-hour service, seven days a week to the local population. The department sees approximately 187,000 patients a year and is one of London's four regional Major Trauma Centres and a Hyper Acute Stroke Unit (HASU).

The department includes a paediatric emergency department dealing with all emergency attendances under the age of 16 years, and with approximately 35,000 attendances per year, is one of the busiest EDs for children in the country. The clinical team consists of children's nurses, junior doctors from paediatric training and emergency medicine training programmes and resident emergency medicine consultant supervision 24/7. There is a paediatric emergency medicine trained consultant dedicated to department average 3-4 out of 7 days (not weekends).

The hospital has a helipad and severely injured patients are received into the department via the Helicopter Emergency Medical Service or land ambulance. Other patients present to the department either by walking into the reception area or arrive by ambulance via a dedicated ambulance-only entrance.

Patients transporting themselves to the department report to the reception area, where they are booked in and await triage by a nurse or GP.

The department consists of a cubicles (majors) area, minor injury and urgent care as well as a resuscitation area for up to eight patients, including two dedicated children bays. The ED has its own x-ray department, including dedicated use of two CT scanners.

Patients attending the ED should be expected to be assessed and admitted, transferred or discharged within a four-hour period in line with the national target. If an immediate decision cannot be reached, a patient may be transferred to the Clinical Decision Unit (CDU) for up to 12 hours or admitted to the Acute Assessment Unit (AAU), for up to 48 hours. CDU forms part of the ED, while AAU is part of the medical speciality.

Children are cared for within a separate paediatric ED that has a children's waiting area, cubicles and a four bay emergency room used for treating and monitoring unwell children. This has equipment within it to provide a step-down facility from the resuscitation room in order to keep availability of the facility in case of emergencies.

During our inspection, we visited ED over three days during our announced inspection and one weekday night as an unannounced inspection. We visited paediatric ED, the UCC and the CDU. We saw patients being treated and we spoke to approximately 60 staff including doctors, nurses, allied health professionals, administrative and support staff. We spoke with 12 patients and relatives, interviewed six senior managers and reviewed 18 patient records as well as information provided by the trust and the public.

Urgent and emergency services

Summary of findings

Overall we have rated the Emergency Department (ED) as requires improvement because:

- The median rate of survival for trauma patients was -1.6, where the expected score of a well-performing unit would be zero or above.
- At the time of our inspection, patients were inappropriately streamed by receptionists on arrival in the department and there could be long delays before they saw a nurse for an initial assessment.
- The department had occasions of overcrowding, with patients being cared for in corridors as there was not enough space in cubicles and there was limited change of practices and processes when this occurred.
- There was a shortage of hospital beds provided to the department to transfer patients who were at risk of developing pressure ulcers and there was no skin assessment completed on patients as part of their care.
- The department performed worse than the national average for the percentage of patients with a total time within ED of more than four hours.

However,

- The vision and strategy of the team working within the department was one of striving for excellence, which was demonstrated through a continuous programme of clinical and professional development. This was delivered by a cohesive, highly enthusiastic team that worked in a culture of mutual respect and trust.
- Staff were encouraged to report incidents and did so confident in the knowledge that learning would take place from them. Learning was shared with all staff via safety briefings and posters were displayed within the department.
- The trust utilised a range of policies and guidelines, which were based on national guidance. Staff were aware of these guidelines and had received appropriate induction and training to carry out their roles.
- The department undertook a large number of clinical audits throughout the year and could show evidence of learning and improvement following these audits.
- The service was part of a number of research projects that it recruited patients to.
- Following a pilot undertaken in the department blood tests were now offered routinely for early diagnosis of HIV and hepatitis.
- The department was the only centre in the country and one of only two in Europe to offer the Resuscitative Endovascular Balloon Occlusion of the Aorta (REBOA) treatment for patients presenting with massive internal haemorrhage.
- A recent 'Code Black' protocol had been introduced within the department for patients who had severe head injuries which had reduced the time taken for these patients to access surgery.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement

We rated the ED at Royal London Hospital for safety as requires improvement because;

- At the time of our inspection, reception staff were responsible for the initial streaming of patients.
- The department had a consistently poorer median time to initial assessment for both adults and children than the England mean.
- Patients arriving via ambulance did not consistently receive an assessment within 15 minutes of arrival which was not in line with Royal College of Emergency Medicine (RCEM) guidance
- No pressure ulcer risk tools were used and patients who were at risk of developing pressure ulcers were nursed on trollies due to a lack of hospital beds.
- The paediatric waiting room was not visible from the nurse's station and the checklist that had been introduced to confirm that staff were reviewing those waiting regularly was not consistently completed.
- Patients were, on occasion cared for in corridors due to overcrowding within the department. We were told this was not uncommon and there did not appear to be significant change of practices and use of escalation tools when this occurred.
- Hand hygiene and cleanliness checklist audits were not consistently carried out.
- Some hand gel dispensers were empty.
- The decontamination room contained two showers and there was no evidence that they had been run recently. There were items stored there inappropriately.
- Doors in the psychiatric assessment room opened inwards.
- Fridge temperature checks were not carried out on a regular basis.
- Manual handling training for nursing staff was below the 90% target.
- Security guards were not always willing to assist with a violent patient.

However:

- Incidents were discussed on a weekly basis and there was evidence of learning from serious incidents.
- Public areas appeared clean and there was good availability of personal protective equipment (PPE).
- The lay-out of the reception ensured privacy of the conversation with the receptionist.
- The equipment and facilities available in the department were of a high standard.
- The time to treatment was consistently better than both the national standard and the England average.
- Staff we spoke with were aware of their responsibilities to protect vulnerable adults and children.
- All staff were fully aware of the duty of candour and were able to give examples of how they applied this requirement in practice.
- National early warning score (NEWS) and paediatric early warning scores (PEWS) were consistently recorded.
- Paediatric ED staff held a regular multidisciplinary team meeting involving other professionals such as social worker, school nurse and youth team.

Incidents

- There were no Never Events reported by the ED between June 2015 and May 2016. Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- We saw learning point briefings compiled from four serious incidents that were available to staff. This included actions for all staff with some time scales of when these would be completed and reviewed.
- We saw a completed root cause analysis for a serious incident that had occurred in the department. The report was thorough and included learning as well as consideration of duty of candour actions required.
- An example was given of practice and guidance being changed following an incident relating to the safeguarding of a child.
- Incidents were discussed at a weekly department clinical governance meeting that was open to all staff. Additionally an email was sent to all staff to inform them about incidents and highlight any changes to practice. A site governance meeting was attended by a consultant each week and learning from any hospital wide incidents was shared with the department.

- We were told of a recently developed memory project which aimed to ensure that learning was thoroughly embedded and continuous learning from incidents was formalised.
- We observed a safety huddle which was held each day and attended by each department and ward. It was predominantly nursing staff but there was a drive to make it more of a multi-disciplinary attendance. Daily 'top four' issues were discussed and key incident learnings were shared as well as staffing levels, patients with additional needs and safeguarding concerns.
- We were told that ED staff attended mortality and morbidity (M&M) meetings held within the hospital as appropriate, such as specific meetings held for trauma or paediatric cases and we saw minutes of where the ED team had been invovled in mortality case reviews.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Staff understood the term 'duty of candour' and their responsibilities related to this. They said that they would direct the patient or relative to a senior clinician when needed.
- Duty of candour was included within trust induction. A patient information leaflet and a training video were available on the safety hub on the intranet. Training was not monitored, but was provided by the governance team for anyone who requested it. Senior nurses or consultants within the department undertook the responsibilities for speaking to patients or relatives as required.
- A consultant told us how, following an incident which caused harm, a letter of explanation was sent and an apology issued. The patient and family members were subsequently invited into the department for a meeting with the consultant. We saw this process had been electronically recorded.

Cleanliness, infection control and hygiene

- Hand hygiene audits for the adult ED were not always carried out. For example, between February and July 2016, there was no available data for three months. Results for the three available audits ranged between 80% and 90% compliant, with 90% being the accepted standard.
- Hand hygiene audits for the paediatric ED were available for the same six month period and compliance was at 100% for five out of the six months.
- Peripheral venous catheter insertion (PVC Ins) audits for the adult ED was available for four months between February and July 2016 with results ranging between 50% and 100%.
- PVC Ins audits for the paediatric ED were available for five months during this same period and ranged between 30% and 50%.
- There were no reported cases of Clostridium difficile (C. diff) between April 2015 and March 2016. There was one case of trust assigned methicillin-resistant Staphylococcus aureus (MRSA) in ED during the same time period.
- The sluice rooms that we inspected had a responsibility matrix on the wall. PPE was available within these rooms for urine testing. We saw records showing regular cleaning of the commode and a sticker on it denoting that it was clean.
- All toilets that we saw were clean and had records showing that regular checks of these were completed.
- We saw that some hand gel dispensers in the urgent care centre were empty and at one hand hygiene disinfection point, the hand gel bottle was missing.
- The department had a book which had a daily checklist that was needed to be signed when it was cleaned by the nursing staff. Very few of these checks had been signed to say they had been completed. In some cases, only one per week. This meant that it was not possible to know whether this area had been cleaned in line with the requirements.
- We were told that the dedicated cleaners were available 24 hours a day within the department. This was a maximum of seven in the day and this decreased at night. We saw cleaners in the department when we visited.
- We observed staff adhering to bare below the elbow policy and cleaning their hands before and after patient contact.

- There was good availability of personal protective equipment (PPE) and we saw that in most cases, staff wore personal protective equipment appropriately, although we did see one nurse remove an IV line from a patient without wearing gloves.
- The decontamination room contained two showers. We looked in this room during our inspection and saw trolleys as well as a bicycle being stored in here inappropriately. There was no evidence that the showers had been run recently and staff were unable to provide us with evidence that this had occurred. An audit that was conducted in June 2016 highlighted that there was an action plan in place for this this to be completed. Following our inspection the department told us that they had reviewed the policy and subsequently implemented a checklist for flushing of appropriate water outlets completed by the matron once a week, although the trust policy stated twice weekly flushing was required.
- The relative's room contained a fabric sofa that was ripped in one place. This meant that it was unable to be cleaned thoroughly and would present a risk for infection.

Environment and equipment

- The department had been built against the HBN 22 Accident & Emergency Facilities for Adults and Children (2nd Edition).
- The main waiting room and walk in entrance to the department was large and spacious with chairs suitable for bariatric patients.
- A red line was in place to indicate where patients should wait until they were called forward by the receptionist to book in. This ensured privacy of the conversation with the receptionist.
- There was a separate reception for paediatric patients. Once the patient was booked in, the receptionist then admitted them into the paediatric waiting room as access was secured. This room was colourful, and had a variety of play equipment, books and a television.
- The paediatric waiting room was not visible to nursing staff and was reliant on nurses doing spot checks to ensure there was no deteriorating patient. A recent review of this practice had resulted in the implementation of a checklist for all staff to complete to ensure regular observations of the waiting room were made and patient safety was maintained.
- The injuries area of the ED department used a consulting room model in order to assess patients without using up cubicle space. There was a dedicated room for maxilla-facial injuries, a plaster room and an eye examination room was available.
- There were eight bays in the resuscitation area, two of which were designated paediatric bays and one of which was equipped with full theatre equipment. Each bay had a resuscitation trolley, which were sealed. We saw evidence to support that they were checked daily. All equipment and the cubicle dividers are on wheels so that space could be created for individual patients as required. All the areas had very clear labelling and there was a process for restocking the areas after use.
- The equipment and facilities available were of a high standard. CT and plain imaging as well as O-negative blood were all immediately available. There was access to staff led blood testing and CT scanning directly from the resuscitation room.
- The paediatric area had a four bay emergency room used for treating and monitoring unwell children. This had equipment within it to provide a step-down facility from the resuscitation room in order to keep availability of the facility in case of emergencies.
- Each bay was clean and contained monitors, suction and oxygen. The paediatric bays had equipment specially adapted for children. We saw that all monitors had in-date portable appliance testing (PAT) stickers.
- We viewed the store rooms and found that equipment was stored in an ordered manner and that there was a system for replacement of items. Staff told us they had access to equipment they needed to do their jobs. All of the equipment we checked was within the expiry date.
- There were a number of patients who waited a long time in the department and were therefore at risk of developing pressure ulcers from lying on a hospital trolley bed. We were told that hospital beds were sometimes provided however there were often not enough for all patients with long stays.
- During our evening inspection when there were a number of patients waiting over four hours in the department we were told that there were three hospital beds available and had been allocated to the patients viewed as highest at risk of pressure ulcers. We observed two patients on these beds. We were told that patients who were not on a hospital bed were encouraged to turn regularly. There was no skin assessment completed on patients as part of their care. We were told that

patients were checked and rolled, however the lack of an evidence based process for this meant that it was not consistent and we were told that sometimes the wrong decision was made about which patient was allocated a bed.

- The department had one psychiatric assessment room available. This room had two doors and a panic alarm available. The chairs within this were heavy and therefore would be unable to be lifted or used as weapons. The room was assessed as being ligature compliant. However, the doors opened inwards, which meant that a patient had the potential to barricade themselves into the room. We spoke with a senior member of staff who told us this had been noted at a recent accreditation assessment and a works requisition had been submitted to alter the doors.

Medicines

- An annual audit of the department conducted in June 2016 had actions required in place as it had highlighted that fridge temperatures were not being recorded. However we noted that the fridge in the resuscitation area had been checked on only six days between the first and the 28th July. The fridges in the paediatric areas were also checked irregularly.
- All medication stored in the fridges was in date.
- Keys to the Controlled Drugs (CD) cupboards were held by registered nurses. We found Controlled Drugs in both the adult and the paediatric areas were correctly documented in the CD register and daily checks were made.
- A Patient Group Direction (PGD) is signed by a doctor and agreed by a pharmacist, can act as a direction to a nurse to supply and/or administer prescription-only medicines (POMs) to patients using their own assessment of patient need, without necessarily referring back to a doctor for an individual prescription.
- PGDs had been highlighted as a risk for the department as it had been identified that these had gone out of date. Authorisation had been given for an extension on the current PGDs and new ones were being re-written. Some had been authorised by the PGD committee and were waiting allocation and it was aimed that the remainder would be completed by September 2016. The tests for those who were using PGDs were under review and once they had been completed all eligible staff would retake them.
- We were sent information following our inspection which evidenced that this continued to be a work in progress with September 2016 remaining the target completion date.
- There was a Pharmacist and dispensary service available 24 hours a day. The Trust has a target of 85% to dispense urgent drugs to take away (TTA) within 1 hour and non-urgent TTAs within 3 hours. Information submitted indicated that dispensing rates for urgent TTAs from August 2015 to April 2016 varied between 55% and 91% and between 79% and 92% for non-urgent TTAs.
- The department had two nurse practitioners that were qualified nurse prescribers.
- Staff had access to the British National Formulary (BNF) online as well as all policies/information relating to medicines management (including the antimicrobial formulary).
- We saw from information on the electronic reporting system that staff understood how to recognise and report medicines safety incidents.

Records

- The department used a 'paper-lite' system which meant that most parts of the patient's record were stored on the computer. There were a few exceptions for this with paper records being held for GP referral letter, some pathways, electrocardiograms (ECGs) and medication administration however it was planned that ECGs would be on the electronic record from October. We were told that this had been delayed to ensure a robust method of the doctor electronically signing the ECG to confirm that it had been reviewed.
- The department used a computer system that fed into the main hospital system. Patient records could also be viewed at other hospitals. Locum and agency staff were issued with a temporary card in order to access the system while they were on a shift.
- No pressure ulcer risk tools were used to determine whether a patient was at risk of developing pressure ulcers whilst in the department. For example, no such assessment had been made of an elderly patient who had been on a trolley for eleven hours. This could mean that a patient's existing pressure ulcer may not have been identified or their risk of developing a pressure ulcer identified.
- In all the notes we looked at the national early warning score (NEWS) were consistently recorded on patient's

electronic records. This is a simple, physiological score whose primary purpose is to prevent delay in intervention or transfer of critically ill patients. The department used the National Early Warning Score (NEWS) to monitor changes in patient's vital signs. Results from the audits between January and March 2016 were on average 77% however had improved in April 2016 to 90%. Consultants told us the department did not wholly rely on this as an escalation tool since consultants were physically present in the department 24 hours a day. This enabled there to be a rapid senior medical review of a patient giving concern.

- We saw that paediatric early warning scores (PEWS) were consistently recorded.
- Patients discharged directly from the department had a letter sent electronically to local GPs.

Safeguarding

- The chief nurse was the executive lead for safeguarding children and adults. In their absence, this was devolved to the deputy chief nurse. There was a lead named nurse for safeguarding children at a corporate level and an on-site named nurse for safeguarding children and safeguarding children advisor.
- There was a site based safeguarding adults lead and coordinator, a learning disability lead and a mental health lead.
- There was a named nurse for safeguarding available for advice 24 hours a day.
- Staff told us that they could access information about safeguarding by using the intranet and showed us how this was done. The safeguarding page included information on bereavement counselling referral, paediatric trauma, child sexual exploitation, domestic violence referral pathway and contacts for support to rough sleepers.
- Nurses could tell us how they raised a safeguarding alert which went to the safeguarding team. Information about children attending the department who had a social worker or a child protection plan was passed onto the safeguarding team to inform them of their attendance in the ED.
- We saw on patient notes how referrals were made to social services for all children under one year old who attended the ED.
- We saw a log of a psychosocial meeting that was conducted for child safeguarding. This was a regular weekly multidisciplinary team meeting involving other professionals such as social worker, school nurse and youth team. Cases of safeguarding are discussed and information shared appropriately with relevant parties.
- We saw a record of a recent quality assurance visit by the local clinical commissioning group (CCG) which focused on how the department safeguarded children. The resulting report was generally positive and commented on the way in which the clinical team worked closely with the extended team members to ensure that children and young people were safeguarded.
- There was annual safeguarding adults and children training for all staff where the trust compliance level was 90% for both.
- Medical staff compliance rates for completion of safeguarding adults level 1 was 98% and level 2 was 67%. Nursing staff compliance rates for completion of safeguarding adults level 1 was 97% and level 2 was and 93%.
- Compliance rates for medical staff for safeguarding children level 1 was 97%, level 2 was 67% and level 3 was 63%. Compliance rates for nursing staff for safeguarding children level 1 was 97%, level 2 was 93% and level 3 was 86%.

Mandatory training

- Mandatory training was completed via a mixture of online 'e-learning' packages and face to face training.
- Subjects covered included dementia awareness, infection control, early warning systems and moving and handling. Staff also completed training in conflict resolution, equality and diversity, fire safety, health and safety and information governance.
- Compliance for mandatory training was high and ranged between 90% and 99%, for both clinical and nursing staff. However, nursing staff were below the 90% target for manual handling at 82%.
- Mental Capacity Act and Deprivation of Liberty were topics covered in the Adult Safeguarding Level 2 module. Compliance rates for medical staff was 67% which was below the trust compliance rate of 90%.

Assessing and responding to patient risk

Urgent and emergency services

- During the hours of 8am to 10pm on arrival in the department an adult patient saw the receptionist and from the information given would be sent to either an illness stream or injury stream where they would have a further assessment undertaken by a nurse practitioner.
- Between 10pm and 8am, once the patient had booked in with the receptionist, all the initial assessments would be undertaken by a senior nurse.
- We were told by reception staff that on occasion, they found it difficult to determine where best to stream the patient. One told us, "we are not clinicians and it is often difficult to determine the level of severity." Nursing staff whom we spoke with recognised this to be a problem and expressed concern for patient safety.
- Following our inspection the trust informed us that the practice of patients being streamed by receptionists had since been reviewed and they were responsible for patient registration only.
- However, we were told that there was a plan for a soundproof 'pod' to be installed in the waiting room from where a senior nurse would conduct a short assessment of each adult patient prior to their booking in at reception. Nurses told us that they were looking forward to the 'pod' arrival as that would mean a senior nurse would be planned in the staffing and be able to complete a short assessment.
- Trusts in England are given a target by the government of triaging 95% of patients within 15 minutes of their arrival in the A&E department. This means that they should have an initial assessment with a nurse or clinician.
- At one point during our inspection, we observed 20 patients waiting to be seen by a nurse in the injury and illness streams. The waiting times varied between 35 and 81 minutes.
- We were told by nurses that this assessment was sometimes difficult to complete within the 15 minute requirement. If there were a large number of patients waiting for this assessment we were told that sometimes another nurse would also be tasked to carry this out but that was not always possible. Some nurses who carried out this assessment told us they would review those waiting on the computer screen list and see patients who were a higher acuity rather than in the order that they arrived.
- We were told that the nurse or practitioner conducting this assessment would observe the people waiting in order to identify if any required more urgent treatment. A signing sheet had been introduced to the department the week before we inspected that required the nurse or practitioner to sign that they had carried out this assessment every 15 minutes.
- We saw copies of this sheet during our inspection and saw that there were times when this had not been completed; therefore there may have been times of up to 30 minutes when patients waiting were not reviewed by a nurse. On a follow up evening inspection a week later we saw copies of this form both in adults and paediatrics and there were a number of times when it had not been completed, which meant that for blocks of time of up to an hour or more it was not clear whether that was because there were no patients within the waiting rooms at that time or whether the checks had not been carried out.
- Patients arriving by ambulance would be handed over by the ambulance crew to a doctor 24 hours a day, seven days per week. Between June 2015 and May 2016 the hospital had taken an average of 17 mins to undertake this assessment which was worse than the target of 15 minutes. The hospital told us that they had seen improvements in this time over the last few weeks and were planning to have a dedicated administrator within this area. Additionally during November 2015 and March 2016 the department recorded 29 handover delays over 30 minutes which was amongst the lowest in the country.
- There were no black breaches recorded by the department between May 2015 and May 26. A black breach is where a patient arriving by ambulance has to wait over an hour before they are admitted to the department.
- The hospital had a median time to treatment that was better than both the 60 minute national standard and the England average throughout the period of May 2015 to May 2016.
- Within the monitored cubicles an electronic feed was available for each monitor to a computer at the nursing station. This meant that any change to the patient observations could be viewed by the lead nurse within this area.
- Children would be booked in by a separate receptionist and then have an initial assessment by a registered sick children's nurse (RSCN). This was meant to happen within 15 minutes of arriving within the department.
- We were told that when the department was very busy and there was not space within cubicles for all patients

then some were placed in trolleys within the corridor of the department. Nurses we spoke with could not tell us how often this happened, although one said that it was 'not uncommon' and said that it may not get reported as an incident if they were too busy. We did not see any reported incidents of this in the data we were provided however during a follow up visit a week after the inspection we observed eight patients on trolleys and one in a wheelchair in the hospital corridors as the cubicles were full. One cubicle had been designated to be used for examination and treatment of these patients which we did see being used, however we also observed one patient having a cannula removed within the main department corridor.

- We saw a copy of the 'nurse in charge of escalation' triggers. This was a document that provided a template for the nurse in charge of actions if the department became busy. It was colour coded to highlight the different levels of response and escalation required. The highest level of this was black where one of the parameters was no vacant trolley space in cubicles, which was evident at the time of the evening inspection, however we did not observe any significant changes in actions of staff and having patients in the corridors was not noted as unusual by the staff we spoke to.
- Increased volume of patients was referred to within the department risk register, however it only acknowledged that that would lead to inadequate staffing and not the additional risks to patients of potential privacy and dignity compromise or corridor accessibility due to extra trolleys within the department. Despite the risk being opened in 2013 it was still listed as no credible plan within the mitigation status.

Nursing staffing

- A nursing handover was conducted at the beginning of each shift. This included an allocation sheet so each nurse was aware of the area that they were working in that night. It also contained information on bed status of the hospital and the number of breaches that had occurred. There was a plan for administrative staff to join the nurses' handover in the future so that they were aware of any issues within the department. This was due to be introduced following completion of a clerical consultation process.
- There had been recent approval for an increase to nursing staffing within the department and this meant that it had been increased from 14 nurses each shift to 18 nurses each shift. This was in response to a report where it was identified that there was an increase in attendances and also higher acuity patients were attending and needed a greater level of care.
- There was a high number of nursing vacancies in the department. At the time of our inspection there were 26 vacancies of band five nurses which was 21% of the establishment. We were told that seven of these posts had been recruited to and further interviews were happening the following week.
- In addition there were four vacancies of band six nurses and interviews were planned for the week following this inspection. There were also 1.9 full time equivalent band seven vacancies and we were told these posts were out for advert. The biggest reason highlighted for difficulties with retention was nurses being offered development posts elsewhere. We were told of plans by the senior leadership team to increase the opportunities for in-house progression for nurses in order to improve retention.
- We were told that vacancies were covered by agency staff and we observed this on our inspection with some shifts having 50% of nursing staff being employed by agency.
- On a follow up visit we were told that an extra nurse had been requested as it had been highlighted that there was a shortage of beds within the hospital to move patients that required admission. We saw that this additional nurse was used within the cubicle area as the capacity increased.
- Nursing staffing was on the department risk register.

Medical staffing

- We saw a business case that requested an uplift of medical staffing. This had been approved and we saw on a night inspection that this had been put into place. This meant that for a night shift there was one consultant, three registrars and six senior house officers. On the night that we attended we saw that patients were being examined by doctors within an appropriate time frame. We were told that this new model also reduced the reliance on locum doctors.
- Consultants made up 28% of the medical staffing skill mix, which was higher than the England average of 26%.
- There were 16 whole time equivalent consultant posts, with 21 individual consultants, 16 of whom were not on full time contracts.

Urgent and emergency services

- The registrar group of doctors made up 50% of the medical staff compared with the England average of 39%. Junior doctors made up 22%, just above the England average of 23%.
- Consultant rotas were drawn up 16 weeks in advance and those rotas we saw evidenced the fact that a consultant was physically present 24 hours per day. Junior doctor numbers were increased from 2pm in response to peaks in clinical workload.
- We observed a morning handover, which was efficient, well attended and held in a room within the department in order to ensure patient confidentiality. Detailed information was passed on to those in attendance

Major incident awareness and training

- The department had a major incident cupboard that contained equipment to be used in the event of a major incident. We checked this during our visit and saw confirmation that equipment was checked regularly. We saw boxes of masks clearly labelled as being out of date which were due to be removed. These were in an area set aside from other in-date equipment to avoid confusion. We were told that in order to avoid equipment going out of date, they were replaced on a rotational basis from stock in the ED department. HEMS held additional pre hospital operational packs, in order to ensure in-date medical supplies.
- A copy of the major incident actions cards and the policy was held within the hospital reception. An additional set was also held within the major incident store.
- We were told that there had been a recent 'table-top' exercise to review the current policy following terrorist incidents in Europe.
- We saw teaching timetables that showed that major incident refresher training was conducted every two weeks which was available to all staff.
- A security guard was based at the doors to the ambulance entrance 24 hours each day. They were available to be called to assist staff if there was an act of aggression by patients or visitors within the department. However, we were told by one nurse that they were sometimes unwilling to intervene with violent patients unless they were told the patient was discharged which could mean a delay in assistance.
- We saw the trust's 'managing abuse and violence' policy 2014, due to be reviewed 2017, which included a yellow card (warning letter to perpetrator) and red card (criminal proceedings) system. Staff whom we spoke with were aware of the policy and one nurse told us they were confident it would be rigorously applied. However, another told us application of the zero tolerance policy for violence was inconsistent as patients who had been violent towards staff in the past had been allowed back into the department.
- There were seven incidents logged for violence towards staff between January and April 2016.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

We rated the ED at Royal London Hospital for effectiveness as Good because;

- the hospital time to CT scan for trauma patients was better than the national average.
- The number of trauma patients presenting with cardio-thoracic injuries treated by a consultant was better than the national average.
- The trust utilised a range of policies and guidelines which were based on national guidance. Staff were aware of these guidelines and had received appropriate induction and training to carry out their roles.
- A dedicated teaching and learning environment hub had been developed.
- There was very good evidence of multi-disciplinary (MDT) working within the department and all members of the MDT worked well together.
- There was a robust induction programme for new nurses and doctors.
- The department undertook a large number of clinical audits throughout the year and could show evidence of learning and improvement following these audits.
- The service was part of a number of research projects that it recruited patients to.

However:

- the median rate of survival for trauma patients presenting to, or related to the ED was -1.6; the expected score of a well-performing unit would be zero or above.
- Pain scores were not consistently recorded.

- Some paediatric guidelines were out of date and had passed their stated review date.
- Appraisal rates were around 80% which was below the trust target of 90%.
- The unplanned re-attendance rate to A&E within 7 days was poorer than the England average.

Evidence-based care and treatment

- Clinical pathways followed included those for management of sepsis, fractured neck of femur, acute coronary syndrome, allergic reaction, first seizure guidance, hyperemesis gravidarum and sore throat. They were all available to view on the hospital computer system. Most guidelines we reviewed included a review date and were within that date.
- However, we found that some guidelines for the paediatric ED were out of date. For example, the safeguarding policy was dated 2009. We asked to see the most up to date copy, but the person we asked was unable to find it. We also saw that the anaphylaxis and allergy policy was issued in 2007, with a review dated of 2009 and the asthma in children policy had a review date of 2013.
- We observed the weekly clinical governance meeting which had a standing clinical update agenda item where key points from guidelines were highlighted.
- We saw clinical guidelines that were based on National Institute of Clinical Excellence (NICE) and Royal College of Emergency Medicine (RCEM) guidelines, including allergic reaction that was reviewed in January 2015 and the Sepsis screening tool.
- We observed a doctor initiating the sepsis pathway for two patients, on both occasions, clear notification of this was issued to staff.
- According to the Royal College of Emergency Medicine (RCEM) audit 2013/4 audit of severe sepsis and septic shock, the trust performed well on most measures. For example, 98% of patients had full observations documented in their notes, and 98% had antibiotics administered in the ED, but only 74% had blood cultures obtained. The RCEM target for all these was 100%.

Pain relief

- The ED used paper based tools to record levels of pain in patients, which were then contemporaneously recorded on the electronic data system. The paediatric ED used the Wong-Baker smiley faces pain rating tool, an age appropriate tool, to record children's pain levels. However we found that pain scores were not consistently recorded. For example, we found there were no pain scores recorded on three of the paediatric assessments we reviewed.
- We observed one adult being treated for a hand injury and there was no pain score recorded throughout the treatment process. However, some patients we spoke with said they had been asked about their pain levels.

Nutrition and hydration

- A water dispenser was available within the cubicles area.
- Sandwiches and cereal were provided for patients who were waiting in the department to be admitted. We saw sandwiches being offered to patients. On one evening we were told that they did not have enough sandwiches and had ordered more at the beginning of the nightshift as they were aware that they would have patients in the department for a long time.
- We were told that provision of drinks for patients in cubicles between 6am and 7am was irregular.
- There was no provision for hot meals to be offered to patients waiting a long time. We were told that it was common for relatives to bring in food for patients.
- We saw tea and coffee being offered to patients waiting in the cubicles area of the department.
- A vending machine was available with snacks for patients in the waiting room.

Patient outcomes

- According to the trauma audit and research network (TARN) data, the rate of survival for ED deviated between -2.28 and -0.95, with a median of -1.6, where the expected score of a well-performing unit would be zero or above.
- For injuries to limbs and pelvis, the number of patients seen by an orthopaedic consultant was 46.2% compared with 72.6% nationally. 52.3% of patients were seen by an STR (includes associate specialist, staff grade, research fellow and all former registrar gradings) when compared with 24.8% nationally.
- However, the hospital time to CT scan was 0.38, which was better than the national average of 0.55 and for cardiothoracic injuries, 95.3% of patients were treated by a consultant which was better than the national average of 67.2%.
- In a report published by the Sentinel Stroke National Audit Programme (SSNAP), outcomes for the hospitals

Hyper-acute stroke unit (HASU) included the number of patients scanned was 91.8% compared with the national average of 99.3%. HASUs are designated specialist centres established by Healthcare for London to improve the quality of stroke care.

- The HASU compared favourably for average time from clock start to scan (hours:mins) as this varied between 0:35 and 1:26 compared with the national average of between 1:06 and 2:48.
- The department had recently introduced a "Code Black" resuscitation call which alerted the department to the imminent arrival of a patient with severe head injury and allowed neurosurgical input from the time of alert. We shown data that showed that this system had halved the time it took for patients to get to the operating theatre from the resuscitation room. We saw an article which had been published in a major journal which substantiated this fact.
- The hospital had research nurses based within the ED and they attended major trauma and stroke handovers by the ambulance crew to ensure early identification of suitable patients for trials that were being undertaken. Current trials being participated in included the 'CRASH 3' and 'HALT-IT' trials, which both involved giving a medication to assist blood clotting to patients with specific conditions, the major trauma patient experience research study which aims to understand the experience of care and the 'BEST' trial, evaluating a new method of taking blood tests for patients with suspected heart attacks.
- The department participated in the Royal College of Emergency Medicine (RCEM) Audit cycle. This included the vital signs in children audit where it had performed in the medium and upper quartiles in four areas and the lower quartile in one area. There was a plan to carry out a re-audit of this in one year to see if improvements had been done. It had mixed results in the venous thromboembolism (VTE) audit where it had one criteria meeting the standard and two criteria in the lower quartiles. A re-audit was planned and a pathway was being produced for this patient group in order to improve the areas that they had not performed well in. We were shown the details of the senior and junior doctors with responsibility for these audits.
- We saw agendas from clinical governance days where the results from RCEM audits were discussed and learning shared in the department. Results were also displayed within the 'ED Hub' where staff not able to attend those meetings could view it.
- The unplanned re-attendance rate to A&E within seven days was between 8% and 9% which was poorer than the England average for the majority of the time period June 2015 to May 2016 and was worse than the national 5% standard for the whole of the reporting period. However, there was a slight improvement to 7.5% in May 2016.

Competent staff

- The department had developed a dedicated teaching and handover room called the 'ED Hub' six months ago. This room had displays on recent initiatives and results from audits that were available for staff to view. The room was also used for handovers so each staff member had a chance to review the information displayed prior to their shift starting. We were told that the introduction of this room had been received positively by staff and this was confirmed by every staff member we spoke to.
- All staff at every level spoke about the excellent teaching and learning environment. We saw timetables for weekly doctor training which included simulation training and refresher training on specific skills.
- The service had performed well in the General Medical Council (GMC) 2016 survey where it was rated 'green' for results.
- We saw a registrar welcome pack that had been compiled for the new starters due in August. We were told that this was sent electronically to new doctors in advance and then it was reviewed during their induction.
- We saw a laminated pack that was provided for locum doctors that were new to the department. We were told a similar pack was also available for agency nurses. A checklist for new agency nurses to complete was available in the 'ED hub' and they would be orientated to the area they were working by the lead nurse for that area.
- The induction process for new nurses in the department consisted of a day with a senior nurse to introduce them to the administrative and IT processes. They would be allocated to one of the teams and would have three days where they were supernumery. The department did not employ newly qualified nurses so that they

already had some registered nursing experience before working in the department. All new nurses had a competency book that was completed between six months to a year and they would have a shift arranged to be supervised by the practice development nurse. There was only one practice development nurse and therefore as there were a large amount of new starters we were told arranging this could sometimes be challenging.

- New emergency department assistants (EDAs) were supervised by a lead EDA in order to orientate them to the department.
- Following the new medical staffing model implementation the doctors all started at three points within the day. This meant that a briefing and handover could be provided at each of these times. At the 8am and 1pm start times a teaching session was also planned. This was only implemented after our main inspection and when we returned on a follow up inspection had only been in place for a day; however it was viewed as positive by staff that we spoke to.
- We were told that a number of permanent staff had left the department and were now doing agency shifts which meant that they were familiar with the department processes. However during the inspection we were told that although other agency staff being used were not new, some of them were limited in their ED knowledge and therefore were restricted in where they could work which could be challenging for nurses supervising them.
- Figures submitted indicated that appraisal rates to date for the department were around 80%, which was below the trust target of 90%.
- Revalidation was introduced by the Nursing and Midwifery Council (NMC) in October 2015, in order to ensure nurses and midwives continued to practise safely and effectively in line with the requirements of professional registration and we saw the trust policy which related to this. We also saw evidence of revalidation approval for ED nursing staff.
- We saw clear records of allocated mentors for doctors within the department, however although we saw records of nursing staff that had completed a mentorship course these records did not show when supervision had been planned or completed.

Multidisciplinary working

- We saw evidence of internal multidisciplinary team work. For example, we observed members of the neurology team visiting a patient in the ED and meeting with ED staff to discuss possible admission onto a ward.
- A drug and alcohol referral team was available within the department for referrals between 8am and 6pm Monday to Friday and between 8am and 5pm on weekends via a bleep system. Between January and March 2016 this service had 157 patients referred to them.
- Youth workers from a charity were based within the department. This was part of a youth violence intervention programme which runs in London's four Major Trauma Centre hospitals and aims to reduce serious youth violence.
- An information sharing protocol [CN2] had been reached with the metropolitan police in order to provide information about locations where violent crime occurred. This information meant that the police could review their patrols in order to reduce violent crime.
- A psychiatric liaison nurse was available in the department 24 hours a day seven days per week.
- There was an admission avoidance team who worked in the department between 8am and 10pm. This consisted of occupational therapists, physiotherapists and social workers who would provide assessment and support for patients who then may not need to be admitted.
- The department worked with the London Ambulance Service to support pre-hospital care. The department had doctors within it that undertook shifts on the London Helicopter Emergency Service (HEMS) that was based at the hospital. Additionally doctors from the department could undertake observation shifts with the Physician Support Unit (PRU) that provided advanced medical support outside of hospital within Tower Hamlets and the City.
- A specialist hospital team were paged when a stroke patient within the time frame for treatment was expected into the department. This team met and assessed the patient within the resuscitation room on their arrival
- The HEMS service ran weekly governance meetings where cases were discussed. Nurses and doctors from the department who had been involved in the care of these patients were able to attend these. An additional monthly HEMS clinical governance meeting was held

and was open to all staff as well as ambulance staff. A member of the ED staff also attended the hospital wide trauma governance meeting and we saw minutes of this involvement.

Seven-day services

- The main ED and children's ED were open 24 hours a day, seven days a week.
- There was a Pharmacist and dispensary service available 24 hours a day seven days a week
- ED consultants were physically present for 24 hours each day.
- There was dedicated access to two CT Scanners and X-ray facilities 24 hours a day. During evenings and weekends the radiography team worked from this facility.
- Blood products were available within the resuscitation room which meant that there was direct access 24 hours a day to patient who required this intervention.

Access to information

- Staff were able to access local policies and procedures on the intranet.
- Patient 'power notes' on computer flagged up particular issues such as safeguarding concerns and vulnerable patients.
- The departmental 'paper-lite' system gave speedy access to patient notes.
- The department had two 'point of care' rooms where nursing staff were trained to carry out some routine blood tests. These were open 24 hours a day seven days each week and meant that results of these tests were available more quickly to staff. There was a working group looking at expansion of this service to include other tests.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Mental Capacity Act and Deprivation of Liberty were topics covered in the Adult Safeguarding Level 2 module, for which the ED department was 76% compliant where the trust target was 90%. Consent training had been completed by 83% of the emergency department staff against the trust target of 90%.
- We saw that the consent to treatment and examination policy had been updated in May 2016.
- Staff had the appropriate skills and knowledge to seek consent from patients and were able to clearly articulate how they sought informed verbal and written consent before providing care or treatment.
- We saw how staff sought consent from patients prior to undertaking any treatment or procedures and documented this clearly in patient records where appropriate.

Are urgent and emergency services caring?

Good

We rated the ED at Royal London Hospital for caring as Good because;

- Staff treated patients with respect and we saw staff interacting in a friendly and professional way with patients and their families.
- The ED provided compassionate care and staff ensured patients were treated with dignity and respect at all times. We noted staff had access to resources to assist them in offering emotional support to bereaved relatives and were able to direct relatives to external agencies for additional support.
- Patients spoke positively about the care they received and the attitude of motivated and considerate staff and were satisfied with the care they received.
- Patients and their relatives and families were kept informed of on-going plans and treatment. They told us that they felt involved in the decision making process and were given clear information about their treatment.

However;

- There was a low response rate for patient feedback.

Compassionate care

- The hospital had a low response rate for patient feedback. They were working to improve the response rate. Although in the results for June it was found that 95.4% of patients would recommend the department, there was only a 2.1% response rate and therefore these results were not reflective of all patients' experiences.
- We were told about a patient who had been assessed and it was determined that they did not need admission to a ward if the correct equipment was provided for

them at home for use by their carers. The hospital arranged transport for the patient and taught the ambulance staff how to use the equipment so that it could be explained to the carers when they met them at the house. The carers failed to arrive at the house and therefore the hospital re-arranged the appointment and a second journey so that the patient could still go home and not be admitted. A bed within the hospital was also arranged should the carers have failed to turn up a second time.

- We observed most staff providing compassionate care to patients and supporting their carers and relatives.
- We observed that patient dignity was respected. Staff members used curtains to maintain privacy and dignity during assessment and treatment.
- There was clear demarcation between male and female beds in the clinical decision unit. The beds were at either end of the unit, separated by a door.
- Staff would provide clothes for use when patients arrived inadequately clothed.

Understanding and involvement of patients and those close to them

- We spoke with 12 patients during our inspection and most were positive about the care they received. One said, "I can't believe the quality of care I am getting, we are very lucky to have such a good local hospital."
- We spoke to a patient who had been signed up to on of the research trials being recruited to within the department. They had an information leaflet and the purpose and details of the research had been explained to them.
- There was a video available in many languages about diarrhoea and vomiting on a laptop for parents in the paediatric waiting area.
- There were posters clearly on display giving patients a range of information about health protection accident prevention and chaperones. There was also information about external support organisations including domestic violence, elderly and carers organisations.
- We were told by a patient for whom English was not their first language that additional time had been taken to explain their treatment in order that they could understand it.
- Patients we spoke with said they had been informed of the plan for their care. Each assessment we observed confirmed that the assessing doctor or nurse clearly explained the process to the patient and ensured they understood before proceeding.

Emotional support

- We saw staff providing emotional support and reassurance to patients and their families.
- One parent told us how staff demonstrated great sensitivity at a time of tremendous stress.
- The paediatric department had an information pack for bereaved parents.
- Staff told us how following a death in the department, there was a debrief on the day with a senior member of staff. There was then a follow up meeting with everyone who was involved from the team as well as the bereavement support service. There was regular follow up from this team and counselling was offered as required.
- There was a 24/7 chaplaincy service available. The chaplains were from the main faith communities, including Church of England, Roman Catholic, Muslim, and Jewish. The hospital provided quiet spaces to pray or for contemplation. These included a sanctuary, Jewish Community Rooms and Muslim Prayer Rooms. The chaplaincy service also organised and led services, delivered training to staff and officiated at Trust funerals.

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

Requires improvement

We rated the ED at Royal London Hospital for responsive as Requires improvement because;

- The department performed worse than the national average for the percentage of patients with a total time within ED of four hours.
- The GP out of hours service was not always available either due to unavailability of doctors or service capacity.

- Leaflets and written information on display were only in English.

However;

- The department had recently introduced a pain tool specifically for people living with dementia and learning difficulties.
- There was a designated room allocated for patients living with dementia, with a learning difficulty or who were patients on a palliative care pathway who were at end of life.
- Following a pilot undertaken in the department blood tests were now offered routinely for early diagnosis of HIV and hepatitis.
- The percentage of patients waiting 4-12 hours from decision to admit to admission was steady and was better than the national average since September 2015.
- Staff showed good understanding of trust complaints procedure and were able to provide examples of complaints or concerns that resulted in change of practice.

Service planning and delivery to meet the needs of local people

- The trust provided 24 hour accident and emergency services for children and adults in the local boroughs of Tower hamlets, Waltham Forest and Newham, and additionally for patient's suffering a stroke or major trauma from across neighbouring London boroughs and counties outside London.
- According to the trusts own 'Transforming services together' publication, it was stated that the hospital needed to work more effectively to serve its local community and a wider population in its role as a specialist centre.

Meeting people's individual needs

- The department had initiated a 'Code Red' system. This was an indication to awaiting staff to expect a patient who had an excessive loss of blood.
- We spoke with a HEMS consultant who told us there was a code red debrief following activation of the code which all staff are encouraged to attend.
- The signs within the ED department were all in English, which would make it more difficult for patients who were not able to read English. There were some pictures on the signs that made it clearer for patients to understand what would happen within each area of the department.
- Adults with learning difficulties who attended the ED had a hospital passport which assisted them to provide hospital staff with important information about them and their health when they are admitted to hospital.
- We were told of a recent introduction of a pain tool specifically for people living with dementia and learning difficulties. It had been launched at the last clinical governance day so use of it had not yet been evaluated.
- One cubicle in the department had been identified as a special care room. This was designated as a room for patients living with dementia, with a learning difficulty or who were patients on a palliative care pathway, who were at end of life and too frail to move. The room was private but could be observed when required by nursing staff. An application had been made to a charity for decoration of the room to make it more suitable for patients with these specific needs.
- The hospital had a play specialist employed in order to provide support to children and their parents attending the department. They especially engaged with children who were about to undergo a procedure or who were in severe pain.
- We were told that the play specialist was currently available three days per week between 9am and 5pm, at other times, there was an on-call play specialist from inpatient teams. However the ED play specialist position was to be extended to five days a week shortly following this inspection.
- Ketamine is a medication mainly used for starting and maintaining anaesthesia in order to avoid general anaesthetic and the paediatric ED operated a ketamine list.
- A fracture referral pathway had been set up where patients requiring a review of their X-rays did not have to attend an outpatient appointment but would be contacted on the telephone and given follow up treatment plans.
- Work had been started in April 2016 to review patients who attended the department frequently. In this time 51 patients had been referred to this program and a fortnightly multi-disciplinary team meeting would be

conducted to review the referrals. As an outcome of this, 93% had a specific care plan produced for them and there had been an estimated reduction of 174 ED attendances since the programme started.

- A screening programme had been introduced into the department in 2013 as part of a pilot study to carry out HIV testing. Following completion of the pilot this was now carried out routinely and had expanded to include hepatitis tests and provided the opportunity for patients who were not displaying symptoms to be diagnosed and treatment could be started earlier, which could improve life expectancy. The results had been published within a health journal in February 2016. In order to undertake this testing staff were trained in how to gain consent for the procedure and positive results followed up by another department. This test was offered to everyone over 18 who were having bloods done. 40% of people in this group had been screened and we saw as yet unpublished data which recorded there had been several new cases diagnosed. We were told that monthly data of positive diagnoses made was provided to the department.
- The hospital was designated as a health based place of safety and had a designated room that complied with the standards for this. If there was more than one patient requiring this room then the police would stay with the patient in another cubicle.
- We were told that patients having acute mental health episodes but who were not under a section would be placed in a cubicle or on a chair in the corridor so that they could be observed by the nursing staff. This decision was made on an individual basis for each patient as to what would be most appropriate. We were told that there were sometimes delays waiting for a patient to have a full psychiatric assessment and could be further delays if the patient needed medical treatment first.
- The Trust had a bilingual heath advocacy and interpreting Service (BHAIS), 65 whole time equivalent Bilingual advocates are employed under Corporate Nursing, using a centralised booking system. Where a face to face service is not available there is 24 hour telephone interpreting available. When BHAIS is unable to respond to the need, the request is outsourced to an external provider.
- We saw patients receiving support from translators on two separate occasions during our inspection.
- Bar coded property bags were recently introduced to enable better management of patient property for patients who arrived by ambulance.

Access and flow

- Data showed that between June 2015 and March 2016, the department average for the percentage of patients with a total time in the department within four hours varied between 86.5% and 82.7%. This was worse than the England average, and below the 95% national standard.
- On all days that we inspected the department we found there were multiple patients waiting in the department for over four hours.
- The percentage of patients waiting 4-12 hours from decision to admit to admission was steady between June 2015 and May 2016 and was better than the national average since September 2015.
- We were told that data was being reviewed to further break down the times within the department for patient waits. This helped to identify where improvements could be made and also provide positive feedback for staff who had delivered performance on their particular area. We were shown data for May 2016 which demonstrated that there were often days when over 95% of paediatric patients were within the four hour target for admission.
- We were told that the hospital was changing the culture which assumed that A&E waiting times was an ED issue only, and had started to be managed as a whole site. This had meant the introduction in the last three months of whole site bed meetings three times a day and a re-establishment of the discharge lounge availability to improve hospital site flow. The regular bed meetings had been introduced and their importance stated by the executive management team, with the director of operations in attendance, however senior ED staff that attended saw this as a positive move and something that assisted with site flow.
- The department rate for patients leaving before being seen varied 3% and 4.5% between June 2015 and May 2016 which was a higher rate than the England average of 2.7%.
- The department had a noticeably longer median total time in A&E than the England average in this same time period, with a mean wait of 164 minutes compared to a national figure of 143.

- Between 10am and 10pm seven days a week a non-clinical navigator could see patients after the initial assessment had been completed and direct them to more suitable services within primary care, such as booking them a GP appointment. After 7pm patients requiring a GP appointment would be referred to the GP out of hours (OOH) service that was available within the hospital. However we were told that there were times when this pathway was not available either due to unavailability of doctors or service capacity and the incident records showed times where this had happened. This meant that there was increased pressure on the ED to see patients that were suitable for primary care services. We were told that the unavailability of this pathway meant that it became more challenging for the nurses who carried out initial assessments as; although they had a card they could give to patients that would direct them to 111 the patient's expectation was that they would see a doctor.
- The department had developed an area of the department known as 'EM Care' running for the last two months. This is managed by a three person multidisciplinary team of nurses and junior doctors and was for patients who were able to sit in a chair and were able to walk but required an enhanced assessment. It was open between midday to midnight seven days a week and reduced the number of patients needing a cubicle. This area was reported on positively by staff that we spoke with as it meant that they were able to manage patients more safely since they had fewer in each area whom they were responsible for.
- We saw that overcrowding due to lack of patient flow when they required admission was one of the high risks on the department risk register.

Learning from complaints and concerns

- The Trust initiated a new complaints management process in September 2015 and we saw the Complaints Management - Standard Operation Procedure policy which was updated in February 2016.
- A Patient Welcome Pack was been recently introduced following feedback received from Friends & Family and 'I want Great Care'. The pack provided basic needs for patients including eye mask, socks, ear plugs and information leaflet.
- The signs within the ED had been re-done five months ago in response to patient feedback. They explained information about each area of the department and where the patient was in their journey through the department.
- The emergency care area had been introduced 18 months ago, following feedback from patients complaining about congestion within the department.

Are urgent and emergency services well-led?

Good

We rated the ED at Royal London Hospital for Well-led as Good because;

- Operational managers and clinical staff worked together as a team to address the challenges faced by the ED on a daily basis.
- There was an open culture so staff could raise concerns.
- There was clear leadership visibility with the department.
- There were clear governance arrangements and we saw evidence of their meetings.

However,

- The department had not had a matron in post since April 2016 and this had led to some deterioration in processes.

Leadership of service

- The Trust had recently changed the management structure. There was now a site based management team and a new department management team had been in place since May.
- The department had not had a matron in post since April 2016 and only appointed an interim matron in July 2016. Following an extended recruitment campaign the department had now appointed two substantive matrons that would be taking up their posts in August and September. The divisional lead nurse had been supporting the department during this period amongst her other duties.

- Managers were aware of the areas where the hospital had challenges and where improvements needed to continue to be made. These included the need to work more effectively to serve its local community and to improve waiting times for patients.
- Due to the recent management reorganisation we were told that relationships with the relevant people had been built through previous structures. The formal process of network working for sharing information and improving practice across the sites had not yet been fully established.
- The nurses and doctors we spoke with were all clear as to their lines of supervision.
- We observed good leadership skills during handovers, consultants and senior nurses gave clear guidance and support to junior staff.

Vision and strategy for this service

- The divisional heads were able to tell us of their vision for the service and expected that the newly established clinical leads to further develop this.
- Included in this vision was for a more joined up approach incorporating out of hours services including 111 into unscheduled care to reduce the strain on the ED service.
- We were also told that they wanted to work more collaboratively with local hospitals in order to establish an acceptance policy which meant patients who had received specialist care could be transferred back more easily.

Governance, risk management and quality measurement

- The new management structure meant that a regular meeting pattern had only just been established. We saw terms of reference for a number of departmental meetings where incidents and learning was discussed. This included the quality safety group, the consultants meeting, a band seven management day and open forums.
- A weekly clinical governance morning was held. This was done as a drop in session and the agenda for the most recent meeting included updates on audits, clinical updates, complaints, incidents, duty of candour and simulation training.
- Most staff were able to articulate the department governance arrangements and which individuals had key lead roles and responsibilities within ED. They were also clear of their own individual roles and responsibilities and commented on the considerable amount of governance information available in the hub.
- The department participated in national and local audits.
- Clinical governance was embedded at local level with regular structured meetings taking place. We observed one such meeting during which there was an extensive level of discussion across a wide range of areas. We also noted from the minutes of previous meetings that complaints, incidents and risk were discussed, evaluated and monitored.

Culture within the service

- The divisional heads told us that they felt it was an open department where staff all felt part of the team. This was reiterated by the senior department managers where we were told that all staff were on first name terms with each other in order to promote better team work.
- Staff we spoke with said that they felt that managers were approachable and felt they could raise an issue with them or ask for support, and were able to challenge senior staff when required.
- We observed collaborative working throughout the department across the different grades and professions.
- All staff whom we spoke with said they felt valued and well supported. They also spoke of a deep sense of pride to be part of Royal London.

Public engagement

- We saw patient feedback response boxes in multiple areas around the department available for patients to provide feedback.
- Work was being undertaken to improve the response rate of the feedback, including staff putting their names on the card and asking patients directly to complete it.
- We were told about an activity on a development day for nurses involved sitting and speaking with patients within the department which was something that they often were not able to do when they were working. This gave staff more of an insight into the background of patients attending the department.
- The hospital had started work to take part in the listening project. This involved going to into the community and listening to people explain the circumstances that had brought them to live in the local area.

- A feedback team, formed of department staff members had recently been established and its aim was to gather patient feedback, through the feedback responses but also through a more holistic manner that they were developing.

Staff engagement

- We were told of a suggestion of a cost improvement that had been suggested by a junior staff member. The staff member had been given the opportunity to pilot their idea to determine the benefits that could be reached.
- A departmental action list had been developed from staff feedback. This had 50 entries on it initially and work was being done to progress these requests.
- One staff member told us how they had developed the idea of 'Em Care' with another staff member and they had been supported by the senior team to pilot and establish it. This was a provision managed by a three person multidisciplinary team of nurses and junior doctors and was for patients who were able to sit in a chair and were able to walk but required an enhanced assessment.
- We were told that the administrative staff had been involved in the consultation about changing of some aspects of their role, for example by choosing their new uniform.
- We had been told about a planned new career structure for nurses within the department by the divisional leads which was being developed in order to increase retention, however when we asked about this new structure to nurses in the department it was reported that there had not been consultation on this and their opinions had not been asked for.

Innovation, improvement and sustainability

- It is a leading major trauma department with 24-hour consultant trauma cover.
- The department was the only centre in the country and one of only two in Europe to offer the Resuscitative Endovascular Balloon Occlusion of the Aorta (REBOA) treatment for patients presenting with massive internal haemorrhage.
- A recent 'Code Black' protocol had been introduced within the department for patients who had severe head injuries. This was the first of its kind in the country and meant that appropriate patients had care led by neurological surgeon from the first time that they arrived in the department and faster access to surgery.
- The department had initiated a 'Code Red' system. This was an indication to awaiting staff to expect a patient who had an excessive loss of blood and blood products were available within the department to ensure that there was no delay in accessing this.

Medical care (including older people's care)

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

Information about the service

Medical care services at the Royal London Hospital include acute, specialist and general medical services within two divisions. Wards are organised into distinct specialties, such as an acute and hyper-acute stroke units and some wards provide a range of specialties, such as ward 10E, which provides inpatient care for gastroenterology, hepatology, irritable bowel disease, nutrition, rheumatology and dermatology. There are dedicated inpatient services for renal and urology patients, a general medicine ward specialising in diabetes, endocrine and metabolic diseases; an inpatient ward for neurosurgery, neurology, ear, nose and throat and maxillofacial patients and an inpatient ward for HIV, immunological disorders, infectious diseases and respiratory conditions.

A 52-bedded acute admissions unit provides inpatient care and treatment for patients admitted with an acute illness and there is a 26-bedded cardiac and respiratory ward and two dedicated wards for elderly patients. As part of our inspection we included the endoscopy unit as well as sexual health services provided on an outpatient basis. This is because sexual health is included in a clinical directorate with inpatient HIV services and so we can better understand and reflect the range of collaborative work between services by inspecting them together. Sexual health services are delivered in the Ambrose King Centre and outpatient HIV services in the Graham Hayton unit. Both centres are on the Royal London Hospital site.

Between January 2015 and December 2015, medical care services treated or provided care for 27,805 patients. Patients were most commonly seen for gastroenterology, general medicine or nephrology. The hospital reported bed occupancy rates of 94% or over in 11 out of the 12 months prior to our inspection.

We previously inspected medical care services at the Royal London Hospital in January 2015. During that inspection, we found medical care services to require improvement overall. Three areas highlighted were short staffing, inconsistent infection control practices and inconsistent patient risk assessments.

We spoke with 65 members of staff, including doctors and nurses of all grades, therapies staff, healthcare assistants, clinical and non-clinical managers, clinical leads, clinical directors and a range of other staff such as from clinical engineering, pharmacy and microbiology. We also spoke with 19 patients and 12 relatives, looked at the standard of nursing and medical records for 34 patients and considered over 113 other individual pieces of evidence.

Medical care (including older people's care)

Summary of findings

Overall we rated medical care services, including older people's services, at the Royal London Hospital as requires improvement. Although there were notable improvements made in clinical care, leadership and governance as well as a developing culture of acting on patient and staff feedback, the hospital had failed to address safety issues previously raised. This included in staff recruitment and the standard of infection control and patient risk assessments. Our significant findings were:

- Oversight of mandatory training was variable between medical services and it was common practice in some areas for staff to complete training unpaid in their own time or as part of holiday leave.
- Standards of infection prevention and control were variable and practice in some areas fell short of trust standards. Auditing processes were in place and senior staff were held accountable when practice was found to be substandard but there was limited evidence of sustained improvement.
- Nurse staffing levels had been a challenge for most medical services for an extended period. A rolling programme of recruitment was in place but overall numbers of registered nurses had decreased between April 2015 and April 2016 and some services relied heavily on agency nurses. This increased safety risks to patient and meant consistency of care was reduced.
- The availability of specialist medical staff at weekends was inconsistent and a number of senior staff raised this as a safety concern. This included substandard communication and cooperative working between consultants of some services that impacted patient care and staff morale.
- Significant improvements were needed in how staff used the dual system of paper records and electronic records. This included the monitoring of deteriorating patients and screening for MRSA.
- There was variable evidence that care was consistently compassionate and kind. This included from surveys, observations and in discussions with patients and relatives. Where staff attitude did not meet expectations, this was usually during periods of increased workload due to short staffing or where the majority of staff on a ward were temporary. There was limited evidence processes in place to address this.
- Engagement with staff by the hospital's senior team and the trust was in evidence but staff varied in their understanding or awareness of this. A number of staff felt the trust behaved in a biased manner when considering promotions and complaints and did not feel their experience or input was important. This feeling was represented across multiple staff grades, from band three healthcare assistants to senior clinicians.

However, we also found areas of good practice:

- Medical care services performed consistently well in environmental audits and there was evidence of service improvement in a number of areas, including in how staffing in the acute admissions unit (AAU) was managed and in prevention strategies for MRSA and Clostridium difficile.
- There was evidence incident reporting was embedded into working practices. Staff were confident in submitting reports and senior staff demonstrated robust processes for investigation and evaluation. However, there was room for improvement in how outcomes and changes to practice were communicated to staff, including temporary staff.
- Multidisciplinary working was embedded in practice and contributed to patient assessment, safety and outcomes. Physiotherapists, dieticians, occupational therapists, pharmacists, speech and language therapists, psychologists, social workers and clinical and medical engineers provided robust, consistent and targeted support to patients and staff. There was evidence of daily multidisciplinary input, including safety reviews and discharge planning.
- Practice development nurses, lead therapists and the critical care outreach team offered ad-hoc and planned structured training and competency checks and junior doctors had access to a comprehensive training programme. Leadership and specialist pathways were available, which incentivised staff to work towards promotion.

Medical care (including older people's care)

- Service planning was developed by staff who understood the changing needs of the local population. Advocates and client support workers who spoke common languages were readily available and significant progress was made in developing services to be dementia friendly. Sexual health and HIV services demonstrated a detailed understanding of the needs of the local population and formed community partnerships, developed research and adapted services to address these.
- Collaborative working between departments, wards and clinical and non-clinical staff led to improved working relationships, communication and opportunities to develop services. There were numerous examples of this, including between endoscopy and colorectal services, across ward clerk teams and between maternity and HIV services.
- Local and national audit data indicated broadly positive patient outcomes and benchmarked practice against national best practice guidance. Where performance fell short, staff worked together to establish improvement plans that were measurable and achievable.
- Clinical governance and leadership structures had been changed as part the trust's overarching improvement plan, which meant there were a number of vacancies at senior management level. However, staff spoke positively of the support they received from service managers and human resources business partners and there was evidence the improvement plan was having a positive effect.
- There were a number of areas of innovation in staff development, research, service expansion and quality improvement and sustainability, particularly in relation to sexual health and HIV services and multidisciplinary working across divisions and services.

Are medical care services safe?

Requires improvement

Overall we rated medical care services as requires improvement for safe because:

- There was an embedded culture of reporting and investigating complaints but variable evidence that learning from outcomes was robust or accessible by all staff.
- Standards of infection prevention and control were variable between wards and clinical areas. There was inconsistent use of hand gel, hand washing and personal protective equipment, which increased the risk of cross infection.
- Although monthly MRSA auditing took place and an improvement plan was in place to reduce infections, monitoring of screening at ward level was inconsistent.
- None of the medical inpatient wards had a register of chemicals in line with control of substances hazardous to health (COSHH) regulations and in some areas chemicals were in plain sight and unsecured.
- The temperature of rooms used to store medicines was not recorded, which meant staff could not be sure medicines were always stored below the manufacturer's safe maximum temperature.
- Patient records in some areas were inconsistent, including illegible or missing staff details and variable completion of regular patient observations.
- Nurse staffing was under significant and sustained pressure from a failure to recruit to vacant posts and high turnover in some areas. The use of agency nurses in some areas, such as older people's services wards sometimes made up 50% of staff per shift. The trust had a rolling recruitment programme that had been effective in some areas such as the renal service and sexual health and HIV services had stable nursing teams. However, the number of registered nurses in medical care services overall decreased by 35 full time posts between April 2015 and April 2016.
- Medical staffing levels varied between wards and services. There was a shortfall of 0.8 whole time equivalent (WTE) consultant cover in older people's services and two WTE posts were filled by locus consultants. A number of clinicians said the lack of specialty cover out of hours compromised patient care.

- Standards of compliance with mandatory training varied between clinical areas and teams. Rates of safeguarding and infection control training overall were very good but there were disparities between training figures provided by the trust and staff knowledge and practice. This was most apparent in training for emergency planning and patient clinical documentation. Training rates for resuscitation and basic life support were poor and none of the medical service wards or departments met the minimum standard.

However:

- Some individual services had implemented structured and targeted quality improvement plans as a result of learning from incidents, including the Ambrose King centre and the acute admissions unit (AAU).
- NHS Safety Thermometer information was collected and displayed on each ward, in line with national best practice guidance.
- The infection prevention and control team was well staffed and used a robust, rolling programme of audits that were beginning to drive positive improvements. Staff maintained decontamination standards in the endoscopy unit in line with national best practice guidance.
- A team of dedicated medical and clinical engineers managed equipment across medical care services and provided training, maintenance and a 24-hour on-call service. This team managed a significant number of risks to service due to old equipment awaiting replacement and ensured patient safety was not compromised.
- Wards and the departure lounge performed consistently well in monthly environmental audits.
- Medicines management was good in all medical areas, with the exception of room temperature recording and storage in endoscopy. Pharmacy cover was provided out of hours and in specialist areas.

Incidents

- Between June 2015 and May 2016 there were no never events in medical care services. A never event is a wholly preventable incident, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level. During the same period there were 36 serious incidents reported. This included 16 pressure ulcers meeting serious incident criteria and five instances of sub-optimal care of the deteriorating patient. This meant patients who were deteriorating were not effectively cared for. The trust audited the use of the national early warning scores (NEWS) system on a monthly basis in 10 medical inpatient wards. Between January 2016 and April 2016, audit results showed variable results against trust standards.
- Each member of staff we spoke with was aware of the procedure for submitting an incident report and was confident in doing so. However, some nurses said they stopped submitting reports about staff shortages because they felt it would not result in change. One nurse said, "No, I don't submit reports about that anymore, even when it causes problems. The ward manager is wonderful but they can't do anything else, we just keep being told there's no money for extra staff." The trust was engaged in a rolling programme of recruitment for nurses, including internationally.
- A named member of staff in each ward or department was responsible for the initial investigation of incidents. In some areas, such as sexual health, a rota system was in place to manage incidents so they were dealt with immediately. This system ensured services followed the guidance of the duty of candour. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. In some areas a specific grade of staff would ensure compliance, such as the consultant in charge of care in HIV services. In other areas a clinical lead or clinical director was responsible for speaking with patients or relatives.
- Some staff told us learning after an incident was highly beneficial to them and the way they worked. For example, one nurse on the stroke unit submitted an incident report about a patient's pressure ulcer. They met with the ward manager and a tissue viability nurse and assessed the patient together to identify if any changes in care or treatment were needed. Where an incident followed a staff error, multidisciplinary support was given. For example, the pharmacy team provided one-to-one support to staff after a medication error and the medical devices team provided support after an error involving equipment.
- There was evidence of improvements in practice following incident investigations. For example, the infection control team conducted a root cause analysis

of a recurring infection on ward 13C and found a housekeeper was not adhering to standards for cleaning equipment. The member of staff was given additional training and there were no further related infections.

- In response to previous incidents of failed patient recall due to out of date personal details, an improvement lead in the Ambrose King centre headed a quality improvement programme to eliminate all patient demographic related incidents by June 30 2016. This plan meant staff monitored all patient demographic-related incidents after this date to build a consistent track record of maintaining up to date patient information.
- In other areas staff had variable understanding of learning from incidents. For example, three consultants, three junior doctors and the majority of staff nurses we asked in six inpatient wards could not give examples of any recent learning from serious incidents. This meant there was room for improvement in how senior teams ensured systems for learning from incidents were accessible and robust.
- A consultant in the acute admissions unit (AAU) restructured the audit and governance structure as part of a broader quality improvement plan. This led to the completion of 95% of the unit's critical incidents.
- Minutes from morbidity and mortality meetings in renal services and dermatology showed they were attended by a range of appropriate staff and individual cases were discussed with the purpose of improving direct patient care, multidisciplinary working and communication between services.

Safety thermometer

- The NHS Safety Thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to patients, such as falls, new pressure ulcers, catheter and urinary tract infections and venous thromboembolism. We found NHS Safety Thermometer information was available on all of the medical wards we inspected in the form of 'safety crosses'. These were easy-to-understand visual displays that enabled staff and visitors to quickly identify areas of good and poor performance in the previous month.
- We saw evidence that safety thermometer data was being routinely used to improve the quality of care, such as the number of 'harm free days' in each area. For example, the trust awarded certificates to individual areas in recognition of providing extended periods of harm-free care. Staff on ward 9E had been awarded a gold certificate in recognition of 160 continuous days without any hospital-acquired pressure ulcers.

Cleanliness, infection control and hygiene

- Sanitising hand gel dispensers were available at the entrance to every ward and clinical area. However, we found six of these to be empty during our inspection. We told staff about this but it was not always clear who was responsible for this as the hand gels had not been replaced when we checked the next day.
- We observed varying levels of compliance with good hand hygiene practice and use of personal protective equipment (PPE). On ward 14F we observed a healthcare assistant (HCA) move between bed spaces where they handled patients without changing their gloves or using hand gel. We observed another HCA on the same ward leave a side room in which an infectious patient was being cared for without washing their hands or using hand gel. This increased the risk of cross-infection. Hand washing sinks were compliant with the Department of Health Building Note 00-09 and all displayed hand washing technique posters in line with World Health Organisation guidance.
- A clinical director for infection prevention and control was responsible for three sites in the trust and was supported by a clinical lead, three band seven nurses and three band six nurses. Each ward had an infection control link nurse. This team conducted monthly hand hygiene audits in every ward and clinical area as part of the 'saving lives' programme. Peer reviews of the audits were due to be implemented shortly after our inspection.
- The infection control team audited 10 patients per month and checked whether they had been screened for MRSA. In addition the team completed a monthly '5:5' audit. This involved selecting five patients and five clinical devices used by staff in treating them. They were checked for cleaning and disinfection.
- Two cases of MRSA were reported in medical care services between April 2015 and March 2016. The trust identified the need for staff to strictly adhere to the aseptic non-touch technique during patient contact, which was monitored.
- The infection control team conducted monthly hand hygiene audits to assess staff practice against the trust's 90% target. Between April 2015 and April 2016 medical

care services overall met the target in November 2015, with an average 93% compliance. Compliance in other months varied from the lowest average of 67% in September 2015 to the highest of 86% in August 2015. Two renal services and ward 14E achieved or exceeded the trust 90% target during the whole period and the Ambrose King centre achieved 100% in every month. The endoscopy unit achieved 100% in eight months and did not submit data in the other five months. The audit team also assessed wards according to the 'saving lives' programme, which monitored how staff managed catheter care, including urinary catheters and central venous catheters.

- An annual infection prevention and control audit took place on each inpatient ward, in which 57 indicators of good practice were assessed. Where standards fell short of trust requirements, the senior ward nurse or ward manager implement an improvement plan. Audit results indicated areas for improvement were in line with our findings, including dirty and cluttered bedside areas, the need for staff to be more vigilant about the safe use of side rooms and contact the cleaning contractor when areas needed attention.
- Between January 2016 and April 2016, the departure lounge scored 100% in monthly cleaning and environmental hygiene audits.
- MRSA screening was inconsistent across medical care services. Between October 2015 and April 2016, average screening rates ranged between 61% and 81%. The stroke unit and ward 9F demonstrated the highest consistent rates of screening in this period, which were above 70% in all cases. The AAU varied significantly, from an average of 35% in March 2016 to 100% in April 2016.
- There was inconsistent recording of MRSA screening on the AAU. We looked in five sets of patient notes, which included daily living nurse care plans. Three patients had a documented MRSA check on admission but staff had not recorded a result. Two patients had no documented MRSA check on admission. The nurse responsible for the patients was not able to explain this and said if no MRSA test result was entered in the notes it was common policy for staff to assume they had tested negative. Annual audits of MRSA screening showed screening on this unit varied widely, from an average of 25% in December 2015 to 100% in April 2016.
- The infection control team adhered to the principles of the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (2013) in relation to the reporting and investigation of needlestick injuries. A trust policy was in place for this and staff were encouraged to submit incident reports after an occurrence. The team planned to introduce safe insulin syringes and safe cannulas following appropriate training for staff.
- Staff used bright green "I am clean" stickers to indicate when an item of equipment had been cleaned and disinfected. The stickers were used inconsistently. For example, on ward 3E there were 15 walking frames ready for use but only two had green stickers on them. However, all equipment ready for use on ward 11C had been labelled appropriately.
- Each inpatient ward and the endoscopy unit had side rooms available, which could be used to care for patients with an infectious condition. Patients with suspected or confirmed tuberculosis were cared for in negative pressure rooms. This prevented the condition spreading to other patients.
- We observed inconsistencies in how staff managed the use of infectious patients in side rooms. For example, three side rooms on ward 14E had notices instructing staff and visitors to use PPE due to the risk of infection. However, the doors were propped open. We asked a member of staff about this who said as most patients were confused or were diagnosed with dementia, it was difficult to keep doors closed as this exacerbated their anxiety and disorientation. There was not a standardised pathway or guidance for staff on managing infection control in patients with dementia.
- A contractor provided housekeeping services. Senior nurses and ward managers we spoke with said they were happy with the standard of cleaning provided and a manager visited wards at least weekly to make sure standards were being maintained. An annual patient-led assessment took place of clinical areas (PLACE), which senior staff used to identify areas for environmental improvement. The latest results from 2015 indicated an assessment of the renal unit, the AAU and ward 10E. This identified a number of areas for improvement, including the removal of clutter and cleaning of patient tables in ward 10E.
- There were significant gaps in understanding and practice in relation to the control of substances hazardous to health (COSHH). This included no register available in any of the inpatient medical services areas we inspected and low levels of knowledge of COSHH

regulations amongst senior ward-based staff. During our unannounced weekend inspection we found chemicals in the AAU were stored in an unlocked room and chlorine tablets were stored in an unlocked cupboard. Chemicals in ward 10E were stored in an unlocked store room and visible as the door was open. Staff in the endoscopy unit, the Ambrose King centre and the Graham Hayton unit demonstrated an understanding of COSHH regulations and products under the legislation were stored securely.

- Where wards were short staffed or were staffed primarily by agency nurses, standards of hygiene and cleanliness were not always maintained. We observed on ward 9F patient bed spaces were not clean and tidy. One patient had a bedside table overflowing with used tissues and a bowl with food that was old and dried out. Staff interacting with the patient did not take action with this for over an hour.
- A dedicated team of decontamination nurses were based in the endoscopy unit. This team conducted a daily safety briefing to ensure all scopes and equipment were prepared for use and adhered to national best practice guidance in their training and practice. This was monitored by regular audits. Instructions for decontamination processes including guidance from the Medicines and Healthcare Products Regulatory Agency were on display. The training programme for decontamination staff was based on the national endoscopy competence framework and was measured and documented using an assessment framework.
- Waste management, including for contaminated and hazardous waste, was in line with national standards.
- Between April 2015 and March 2016, 13 cases of hospital-acquired Clostridium difficile were reported in medical care services. The trust conducted a root cause analysis of each case and found there were no clusters of infection in any specific area. The analysis found delays in isolation, delays in sample taking and a failure to cease laxatives 24 hours before sampling were the most common causes. A microbiologist reviewed all patients who tested positive. In response, the trust implemented an improvement strategy that included more frequent and robust governance.
- The endoscopy unit was compliant with Department of Health Technical Memorandum 01-06 relating to the management and decontamination of flexible endoscopes, including in monitoring and auditing.

Environment and equipment

- The clinical engineering department provided maintenance support with a workshop, two librarians, an administrator and eight engineers. This team prioritised repair work based on the high risk nature of equipment and against timescales for planned maintenance and response to breakdown repairs. A clinical engineering training team provided practical guidance and support to clinical staff in medical areas.
- Medical engineers tested equipment in all areas for electrical safety. We checked 37 individual items of equipment and found them have an up to date portable appliance testing (PAT) check.
- Each ward manager or senior nurse was responsible for establishing their own system for stock rotation and ordering of consumables. For example, on the stroke unit there was a dedicated HCA for monitoring stock. However, some staff told us they wanted an audit to be put in place to make sure stock levels were maintained consistently. This followed an incident where they needed a bag valve mask, used to provide positive pressure ventilation, but there were none in stock. This resulted in a delay to treatment whilst they had to leave the ward and obtain one elsewhere.
- The design of the endoscopy unit ensured patients were protected from risks associated with infection. For example, each treatment room had direct access to the decontamination area. This meant used scopes and equipment could be transported directly to be decontaminated without the risk of cross-infection in other areas.
- Each clinical area had resuscitation equipment with emergency drugs, oxygen and an echocardiogram machine. Hospital policy for equipment to be checked by a member of staff daily. Daily checks were documented in every area we visited and the resuscitation team completed a monthly audit of equipment.
- There were significant challenges in the maintenance and upkeep of medical equipment. Senior staff described concerns about the equipment in endoscopy and this was indicated on the service's risk register. In addition, several items of respiratory equipment were obsolete and could not be used. Funding had been approved for new non-invasive ventilation equipment and senior staff were organising training from the manufacturer.

- Facilities for staff teams to work safely and efficiently varied between locations. For example, some wards had dedicated multidisciplinary rooms where therapists and nurses were based, which contributed to positive working practices. However, the medical engineering team was based in a workshop that was restricted in terms of space and was not conducive to offering a full service. In addition, five junior doctors across medical services said the lack of dedicated space for them to write up patient notes, conduct research or meet together had a significant impact on their ability to perform appropriately.
- A monthly environmental audit took place in all areas of the hospital to assess the condition of facilities and daily maintenance and upkeep. Medical care services performed consistently well in this audit. Between April 2015 and April 2016, each medical area achieved 94% or above every month. In this period, ward 3E achieved 100% every month and the Ambrose King centre, Graham Hayton unit, endoscopy and ward 13F all achieved 100% in 11 out of 12 months.

Medicines

- We visited the treatment rooms, storage rooms and medicine preparation areas in all medical care services. Treatment rooms were clean and tidy, with no medicines seen lying around unnecessarily.
- To take out (TTO) medicines were stored securely and appropriately in designated cupboards or patient bedside lockers.
- A registered nurse was responsible for the keys to the drug cupboards and lockers and the doors to the room housing medicines were locked.
- Drug trolleys were secured or immobilised when not in use.
- Staff recorded maximum and minimum fridge temperatures on a daily basis, which were all within the recommended ranges of each drug manufacturer.
- Staff did not consistently record room temperatures in every area used to store medicine. This meant they could not be certain medicine was always stored at below 25 degrees Celsius, which is the maximum recommended temperature by manufacturers. Storage of medicine above this temperature can reduce their efficacy. After our inspection the trust provided evidence room temperatures were monitored centrally and showed us in a sample that all rooms were maintained at a temperature within safe limits for the storage of medicine. It was not clear why staff in some areas were unaware of temperature monitoring arrangements.
- In endoscopy, bulk fluids were stored inappropriately within the recovery area on the ward. This meant access was not restricted to staff.
- Controlled drugs (CDs) were audited on a daily basis by two nurses, with a separate signing sheet. CDs were correctly documented in a register, which was in line with National Institute of Health and Care Excellence guidelines.
- Most wards had a dedicated pharmacist available Monday to Friday between 9am and 5pm. Three HIV specialist pharmacists were available. Pharmacists were responsible for screening drug charts, medicines reconciliation, ordering of drugs, ordering the TTO medicines for patients and counselling certain patients on specific medicines such as immunosuppressants. The Ambrose King centre and Graham Hayton units had on-site pharmacists.
- Most nursing and medical staff told us they were happy with the pharmacy service received out of hours during evenings and weekends. They commended the support and advice received by the on-call pharmacist, but stated they thought TTOs could be dispensed more quickly than actually received. However, some nursing staff we spoke to on AAU said it was difficult to get hold of the on-call pharmacist sometimes and also reported lengthy delays in obtaining discharge medicines for patients.
- Practice development nurses and pharmacy teams used a medicines management competency framework to establish staff ability and knowledge at a minimum standard before they were able to administer medicines.
- Medicines management training was mandatory for all nursing staff, with a 90% minimum target for up to date completion. Wards 9E, 9F, 10E, 13F and 14F achieved 100% compliance with this and all other areas except ward 3E, 11C, the endoscopy unit and the Graham Hayton unit met or exceeded the 90% target.

Records

- Several areas of the hospital were preparing to transition from using paper notes to an electronic system. However, this system was not yet in place and most areas relied on a mixture of paper and electronic

notes, with separate files for medical notes, nursing care plans and multidisciplinary notes. This meant there were delays in staff accessing information about patients because they had to look in different places. One nurse showed us the delays this could cause because there was also a lack of consistency in where staff recorded their notes. For example, some doctors made notes electronically and in the paper files whereas some chose only to make electronic notes. Staff in endoscopy recognised this as a risk as it meant paper referral records could be lost or delayed. The service manager worked with the administration team to mitigate the risks and the unit planned to be fully electronic from September 2016.

- The Ambrose King centre and Graham Hayton unit operated paperless environments and reception staff had recently completed a project to ensure patient contact details were up to date and captured consistently.
- There were significant shortfalls in the consistency and accuracy of notes in several areas. For example, on ward 14F, an older people's services ward, an occupational therapist was working with a patient who had no documented goals or therapies plan. The therapist told us they just knew what to do because they worked with the patient a lot. This meant it was not clear how staff monitored patient therapies needs or outcomes.
- In three medical records on each of wards 3E, 9F, 10E and 14F there was no indication of the name, grade or contact details of staff who recorded information and drug charts for the patients had no legible name or General Medical Council number. This meant it was not possible to trace staff who had made treatment decisions. In the records we looked at on ward 14F, there was not always evidence of daily consultant input. Consistency of records was better in other areas. For example, in six records we looked at on ward 12E, all drug charts and risk assessments were completed legibly.
- Records were not always stored in a way that ensured patient confidentiality. For example, we saw on the stroke unit a meeting room that contained unsecured patient notes was propped open and unattended for over 20 minutes. This room also contained a board with personal information of each patient on display. During our weekend unannounced inspection we found 12 sets of patient bedside notes unattended on two nurse stations. Some of the notes were open with patient details visible. We did not observe this elsewhere. For example, on ward 13E, staff closed the blinds to the room where the patient information board was stored during board rounds so that patient details were protected.
- Staff used 'intentional rounding' in some areas to document regular checks on a patient, such as if they have a call bell and drink in reach and if they have been turned. The checks were also used to monitor patients with a high waterlow score, which meant they were at risk of pressure ulcers. In five patient records on the AAU intentional rounding and other checks were incomplete, delayed or missing. For example, one patient who was at risk of pressure sores required turning every two hours but staff had not documented this in the previous 24 hours. Another patient was due to have intentional rounding every hour but there were no documented checks in the past seven hours. One patient had a peripheral venous cannula care plan and needed this checked three times each day. Staff had not documented a check in the previous 48 hours. We asked a nurse and HCA about this. One member of staff said, "We rush through it [the checks] so the quality is low, we just don't have time." Another member of staff said, "It's a struggle reminding agency nurses where to record what they're doing. We spend a lot of time supervising them so the care of our own patients gets neglected."
- Nurses received clinical documentation training as part of their induction and ongoing mandatory training. Each ward or department met or exceeded the trust's 90% minimum target for this and in most areas 100% of staff up to date training. We were not able to explain the disparity between rates of training and poor completion of documentation.
- Differences in how patient notes were recorded presented an escalated risk in some cases. For example, after one patient suffered a fall, the ward manager did not know where the assessment of this and treatment given would be recorded. This was because of the dual system in place that involved both paper and electronic notes and the lack of consistency in where staff recorded information. In addition, agency nurses did not have access to electronic notes. This significantly increased patient risk because on wards where most of the nurses were from an agency at times. This meant there were occasions when only one or two staff on the ward had access to electronic notes.

Medical care (including older people's care)

Safeguarding

- The trust required all staff to undertake safeguarding adults level one and safeguarding children one training, with more advanced levels for clinical staff depending on their role. There was a 90% minimum target for up to date safeguarding training amongst staff teams. Rates of training were high in the Ambrose King centre, Graham Hayton unit and endoscopy where all nurses, health advisers and administration staff had up to date level one training. There were some areas where teams did not meet the 90% minimum target. For example, 50% of administration staff on ward 11C had up to date safeguarding training and on the AAU 44% of nurses had up to date safeguarding adults level two training. Medical staff in the Ambrose King centre did not meet the target for safeguarding adults level two (75%), safeguarding children level two (87%) or safeguarding children level three (43%). None of the medical staff in the endoscopy unit had up to date safeguarding adults level two training.
- Staff we spoke with had an excellent understanding of the principles of safeguarding, including warning signs of abuse such as unexplained bruising and suspicious behaviour. Staff in each area had their own link nurse or champion for this and knew how to contact the trust's safeguarding team.
- Although knowledge of safeguarding in principle was very good, ward staff did not always demonstrate adherence to this in practice. For example, staff on ward 9F, a renal ward, indicated in their handover that one patient had a learning disability. However, they had noted in the care plan that the patient had no condition that affected their mind or thinking. Staff also noted that a safeguarding alert had been raised due to 'social issues' but none of the nurses who were providing care for the patient knew about this. We asked the nurse in charge who told us the patient had been transferred from another ward and the safeguarding alert was made there. They did not know why and they could not reach any staff on the ward who knew about it. To mitigate any risk to the patient, they had implemented the hospital passport to assess the patient's social needs. Although this represented good practice, there were no processes in place to enable staff to trace safeguarding concerns or to communicate with colleagues who had conducted mental health assessments.
- Safeguarding practices in the Ambrose King centre, Graham Hayton unit and in HIV inpatient services were exemplary. This included multidisciplinary specialist input from community-based professionals or organisations that supplemented the trust's own safeguarding team. Specialists in trafficking, sexual exploitation and sexual violence were readily available and staff worked closely with local authority social workers to protect patient wellbeing.

Mandatory training

- Mandatory training topics such were established by the trust and each clinical area managed this in line with staffing levels. The trust had a 90% minimum target for up to date training and included modules such as infection control, equality and diversity, fire safety and moving and handling. Completion rates against trust standards varied between services, modules and teams. For example, wards 9F and 14F were 100% compliant with infection control training in all staff teams. The Graham Hayton unit was 92% compliant across all staff groups except health advisers, who all had up to date training. However, in the endoscopy unit only 53% of staff had up to date infection control training. Moving and handling training in wards where patients were at high risk of falls did not meet minimum trust targets. In ward 14E 61% of staff had up to date training and in ward 14F 52% of staff were up to date. In the stroke unit, 81% of staff had up to date training.
- Some areas had mandatory training specific to their service. For example, mandatory training for endoscopy staff included admission and discharge records and processes and basic and advanced endoscopy skills. At the time of our inspection 100% of nursing staff in this unit were up to date with this training and all newly appointed staff had started their training.
- Staff were not always given protected time to complete online mandatory training. Three nurses on AAU told us they had to use their annual leave to complete this training due to short staffing pressures. A nurse in renal services said they managed to complete it because they worked a lot of night shift and could usually complete it then. Two nurses on the stroke unit said they sometimes had time to complete training at work but they often had to do this in their own time. Staff on 10E were given study leave to complete training.
- Agencies provided their own staff with training and the hospital offered them more specialised training where

necessary. For example, locum physiotherapists were given mandatory training by their employer and then the hospital offered them specialist training depending on their area of work, such as dementia training. An agency physiotherapist said although they had completed all mandatory training, their agency charged them for a copy of their certificate. This meant they could only provide evidence of their training if they paid for it.

Assessing and responding to patient risk

- Resuscitation and basic life support training formed part of the trust's mandatory training provision and had a 90% minimum completion rate for each team. However, training rates overall were very poor and no medical ward or service met this overall. In ward 11C only 30% of staff had up to date training and in ward 14F only 44% of staff had up to date training. Only three medical areas achieved an overall compliance rate of over 75%; ward 9F, the Ambrose King centre and the Graham Hayton unit. Within the average rates of training for services, three teams achieved or exceeded the trust target. This was 100% of nursing staff in the Ambrose King centre, 100% of additional clinical staff in the Graham Hayton unit and 90% of additional clinical staff in the Ambrose King centre.
- Staff used the patient at risk (PAR) and national early warning scores (NEWS) systems to identify patients who were at risk of deteriorating. Where patients were identified to be at risk, staff reviewed their needs during a mid-shift briefing in addition to at handovers and during ward rounds. However, staff did not consistently record observations relating to an elevated NEWS score. For example, one patient on ward 14E had triggered a NEWS score that required staff to make four hourly observations. There was no recorded update in the previous six hours. We observed more proactive and timely responses to deteriorating patients in other areas. In ward 11C we observed staff respond in an exemplary manner to a patient who deteriorated rapidly. The team worked well together, which contributed to a good patient outcome.
- The management of NEWS was included in mandatory training. All medical teams achieved or exceeded the trust's 90% minimum target for up to date training.
- A monthly audit of compliance with vital signs observations, accurate calculation of NEWS and identification of deteriorating patients was undertaken in 10 medical inpatient wards. Overall results between January 2016 and April 2016 demonstrated variable staff compliance. For example, compliance on ward 12D fluctuated from 87% in January 2016, to 94% in March 2016 and 88% in April 2016. Ward 14E demonstrated consistent compliance above the trust target, with 100% compliance in January 2016 and February 2016. Ward 10F demonstrated a sustained improvement in compliance between January 2016 and April 2016, with results of 80%, 96%, 99% and 99%.
- A critical care outreach team (CCOT) of six staff, including a nurse consultant and a specialist physiotherapist provided support to ward-based staff in the care of patients who were deteriorating. This team was available from 7.30am to 8.30pm seven days a week. Outside of these hours a hospital at night team provided support. We asked a member of the CCOT team about the documentation of deteriorating patients. They told us referrals for elevated NEWS scores were made on paper and medical wards did not audit these, which meant there was no track record of effectiveness or improvement.
- Therapies staff prioritised patients based on clinical risk and need and modified their working patterns to ensure patients were seen appropriately. For example, the speech and language therapy team (SaLT) worked Monday to Friday and there was no weekend cover. To mitigate this, the SaLT team did not schedule meetings for Mondays so they could prioritise one-to-one patient care for those admitted over the weekend.
- Clinical staff used established pathways to provide risk assessment and management. This included an inpatient post-fall pathway to ensure the risk of falls was minimised and a bed rails assessment tool. This included an assessment of capacity and risk. Care pathways were accessible on the intranet but not all staff knew how to find them. For example, a senior nurse caring for stroke patients could not find the stroke pathway on the intranet. A senior clinician told us the pathway for patients admitted to the respiratory ward from the emergency department gave inappropriate focus to patients who had experienced a trauma to the detriment of other patients with equally life-threatening conditions.
- Nurses on ward 3E documented four hourly bedside safety checks, including a check of the monitor alarm, tracheostomy care and a record of damp dusting for infection control.

- A senior clinician raised significant concerns with us about the ability of the consultant team to provide specialist support out of hours. They said a relative had driven a sick patient to another hospital on a weekend when a respiratory on-call consultant refused to attend the hospital. In another case they said the neurology team refused to see a sick patient and this led to a poor outcome for the patient. The trust had acknowledged the lack of specialty weekend cover out of hours and services were making improvements. For example, the AAU introduced a 'one team model' that enabled doctors to share medical care of patients between the AAU and the emergency department and additional consultants had been recruited to enable the endoscopy unit offer an extended Saturday service.

Nursing staffing

- The hospital used the Shelford Group Safer Nursing Care tool to establish the minimum staffing requirements in inpatient areas based on patient acuity. This was monitored on a monthly basis against established criteria for the nurse to patio ratios. Between December 2015 and March 2016, acute medical wards achieved their minimum staffing requirement during day shifts for registered nurses on only three occasions. This was in January 2016 on wards 10E and 13F and in March 2016 on ward 11C. Nurse staffing levels in all other cases ranged from 79% in December 2015 on ward 13E to 98% in March 2016 on ward 10E. Nurse staffing levels were more stable during night shifts and on the acute wards the minimum was achieved on nine occasions. Wards 10E and 11C achieved at least the minimum nurse staffing required at all times on night shift in this period.
- As part of the trust's 'safe and compassionate' improvement plan, 32 essential nursing standards had been established. The standards included safety critical areas such as the need for consistent, patient-centred handovers and a focus on medication safety. Nurses were issued with compact cards detailing the 32 standards and permanently employed nurses spoke positively about the programme.
- Four relatives raised concerns with us during our inspection about the effect of short staffing on patient care in the care of the elderly ward and the stroke unit. In two cases relatives told us their family member was left in their own excrement because staff were too busy to help them use a bedpan or commode. In another instance a relative stopped an agency nurse trying to feed their family member lunch when they were on a 'nil by mouth' regiment. The agency nurse had not been briefed on the patient's needs as there were not enough permanent staff to supervise. There was evidence of the impact of short staffing during out observations. On ward 14E we observed patients waiting extended periods of time for staff to answer call bells and a nurse told one patient who wanted to get out of bed they were too busy to help.
- On entry to the AAU during one day of our inspection we observed staff were too busy to stop and ask visitors to the unit who they were and what they were doing. It took several minutes to find out who was in charge of the ward and staff did not routinely ask people for identification.
- Nurse to patient ratios in some areas were further pressurised due to the layout of wards and the way allocation took place. For example, on one day in ward 9E, one nurse had responsibility for seven patients. Six patients were in separate side rooms and one patient was in a shared bed bay in another part of the ward. The nurse could not monitor patients from a single location. Nurses were supported by healthcare assistants (HCAs) but told us their workload meant they did not get to spend enough time with patients.
- HCAs were assigned to each inpatient ward and they had different levels of responsibility in each area. For example, in the stroke unit, HCAs provided personal care and were responsible for turning patients. Nurses said HCAs were often so busy they had to do this themselves, which meant either other care was delayed or patients did not receive personal care.
- Nurse vacancies in older people's services were 50% of the established number needed for band five and band six nurses. Senior staff recognised this significantly increased the risk of incidents of pressure ulcers, patient falls, complaints and medication errors and was on the risk register for the service. During our weekend unannounced inspection we found the only permanent member of staff on ward 14E to be a band five nurse from another ward. All other nurses and HCAs were agency staff. We did not observe well-organised patient care on this ward and escalated the situation to the site manager. This was because other than the nurse in charge, there was no evidence of patient-centred care, no medical presence and not all patients were safely supervised. One patient had a completely full catheter bag, two patients were shouting out for attention but

there were no nurses close enough to hear and two patients were wearing soiled clothes. Six patients did not have a named nurse or doctor on display on their bedside information board. This situation resulted from short staffing and although the nurse in charge ensured the ward was able to run with no available permanent staff, there was insufficient support for her.

- Nursing staff in other areas was more stable. For example, the Ambrose King centre and Graham Hayton unit demonstrated no agency staff usage from January 2016 to April 2016 and consistently achieved high fill rates for planned shifts; typically above 85%. HIV services on ward 13F achieved a similar fill rate and reported low levels of agency nurses such as 2.3 whole time equivalent (WTE) staff in April 2016.
- Each ward had an established ratio of nurses to patients based on the layout of the ward. For example, in side rooms with four beds, wards required one nurse to be present at all times where patients were present with a falls risk. However, staffing levels did not always ensure this was followed. During our inspection a patient on ward 3E suffered a fall when the nurse assigned to their bed bay left to help a colleague. This meant staffing levels and how staff managed themselves were not always robust enough to ensure patient safety.
- Some areas had been successful in recruiting new nurses. For example, renal services had recruited 21 new nurses. Practice development nurses would lead their initial training and the renal ward manager supported a haemodialysis training programme for nurses. This was important because a renal high dependency unit regularly discharged patients to the renal ward.
- Senior staff on ward 13E, a respiratory ward, said low levels of trained and permanent staff was a significant safety concern.
- A senior nurse in each area completed a pre-assessment of agency staff before they were able to work on a ward. Agency nurses in the renal ward demonstrated an appropriate level of skill and knowledge in this area.
- A team of practice development nurses were available on-site between 9am and 5pm, Monday to Friday and provided on-demand support for staff as well as scheduled drop-in training sessions.
- We observed a nurse handover in ward 9F. Staff demonstrated a good understanding of patient need, including social needs and relationships with family. As part of the handover, nurses completed a bedside safety checklist that ensured each patient could reach their call bell and a check of their bed position. The handover was detailed and included identification of patients with similar-sounding names and those at risk of pressure sores and falls. This standard was not consistent in all areas we looked at. For example, a handover from day staff to night staff on ward 14F started late was poorly organised, and staff were unfocused and distracted throughout. In addition, the paperwork included a number of abbreviations that were not explained to agency staff as part of the handover. This meant the nurse in charge could not be certain each member of staff was fully briefed on patient needs because information given was unclear and staff understanding was not confirmed.
- Nurses working in the endoscopy unit conducted a daily safety briefing followed by a briefing after the preparation rooms were set up. We observed this process and noted it included a review of all planned patient procedures and any issues with the equipment or facilities. For example, two patients were booked in who would need staff to use special scopes. The nurse coordinator checked these were available and staff were familiar with their use. The staffing structure was clear and the shift leader checked the planned number of staff were present.
- Band seven nurse practitioners in sexual health services were trained as independent prescribers and provided care for clinically complex patients.
- A team of 20 health advisors worked in sexual health and HIV services. This team of staff provided targeted one-to-one support, guidance, testing and treatment within defined pathways to walk-in patients, both in the hospital and as part of the service's outreach programme.
- Nurses we spoke with were positive about their induction experiences, which included sessions with a range of specialist departments. The medical devices team delivered training during induction, including on essential equipment and how to book training for specialist equipment.

Medical staffing

- The trust employed 782 WTE doctors in medical care services. This figure included the Royal London Hospital and was made up of 16% junior doctors, 46% registrars, 4% middle career doctors and 34% consultants.

Numbers of consultants, middle career doctors and junior doctors were slightly lower than the England average and the numbers of registrars was significantly higher than the national average (36%).

- Wards 14E and 14F, which provided care for elderly and older patients, were funded for six full time consultants and had three posts vacant at the time of our inspection. Recruitment into these posts had been unsuccessful and as such the risk of failure to provide continual consultant-led care had been entered onto the service's risk register. In addition, three registrars two clinical fellows, 10 senior house officers and five junior doctors worked in this service.
- In acute medicine, 11.3 WTE consultants were in post out of funding for 12 WTE staff. At the time of our inspection the consultant team was short of 1.6 WTE staff due to leave, which was covered internally without significant disruption to the service. Two acute medicine training registrars were in post out of the three needed. The hospital recognised the inability of specialist teams to provide medical registrars for the acute 'take' and this meant the recommendation of the Royal College of Physicians that medical specialists lead this process was not being met. This was an item on the services risk register and was due for review in September 2016. The risk meant that patients spent time inappropriately in the AAU without being seen by an appropriate specialist and moved to the best ward for their treatment. We spoke with a consultant about this. They said because of a change in working patterns by specialty doctors, weekend cover was left solely to acute teams. They told us, "Getting specialty input at a weekend is almost impossible." However, during our weekend unannounced inspection we observed a board round in AAU with the presence of consultants from three specialties.
- A registrar from most specialties was available at weekends but they worked cross-site at St Bartholomew's Hospital, which meant cover at the Royal London was inconsistent and sometimes unpredictable. A consultant said this presented a significant safety risk to patients in some services. They said, "Cover for cardiology at a weekend is almost impossible to get. A cardiology consultant does a ward round after they've finished at [another hospital] but this is at an indeterminate time." Consultant cardiology cover was provided for two hours each day from Monday to Friday. This was not sufficient to ensure patients were safely or adequately assessed and treated. A consultant said they were concerned about the ability of the cardiology service to perform as a registrar-led specialty and also highlighted the lack of respiratory doctor and endocrine presence out of hours.
- Where staffing levels did facilitate efficient acute take from the AAU, we observed this was completed safely and with a structured handover between medical teams.
- Consultant cover on the AAU was provided from 8am to 10pm seven days a week and a consultant led an acute ward round every day.
- Three consultants and three specialist registrars covered renal medicine from 8am to 6.30pm Monday to Friday. Two consultants and two specialist registrars covered metabolic medicine during the same period. Overnight and at weekends a consultant was always available and a range of registrars, clinical fellows and junior doctors were always on site.
- Medical cover at weekends did not meet the demands of the service or the needs of patients. For example during weekend daytimes, two doctors were on shift to cover stroke and neurology patients and a single junior doctor was responsible for both care of the elderly and gastroenterology, which represented up to 38 patients.
- Consultants in acute medicine worked seven consecutive days to provide continuity of care to patients. On a weekend a consultant was on-site and supported by two consultants on-call. We spoke with a consultant about this. They said, "On a weekend, we can work continuously from 1pm on Friday until 9am on Monday and then have to stay and work all day. Acute consultants sometimes work five weeks without a day off. It runs us into the ground and it is not safe."
- Consultant cover for the Ambrose King centre and Graham Hayton unit was provided by 3.5 WTE consultants who were shared with St Bartholomew's Hospital. Specialist registrars, junior doctors and GPs also provided medical cover.
- All 16 funded posts for core medical trainees and Royal College of Anaesthetists Acute Care Common Stem trainees were filled along with three academic junior doctors and five other junior doctors.
- Consultants told us geriatricians were on-site on weekends and provided continuity of care as well as assessments for new patients. However, we did not always see evidence of this from looking at patient notes and speaking with nurses.

- The AAU had established a 'one team working' model with the emergency department. This enabled junior doctors in both departments to care for medical patients jointly. This model provided a structure for junior doctor learning and more efficient management of patients.
- An HIV specialist consultant led inpatient care Monday to Friday and was available on-call out of hours. At weekends a specialist registrar was responsible for new patient admissions.
- Three consultant dermatologists were on site from 9am to 5pm Monday to Friday. Outside of these hours a specialist registrar covered dermatology services across four trust sites supported by an on-call consultant.

Major incident awareness and training

- All of the staff we spoke with had recent fire safety training but very few said they had major incident training, or understood the principles of this. This was contradicted by training records, which indicated high rates of training for emergency planning in medical areas. Al areas except ward 10E and the endoscopy unit exceeded the trust's 90% minimum target for emergency planning training. In addition not all medical areas had a fire warden in post, including the endoscopy unit.
- Staff in some areas were vulnerable to abuse and attack from patients due to delirium, confusion and dementia. However, staff in these areas told us they had not received conflict management, breakaway or self-defence training. We spoke with a senior nurse about this. They said ward managers and charge nurses had recently been given more training and support to deal with abuse towards staff. This included the use of verbal and written warnings when needed and training with the security team to understand the triggers to aggressive behaviour.
- The trust had well established contingency plans for winter pressures that divisional and service managers demonstrated a good understanding of. In addition, individual wards or departments had their own procedures in place. For example, HIV patients were admitted under the same specialist medicine service as respiratory patients. This meant beds were not guaranteed to be available for HIV patients. This had been identified as a risk by clinical leads and directors and had been mitigated by an improved management structure. This risk was of particular concern during the winter pressures period as the respiratory ward would treat patients with chronic obstructive pulmonary disease. However, patients with HIV could be admitted to other medical areas and an HIV specialist consultant was able to provide the same level of care to them.
- The Ambrose King centre was undergoing major refurbishment that involved the closure of some areas whilst new internal waiting areas, reception and treatment facilities were constructed. This involved construction work in the building that resulted in changes to exit routes and access points. The trust supplied the latest premises fire risk assessment, dated July 2016. This made a number of recommendations, including a requirement that previously-identified high levels of risk be addressed as a matter of urgency. This included a high level of fire risk caused by old electrical wiring and risk to safety caused by no evacuation plan for people with reduced mobility. This was due to be completed one month after our inspection. The recommendation that temporary fire alarms be installed had been implemented. This report also highlighted the risk from intentional actions, following an arson attack on the building previously and evidence someone had tried to ignite signage. During our weekend unannounced inspection we noted trust security staff patrolled the area around the building entrance regularly, in line with the recommendations. All of the staff we spoke with in the Ambrose King centre were aware of modified fire safety and evacuation policies during the refurbishment work. Two fire wardens were on shift per floor of the Ambrose King centre and Graham Hayton unit at all times the building was open to the public.
- During our weekend unannounced inspection the hospital experienced a major systems outage caused by a fire in an IT server room. This placed pressure on all services as phone lines were out of use and several computer systems failed. We spoke with senior clinicians and the site manager who showed us contingency plans had been effectively put in place and back up communication systems had worked as planned. Ward staff told us they had been unable to upload any blood tests or lab results during the outage but urgent care had not been affected.

Are medical care services effective?

Medical care (including older people's care)

Good

Overall we rated medical care services as good for effective because:

- Local and national audits were used to benchmark care, treatment and practice against guidance established by a range of organisations that represented best practice. This included organisations directly involved in health and social care, such as the National Institute for Health and Care Excellence, the World Health Organisation and the Health and Care Professions Council. In addition, services sought to enhance patient experience by ensuring they adhered to national and international legislation including that of the Food Standards Agency and the EU Food Information for Consumers Regulation. Audit programmes were diverse and represented a significant portfolio of practice evaluation, improvement and learning.
- Specialist services measured care, treatment and patient outcomes against standards set by organisations in their sector of health, such as the British Association for Sexual Health and HIV and the British HIV Association. Additional clinical and support services that worked with medical care staff conducted their own programme of audits to ensure quality of practice. This included a comprehensive therapies programme and a rolling programme of audits led by microbiology.
- The endoscopy unit was accredited by the Joint Advisory Group on gastrointestinal endoscopy and had achieved the maximum 'A' grade for quality of care and safety of practice.
- There was evidence services adhered to the Faculty of Pain Medicine's Core Standards for Pain Management (2015), which meant patients were effectively managed for pain relief.
- Multidisciplinary staff on the stroke unit had undertaken pilot projects to improve mealtime experiences for patients.
- Medical services performed better or significantly better than the England average for 12 of the 17 measures in the 2015 National Diabetes Inpatient Audit.
- In the Sentinel Stroke National Audit Programme (SSNAP), the stroke unit scored the highest possible 'A'-grade score.
- Reviews of service provision and governance in renal and stroke services led to improved patient outcomes, including in time to treatment and in the length of time patients spent in hospital. Treatment times in sexual health services were consistently good, with 98% of patients treated within 10 days of diagnosis.
- A number of teams provided ward-based staff with structured specialist training and ad-hoc clinical supervision, including practice development nurses, therapies staff and the critical care outreach team. Junior doctors were offered weekly consultant-led supervision and training sessions and practice development nurses were supporting the delivery of dementia training across all medical services.
- Multidisciplinary teams worked well together in wards and clinical services, including pharmacists, physiotherapies, occupational therapists, dieticians, speech and language therapists and community-based staff such as social workers. Teams worked together to plan patient experience and care from the decision to admit to the point of discharge.
- There were numerous examples of multidisciplinary staff from various services working together to improve policy, practice and patient outcomes. This included clinical and non-clinical staff of all grades and there was evidence of sustained improvement in working relationships and collaborative practice as a result.
- Several services offered cover 24-hours, seven days a week including pharmacy, clinical and medical engineering and a range of therapies. Where therapies were not available at all times, such as speech and language therapy, staff adhered to maximum referral times. Consultant cover was provided in most medical areas seven days a week although there was not always evidence of this in older people's services, respiratory medicine or cardiology.
- Staff knowledge and practice of the principles of mental capacity and consent were consistently good although documentation of this was inconsistent in some areas.

However, we also found areas for improvement:

- In some areas documentation relating to nutrition and hydration was inconsistent and there were not always enough permanent staff on shift who could confirm a patient had eaten. Relatives gave us varied opinions of meal times.
- A new one team working model for medical staff in the acute admissions unit (AAU) had not yet resulted in

efficient and consistent multidisciplinary medical working out of hours. There was evidence this resulted in delayed diagnosis and admission and a consultant raised this as a safety concern.
- Although audits in sexual health, HIV and immunology reflected a substantive portfolio of service evaluation and development, 43% of audits in the previous two years were incomplete. This meant some audits were of limited value.
- Cardiologist cover was inconsistent and we did not find that input was available as often as information the trust provided indicated.

Evidence-based care and treatment

- Understanding of and adherence to National Institute for Health and Care Excellence (NICE) guidelines was embedded in multidisciplinary working and evidenced through the use of audit programmes to benchmark practice. For example, the therapies audit programme included evaluation of how physiotherapy was managed in patients with a fragility hip fracture when patients moved between the inpatient setting to community services. Therapies staff used this to assess compliance with NICE quality standards. Similarly, the audit and training programme included an evaluation of the management of fractured neck of femurs in line with NICE clinical guidance. This meant therapists who worked daily with patients in rehabilitation could benchmark their work against best practice standards.
- Research nurses worked on the stroke unit to explore best practice and novel treatments. This had recently included a trial to explore the best bed positions to promote blood flow to the brain. This demonstrated good practice with multidisciplinary working as the project was collaborative with staff from the emergency department and therapies.
- Staff in the stroke unit had developed the meal time service to be evidence-based on legislation, including the EU Food Information for Consumers Regulation and food labelling guidance from the Food Standards Agency.
- Endoscopy staff used the World Health Organisation (WHO) surgical safety checklist for each procedure. This meant patients received consistent care and treatment to established standards. We looked at five sets of patient records and found staff had fully completed the WHO checklist in each case. Staff in this unit were working towards achieving the National Safety Standards for Invasive Procedures (NatSSIPs) established by NHS England in 2015. This included dedicated staff to review procedures and protocols and an assessment of patient safety data.
- Therapies services completed an annual notes audit and peer review of over 229 patient notes, equating to a random sample of 10 sets of notes per doctor. This audit adhered to the quality principles of the Health and Care Professions Council and was used to benchmark good practice in the quality of notes, referrals and observations relating to therapies.
- Staff on ward 12F had undertaken local audits in the management of pain, malnutrition and venous thromboembolism. The results highlighted where improvements could be made and as a result staff documented these areas routinely and consistently.
- Staff adhered to the 'sepsis six' treatment bundle to reduce the risk of mortality in patients with sepsis. Information relating to this was readily available to staff in staff rooms and on the intranet.
- Clinical leads in each medical service established the audit programme for the coming year. Sexual health services had completed 20 clinical audits in 2015/16, dermatology services planned nine local audits for the 2016/17, renal inpatient services had three audits planned as part of the wider service audit programme and rheumatology planned 20 local audits in the same period. Audits were planned based on the needs of the patients treated by the respective service. For example, retrospective reviews of patients with certain conditions in dermatology, the management of recurrent conditions in sexual health, ongoing infection control audits in renal services and treatment outcomes in rheumatology.
- Microbiology services conducted audits across all hospital services, including six medical care areas. Recently this included an audit of the investigation and referral of patients newly diagnosed with chronic hepatitis B against NICE guidelines and the treatment of hospital-acquired pneumonia in older people's services.
- The acute admissions unit (AAU) had an eight part quality improvement plan in place to address recruitment, patient flow, staff training, the IT system and audit and governance. Staff had a number of areas of success within this plan, including the restructure and recruitment of more consultants to enable a safe seven day service, the introduction of paperless rounds and a

significantly improved multidisciplinary governance system that led to the implementation of monthly audit and governance meetings with colleagues in the emergency department.
- Endoscopy services were last audited in April 2016. The unit, its staff and procedures were audited against national guidance for safety and decontamination. It was recommended that procedures be introduced for the provision of emergency endoscopy services outside of clinic opening times and for the suspension of the service if automatic decontamination equipment failed.
- Sexual health, HIV and immunology services reported 28 audits between April 2014 and May 2016. Staff used the audit process and results to explore service efficacy, patient experience and outcomes targeted for the local population in east London. This included auditing compliance with national guidelines on treating patients with HIV and Hepatitis B and a continual quarterly audit cycle of sexual health screening offered to new patients. Although audits were clearly based on the needs and presentation of patients in sexual health services, 43% were recorded as closed and incomplete. This meant there was room for improvement in how the audit process was monitored and used to drive change.

Pain relief

- The hospital had implemented the Faculty of Pain Medicine's Core Standards for Pain Management (2015) and there was consistent evidence staff followed this in practice.
- Staff recorded pain scores routinely and consistently and these were up to date in 27 patient records we looked at. We asked seven patients about pain relief. In each case they said their pain was managed well and staff asked them frequently how they were feeling.
- An acute and chronic pain relief team was available 24-hours, seven days a week. This team was fully staffed and the latest data available, for April 2016, showed a 105% fill rate of planned shifts and no use of agency staff.

Nutrition and hydration

- Multidisciplinary therapy teams used an audit and training programme to evaluate mealtime experiences on inpatient wards, which was used to make improvements. For example, audits were undertaken to establish the availability of soft diet options to inpatients and the appropriateness of the options available. Therapies teams had a focus on the stroke units to ensure mealtimes were managed in patients' best interests and had piloted the use of a 'red tray system' to indicate to staff when a patient was at risk of choking.
- Staff in the stroke unit had developed a mealtime charter following a pilot exercise during 'feeding week' in May 2016. Named 'The 5 Rights' this charter instructed staff to ensure they considered the right patient, food, consistency, amount and posture during mealtimes. This was in response to incidents in which patients had been fed incorrectly despite input from the speech and language therapy (SaLT) team. Since its implementation, there had been no further incidents.
- Documentation of food and fluid balance charts was inconsistent in some areas. On ward 14F, one patient who needed continual monitoring for food and fluid intake had no recorded drinks in the previous 24 hours and no recorded food in the previous 48 hours. We asked a nurse about this. They said healthcare assistants (HCAs) were responsible for recording this and they sometimes wrote this information on their hand and forgot to transfer it later on. We spoke with an HCA about this. They said they found completing documentation, "difficult because we don't get much training." This meant we could not confirm patients received adequate nutrition and hydration because documentation was not fit for purpose. We observed gaps or delays in recording this information in 13 patients in five wards.
- Two relatives we spoke with on ward 14F said they were not sure their family members were fed if they were not present. We looked at relevant notes and found staff regularly documented 'refused' on documentation relating to meals. The nurses on shift were from an agency and not familiar with either patient, and the nurse in charge was not able to provide further information.
- Despite the variable standards of documentation, training records indicated staff training rates in nutrition and hydration met or exceeded the trust's minimum 90% requirement in all medical areas.

Patient outcomes

- Medical services performed better or significantly better than the England average for 12 of the 17 measures in the 2015 National Diabetes Inpatient Audit. For example, 80% of patients had a foot risk assessment during their

stay, compared to the England average of 34%. The trust formed an action plan to improve diabetes services. At the Royal London site improvement plans were to increase consultant cover and to increase utilisation of community screening and treatment to reduce the need for non-essential hospital admissions. The action plan was next due to be reviewed in September 2016.

- The latest available data for the national heart failure audit was dated 2014. The hospital performed better or significantly better than the England average for two out of four of the in-hospital indicators and five out of seven discharge indicators. For example, 96% of patients had input from a consultant cardiologist compared with the England average of 60% and 96% of patients were admitted as a cardiology inpatient, compared to the England average of 49%. There was room for improvement in one area. On discharge, 76% of patients were prescribed appropriate enzyme-blocking medicine to reduce blood pressure, compared to the England average of 85%.
- In the Sentinel Stroke National Audit Programme (SSNAP), the stroke unit scored the highest possible 'A'-grade score for the most recent two quarters available. The score for the hyper-acute stroke unit was downgraded during October 2015 to December 2015 to grade C. This related to provision of occupational therapy and speech and language therapy, which was being addressed by the head of therapies through staff recruitment.
- The relative risk of readmission at the hospital was higher than the England average. At specialty level it was highest for elective gastroenterology and nephrology although the highest number of patients were proportionately within these areas. Relative risk of readmission was below the England average in neurology.
- Senior divisional clinical staff had worked closely with stroke unit nurses who provided care for thrombolysis patients. This resulted in more targeted care and treatment and meant patients spent less time on the hyper-acute stroke unit. In addition, the 'door to needle' time for thrombolysis patients had been significantly reduced following a review of working practices.
- Renal services had undergone a peer review in May 2016. This resulted in an improvement in patient care following incidents because it was identified investigations and learning needed to be more transparent and more fully disseminated. Senior staff identified the need for governance boards in these areas that would demonstrate the differences between incidents and serious incidents.
- A lack of specialty medical cover and lack of coherence and cooperation between medical staff at weekends meant patient outcomes were at risk. For example, during our unannounced weekend inspection of medical care services, one patient had spent eight hours in the emergency department where a stroke registrar had not completed any clerking documentation or written assessments. An on-call medical consultant eventually saw the patient who was admitted to intensive care without any blood tests or x-rays. We asked a senior consultant about this. They said, "We have a new one-team system where doctors on a weekend should be working together to make sure every patient is seen and all specialties are covered. There is not enough cooperation between the medical teams and so this doesn't happen. It's a major risk for patient safety."
- An electronic recall system in sexual health services meant 98% of patients received treatment within 10 days, which was significantly higher than the national average. A nurse coordinator led this process.
- The endoscopy unit was accredited with the maximum grade A by the Joint Advisory Group on Gastrointestinal Endoscopy (JAG). This meant the endoscopy unit and its staff was assessed and monitored for quality performance and clinical safety against established international benchmarks, including in the quality and training of its workforce and focus on comfort and dignity for patients.

Competent staff

- The National Diabetes Inpatient Audit indicated there was room for improvement in how medical staff managed patients with diabetes. For example, the audit showed 57% of staff knew enough about diabetes to care for patients effectively, compared with the national average of 61%.
- Staff working in or with therapies teams had access to audit programmes, seminars and training. This included specialist areas such as managing mealtimes effectively in the acute stroke unit and evaluation of the respiratory support provided to inpatients with cancer and respiratory failure. Such training was combined with the results of therapies-led audit programmes and informed

the development of good practice across medical care services. Audit and training sessions were well attended and ward and service managers supported staff to attend them whenever possible.

- Therapies staff had specialist training for the areas they worked in, in addition to their professional development training. This included bi-weekly ward-based training for occupational therapists that worked with patients with dementia. Some ward therapy teams conducted daily 10 minute learning sessions, which took place at the patient bedside and was an opportunity for staff to develop skills and competencies in specialist areas.
- The trust provided an international nurse programme for staff recruited outside of the UK, including an English language support programme. Following this, international nurses were enrolled on a preceptorship course to enable them to develop the skills needed to work in their own area.
- A team of four practice development nurses (PDNs) provided educational learning and teaching to staff in networked renal and haematology services. There was a separate PDN team for trust-wide education and PDNs were supported by nurse educators in some areas, including in the stroke unit. The critical care outreach team provided staff nurses with targeted training on managing acutely unwell patients, including in the management of tracheostomy patients and ward staff regularly shadowed this team to build their skills.
- In some areas, therapists dedicated to wards provided weekly multidisciplinary teaching sessions to nurses, which helped to build team cohesion and understanding of roles.
- The trust offered clinical staff training specific to their role and area of work. For example, 47% of nursing staff in the endoscopy unit were trained in tracheostomy care. In the cardiac and respiratory ward, it was planned that all nurses would be trained and competency-checked in non-invasive ventilation and nurses in the renal wards would have specialist renal training. PDNs had developed a renal pathway programme for band five nurses and a patient training programme to help them manage haematology treatment at home. This team monitored staff competencies on equipment use and conducted simulated training to develop staff skill in specific scenarios and in prioritising patient care. In addition, nurses who worked in the AAU received training in nutrition management and the use of nasogastric feeding tubes to care for patients who were intubated.
- The trust had started a rolling programme of dementia training for all staff, supported by the PDNs and educational link nurses in medical areas. Staff who had undertaken the training were very positive about it and told us they felt much more confident in providing care to patients as a result. A nurse in charge on an older person's services ward said the team as a whole was better prepared now to provide one-to-one care to patients. Although we saw evidence of this in our observations of and discussions with permanent nurses, this level of skill and knowledge was not apparent amongst agency staff, healthcare assistants or volunteers. Training records indicated completion of this training was relatively high. All but four teams within medical care services achieved or exceeded the trust's minimum 90% target for completion. All of the four teams were non-clinical and would undertake training as the programme developed.
- Junior doctors had weekly learning sessions with consultants and received structured training on effective discharge summaries. There had been significant investment in training and education for junior doctors, including simulation-based learning and academic opportunities.
- Although senior ward staff were responsible for checking the competencies of agency nurses before they started a shift, there was no system in place to ensure the ongoing compliance of nurses with minimum standards of training and ability. This was particularly the case in relation to infection prevention and control, in which area senior staff told us they had no way to ensure agency nurses were suitably qualified and competent. The clinical director for infection prevention and control had involvement with the on-site training academy for housekeeping staff. This ensured they were trained appropriately in hospital infection control standards.
- The clinical engineering team had completed a training needs analysis in medical areas. This led to the development of a targeted training programme for nurses, doctors and other ward-based staff.

- An audit of the endoscopy unit in April 2016 recommended staff decontamination process competencies were updated annually. Senior staff were in the process of implementing this.

Multidisciplinary working

- Specialist pharmacists were placed in medical services, including gastroenterology and respiratory wards. The chief pharmacist had approved seven non-medical prescribers in specialist areas including haematology and HIV. This meant staff and patients in these wards had direct access to pharmacy support.
- A team of 128 therapists provided support to medical care patients including 27 occupational therapists, 14 dieticians, 44 physiotherapists, 17 SaLT therapists, 24 rehabilitation support workers and staff dedicated specifically to stroke, the AAU and older people's services wards. This team sometimes relied on bank, agency and locum staff due to an overall staff vacancy rate of 8% and staff worked across multiple sites within the trust. However, use of bank staff was less than 3% from January 2016 to April 2016. We spoke with a locum physiotherapist who was up to date with mandatory training and had been given dementia training by the trust. They told us they were well supported and felt part of the ward team.
- A specialist neurotherapy team of physiotherapists, occupational therapists and rehabilitation assistants supported patients with neurological conditions or needs relating to a stroke using a structured charter. This ensured patients were seen within 24 hours of an identified need and provided one-to-one education and support, such as through a postural management team.
- Therapist cover was allocated on an individual ward basis. Wards 9E and 9F, which cared for renal and urology patients, had physiotherapist cover seven days a week and a dietician visited four days a week.
- Results from the 2015 National Diabetes Inpatient Audit indicated effective multidisciplinary working. For example, 86% of patients were visited by a specialist diabetes team compared to the England average of 36% and 90% of patients were seen by a multidisciplinary foot team within 24 hours of admission, compared to the England average of 58%.
- Multidisciplinary teams were involved in discharge planning. For example, we observed a social worker and occupational therapist worked closely with nursing staff on ward 14F to plan a complex discharge.
- A multidisciplinary board round took place on each inpatient ward at least once daily. In some areas this was led by a consultant. The process was used to assess the needs of all patients as a team and to discuss treatment and discharge plans. We observed a board round on the stroke unit, which was attended by the ward manager, doctors, nurses, and three therapists. Staff discussed each patient in depth and reviewed each patient's current risk status for venous thromboembolism (VTE). The process was not consistent across all medical areas. For example, during a board round on ward 14F, staff did not discuss VTE assessments. We also observed board rounds on wards 13E and 13F. In both instances staff communicated well, demonstrated a good understanding of each patient and a multidisciplinary focus on discharge plans.
- We observed a board round on the AAU as part of our weekend unannounced inspection. Doctors from three specialties attended this along with a locum consultant, a social worker, a pharmacist, a physiotherapist and an occupational therapist. Following this the nurse in charge led a safety huddle with nurses and HCAs to discuss their plan for each patient. Both meetings demonstrated good practice with clear communication and evidence of positive multidisciplinary working.
- On the stroke unit, therapists met separately after the board round to focus on recovery and discharge plans. They received support from the hospital's repatriation officer for the transfer of patients to their home area. However, the hyper-acute stroke unit did not have dedicated support from a dietician or psychologist.
- Psychiatric liaison nurses were available on-call for medical wards and an urgent mental health referral service was available for sexual health and HIV patients, for whom a consultant and psychologist consultant offered psychosexual services.
- Senior divisional staff wanted to improve the integration within non-clinical teams and their relationships with clinical colleagues. To achieve this several areas of 'crossover working' were established. This included meetings between all ward clerks in medical services, which helped staff to build a wider professional network and improve communication between services. In renal wards, ward clerks joined the ward round so they could better understand the treatment position of each patient. In sexual health services, non-clinical staff

joined weekly meetings so teams gained a better understanding of the challenges facing each other. There was evidence of learning and positive working in the minutes of meetings.
- Endoscopy and colorectal staff worked together to improve the planning of clinics and the capacity needed in endoscopy. This was in response to an increase in the number of referrals and helped to ensure procedure lists were used to their full capacity.
- Service managers across medical services demonstrated a proactive approach to working together in the best interests of their respective departments. For example, a service manager from dermatology had worked with the service manager in endoscopy to establish best working practices with aspects of a booking system .
- Sexual health staff worked with colleagues in maternity areas to provide care for women who were survivors of sexual violence.

Seven-day services

- Consultant cover overnight and at weekends was provided to varying degrees in different medical areas. Three consultant nephrologists for renal medicine were on shift from 6pm to 8.30am on weeknights and one metabolic consultant was on call. At weekends, a consultant metabolic medicine physician was available. Renal consultants undertook a ward round on Saturdays and Sundays.
- The trust provided information on cardiologist cover that indicated this was provided either on-site or on-call 24-hours, seven days a week. However, senior clinicians during our inspection told us cardiology cover was insufficient to meet patient need and they often found it difficult or impossible to obtain specialist input from a cardiologist.
- Pharmacy services were available 24-hours, seven days a week. This included a dispensary lead, staff with full access to stores and a pharmacy lead.
- Occupational therapy and physiotherapy services were provided seven days a week from 8am to 6pm. However, the number of staff on a weekend meant patients had to be prioritised for assessment and treatment and staff were not able to confirm that all patients would be seen. This was because one physiotherapist typically covered five wards on a weekend and prioritised respiratory patients and those awaiting discharge.
- Dietetics support was available from 9am to 5pm Monday to Friday. SaLT therapists were available from 8am to 6pm Monday to Friday. The SaLT team worked to a service agreement to provide an assessment of patients within 48 hours of referral.
- Clinical and medical engineering services were available 24-hours, seven days a week. Overnight and at weekends a medical engineer was on call. Clinical staff spoke highly of this service and said the team were very responsive whenever they needed them.
- Senior divisional staff were developing a ward manager acceleration programme to help meet the needs of providing a seven-day service in more job roles. This included working with different teams and at weekends to help ward managers build a skill set that would lead to substantive working improvements for patients and staff.

Access to information

- Staff working in networked services, such as renal and sexual health, had access to health records from all satellite centres. This meant if a patient was admitted at the Royal London Hospital, staff could access their previous medical records regardless of where they had previously been seen.
- A dedicated administration team managed test results in HIV and sexual health services. This team managed 500,000 results per year and provided partner notifications, contacted patients for recall after non-standard test results and provided oversight to community pharmacy services.
- The dual systems of paper-based records and electronic records meant it was often difficult for staff to trace previous medical details when needed. In endoscopy, the different systems in use sometimes meant patients received more than one appointment or that referral information was misplaced in transit.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Permanent therapies staff demonstrated an excellent knowledge of the principles of informed and implied consent as well as the Mental Capacity Act (2005) in relation to patients with dementia. Staff who had been recruited from outside of the UK told us they felt the induction and training on this topic was "excellent" and they felt well prepared to care for patients as a result. There was room for improvement in the provision of

training for agency and locum therapists. For example, one locum physiotherapist did not know where to find the consent policy on the intranet and when they did find it after some time, it had been due for review in 2010.
- Staff did not consistently document mental capacity assessments. In three patient records on ward 14F mental capacity forms were blank. Staff on shift were not able to explain this.
- The neurotherapy team provided cognitive screening within 24 hours of initial assessment for those who had an acquired brain injury. This supported the medical team in assessing levels of cognition and capacity.
- A care pathway and assessment protocol was in place for staff to assess the need to apply for a Deprivation of Liberty Safeguards (DoLS) authorisation where they were not able to make their own decisions. This process was available electronically only, which meant agency nurses and locum doctors could be delayed in accessing information they needed to make a decision.
- Staff in sexual health and HIV services adhered to the Gillick competencies and Fraser guidelines when providing advice and treatment. This meant they considered the ability of young people to give consent and their capacity to understand tests, screening and care

Are medical care services caring?

Requires improvement

Overall we rated medical care services as requires improvement for caring because:

- Agency nurses and healthcare assistants did not always demonstrate they had the skills or understanding to treat patients with dementia appropriately. This included a demonstrable inability to adapt communication techniques and a lack of understanding when patients were becoming confused or anxious. This was exacerbated in inpatient wards that relied heavily on agency staff and where the nurse in charge was not able to provide consistent oversight due to workload.
- Staff did not always recognise when patients needed support or help with personal care to maintain their dignity.
- Feedback from patients and relatives was variable in relation to staff compassion and people raised concerns about staff attitude and approach on the acute admissions unit and ward 3E. This included the approach of a junior doctor when a patient had fallen, which a visitor told us made them feel uncomfortable.
- Volunteers were available to spend time with older patients and reduce the risk of social isolation. This represented good practice in principle but from our observations we did not see volunteers were appropriately trained or assessed to ensure they provided a caring and compassionate service.

However, we also found areas of good practice:

- Some wards and clinical areas demonstrated a track record of good performance in the NHS Friends and Family Test particularly in ward 13F and the endoscopy unit. Local surveys specific to wards ranked medical care services against other hospital areas for patient recommendation and a star rating based on how people felt they had been treated. Results were variable and some areas showed a high level of performance and recommendation rates, such as ward 10F, which ranked 14th out of 176 areas with a 93% recommendation rate in April 2016.
- Patients consistently recommended sexual health walk-in services and acknowledged kind, compassionate and welcoming staff in the Ambrose King centre and Graham Hayton unit. We observed consistently caring staff in both areas, including non-clinical staff.
- Most staff we observed treated patients and relatives with dignity, respect and compassion.
- Patients told us they felt involved in their care and treatment and we observed doctors, nurses and therapies staff explaining tests and treatment to patients. Staff worked well within multidisciplinary teams to achieve this, including with translators.
- Emotional guidance was provided to patients and relatives through counselling and psychotherapy teams. Staff in older people's services signposted relatives and friends to advice from specialist organisations.
- Emotional support in the Graham Hayton unit and Ambrose King centre included reception staff trained in supporting patients in emotional distress and the use of peer mentors to provide one-to-one support to patients newly diagnosed with HIV.

Medical care (including older people's care)

Compassionate care

- The trust participated in the NHS Friends and Family Test (FFT) and individual wards were responsible for displaying and acting on results. Between April 2015 and March 2016, six medical care areas (wards 9F, 11E, 11F, 13E, 13F and endoscopy) received over 100 responses to the survey per month and scored consistently highly. During this period ward 13F, which cared for patients with HIV or respiratory problems, scored the maximum 100% satisfaction score in three months and the endoscopy unit achieved 100% satisfaction in seven months.
- The trust operated local patient surveys in wards in addition to the FFT. Results were published monthly and enabled staff to see month-on-month changes in how patients and relatives felt about the service. The results meant each ward had a star rating out of five, a percentage of people who would recommend the unit and narrative comments about the care people experienced. This survey incentivised staff to offer compassionate care as it ranked each ward within the trust's 176 service areas. Medical wards varied in their results in the latest available data from April 2016. For example, ward 10F was ranked 14th out of 176 with a 93% recommendation rate and ward 11F was rated 132nd with an 85% recommendation rate. There were some significant changes in ranking from month to month. For example, in March 2016 the Graham Hayton unit was ranked 17th with a 95% recommendation rate. This changed to a rank of 43rd the next month with a recommendation rate of 94%. This meant the survey was very sensitive based on the number of respondents although staff we spoke with felt it was a useful tool for them to gauge service quality by.
- Sexual health services operated a quarterly survey for walk-in patients. The latest available results for the Ambrose King centre, from April 2016, indicated 95% of patients would recommend the service and 95% said they were treated with dignity and respect.
- In the 2015 National Diabetes Inpatient Audit, 90% of patients reported overall satisfaction with diabetes services, which was better than the England average of 84%.
- The interactions we observed between permanent staff and patients were positive and compassionate in most instances. On ward 14E, an older people's services ward, a doctor found out it was a patient's birthday and sang to them during lunch. The patient had been stressed and anxious and this compassionate approach had a demonstrable and immediate calming effect on them. However, we observed one nurse on ward 14F speak rudely and inappropriately to a relative who was concerned about their family member.
- During our weekend unannounced visit we observed agency nurses and healthcare assistants (HCAs) on ward 14F did not always treat patients with respect, compassion, friendliness or dignity. For example, one patient who had dementia was clearly confused and becoming agitated. The patient had one-to-one care from an HCA but the member of staff did not interact positively with them. They stood in the vicinity of the patient leaning against the wall for several minutes and did not try to speak, despite the patient talking to them. The patient was dishevelled, wore only one sock and had a loose bandage on one foot. We escalated this at the time of our inspection to the nurse in charge who intervened. However, other patients under the care of agency staff also appeared to be dishevelled and wore dirty clothes.
- We observed staff take action to ensure patient privacy. In a shared bed bay on the stroke unit, the nurse administering medication asked relatives to leave the room during this period so medicine could be given privately.
- Patients we spoke with gave varying feedback about their interactions with staff. For example, three patients on the acute admissions unit (AAU) said staff were quite abrupt with them and their perception was that this was caused by the busyness of staff rather than their attitude. We observed a patient on this unit who received one-to-one support from a member of staff to keep them safe as they wandered around the area a lot due to dementia. The member of staff assigned to them was distracted repeatedly and on three occasions in 30 minutes had to ask a colleague to support the patient whilst they dealt with another matter. Staff did not demonstrate a good understanding of this patient's needs and they were only provided with water to drink when we asked why they didn't have this. This meant the level of compassion offered to patients was variable and could be affected by staffing levels.
- A relative on ward 3E raised concerns about the lack of compassion they felt some members of the medical team demonstrated. They told us, "A patient fell coming out of the shower yesterday and I saw the junior doctor

stand over the top of them with his hands in his pockets. It looked odd, there was no compassion. Why didn't he kneel down to their level to reassure them?" A relative had previously raised concerns about the tone of voice and approach of a nurse on this ward in the patient survey in April 2016. There had been a decrease in how patients rated dignity, respect, involvement and general staff in this area although 95% said they would recommend the ward.

Understanding and involvement of patients and those close to them

- During our observations we saw numerous examples of therapies staff involving patients in their care. This included an occupational therapist on ward 14F who explained to a patient what they were doing, why they were doing it, and how it was supposed to benefit them. Their caring and compassionate attitude meant they gained the patient's trust, who told us afterwards they felt respected by the member of staff because of the way they were spoken to.
- Patients we spoke with on the AAU told us staff always introduced themselves and explained what they were doing before providing care. Ten patients on wards 11C and 12F told us they felt involved in their care and said they had been offered printed information about their condition and treatment.
- We observed positive interactions between doctors, nurses and patients in some cases on ward 14E. A doctor explained a procedure and treatment plan to a patient using simple language that helped them to understand despite their confusion. In another case a translator was present and the doctor demonstrated patience and compassion despite not being able to communicate with the patient directly.
- We spoke with a relative on ward 3E who was distressed because they had not seen or spoken to a doctor in the five days since their family member was admitted. The patient was not able to communicate clearly and their relative had not been involved in any discussions about their treatment plan. The nurse in charge acknowledged this but was not able to contact a doctor who could speak to the relative. The relative told us they felt there was no sense of urgency from the medical team in obtaining scans and reports that had been completed elsewhere. The nurse in charge did not have a good understanding of this patient, which contributed to the escalating situation. Despite this instance, there was evidence admitting doctors discussed discharge planning with patients as part of the admission process. This helped patients to understand their treatment plan and help them know what to expect in terms of length of stay.
- A dedicated home dialysis nurse worked one-to-one with haemodialysis patients to develop a home management training programme so they could safely take care of themselves at home.
- Patients on wards 14E and 14F had been involved in a feedback exercise to improve the meal service on the ward. Patients had told staff they did not like large meals with long gaps between them. In response staff implemented smaller main meals and offered snacks such as soup and ice cream each afternoon. Patients we spoke with told us they enjoyed this and felt staff involved them in the running of the ward.

Emotional support

- All of the staff we spoke with were aware of the on-call arrangements for counselling and bereavement.
- Some services had developed their own resources to help provide emotional support to relatives. For example, older people's services used best practice guidance from the Alzheimer's Society and Dementia UK to help relatives and friends of patients understand complex mental health needs and signpost them to support.
- Urgent emotional support services were available for patients in sexual health and HIV services. This included on-site support after an HIV positive diagnosis and targeted support for patients who used recreational drugs. Reception staff in the Graham Hayton unit and Ambrose King centre received emotional support training to assist patients in distress. This enabled the service to provide enhanced care while patients waited in the walk-in clinics. In addition, the service had recruited peer mentors as volunteer support workers. This team provided emotional support to patients newly diagnosed with HIV as part of the service's work to promote wellbeing, positive coping strategies and good mental health.
- Hospital volunteers were available to provide one-to-one support to reduce the risk of social isolation in older people's services. However, the remit and suitability of the volunteers we observed was not clear. For example, a nurse had asked one volunteer to spend time with a patient with dementia who appeared

anxious and agitated. The volunteer was visibly uncomfortable and did not speak to the patient, instead following them and observing from a distance. During our weekend unannounced inspection a volunteer sat at a nurses station and did not know who the nurse in charge was or how to contact them. Two patients who had difficulty communicating tried to speak to them but the volunteer did not reply nor attempt to find a member of staff who could help. We asked the nurse in charge about this. They said volunteers were in place to support the most socially vulnerable patients but training was not sufficient and they often had to spend time away from clinical duties supporting them.

Are medical care services responsive?

Good

Overall we rated medical care services as good for responsive because:

- There was evidence of service planning to meet the specific needs of the local population. This included the provision of Polish and Bangladeshi-speaking patient advocates, service adaptations to address an increasing number of patients admitted with dementia and an intravenous therapy service coordinator to support patients on discharge. Endoscopy and sexual health services had employed Bengali-speaking client support workers to provide support to the significant number of patients from this ethnic group.
- Staff in sexual health and HIV services demonstrated a substantive commitment to exploring and addressing the changing needs of people in the local area. This included extensive targeted community outreach work, specialist provision for young people, men who have sex with men and patients who used recreational drugs as part of sexual activity. Such planning and service development was collaborative with specialist non-profit organisations and clinical services were adapted accordingly. A joint medical and clinical psychology service was offered as part of a broad psychosexual service remit.
- A senior sister led an inflammatory bowel disease screening service in the endoscopy unit to broaden the scope of screening and prevention.
- Between May 2015 and May 2016, 81% of patients stayed in the same bed throughout their admission. This represented a 2% improvement on the previous year and took place during a period of consistently high bed occupancy.
- The trust had established an improvement programme for the validity of its referral to treatment data. This was used to assess the time taken to treat patients following an identified need against a national standard of a maximum of 18 weeks.
- The endoscopy unit had an excellent and sustained track record of procedure scheduling and management, with very few cancellations due to hospital-related problems.
- Dedicated staff were in post to help reduce delays in admission, discharge and access to services. This included two patient flow coordinators in addition to bed managers and discharge coordinators as well as a primary care pathway coordinator and GP pathway coordinator for sexual health services and community liaison service for the acute admissions unit (AAU).
- Facilities for patients, their relatives and visitors included accessible toilets and showers, private rooms and day rooms and drinks and snack facilities.
- The trust was rolling out dementia training to all staff and individuals who had received this spoke positively about it. In addition, staff in wards 14E and 14F had adapted the environment and service to better meet the needs of patients with dementia. This included extended visiting hours, afternoon tea events, fundraising by staff and reminiscence displays of photos and artefacts on the unit.
- An on-call alcohol and drug liaison team was available 24-hours, seven days a week.

However, we also found areas for improvement:

- The average length of stay for inpatients was higher than the England average for medical inpatient services with the exception of nephrology.
- Awareness of learning disabilities and adapted communication techniques was inconsistent although staff had access to visual support aids and knew where to get help.
- Staff were not always equipped to respond appropriately to minor complaints and concerns raised by patients and relatives.

Medical care (including older people's care)

Service planning and delivery to meet the needs of local people

- The hospital recognised public health needs in the local area and worked closely with local authorities to provide targeted services. For example, wards that provided care for patients with dementia, which was increasing in the local area, were being adapted to make them more accessible. This included installation of large pictorial signs to help patients understand where the toilets and showers were.
- The hospital did not have any dedicated neurorehabilitation beds. This meant patients who underwent neurosurgery could often be delayed if neuroscience beds were unavailable and they had to wait for transfer to another hospital.
- A transfer pathway was in place for high acuity respiratory patients who could be more appropriately treated at St Bartholomew's Hospital, which was part of Barts Health NHS Trust. This was used where highly specialised care and treatment was needed or where medical staffing levels meant patients could not be cared for adequately. Respiratory nurses had training in the safe transfer of patients.
- Senior staff had sourced advocates to help deliver services to population groups that had grown in number in the local area and for whom ad-hoc translation services were insufficient. This included on-call Polish and Bangladeshi advocates who could support communication, admission and discharge processes.
- An intravenous (IV) therapy service coordinator was in post and helped with planning discharges. This member of staff was able to visit patients at home after they left acute services as an inpatient to support them with administering IV fluids.
- Staff in sexual health services worked closely with local commissioners and non-profit organisations to ensure open-access services met the needs of the local population. This included reaching patients in high-risk populations with information to help them understand the scope of each service offered. Community organisations attended the Ambrose King centre and Graham Hayton unit during specific clinics to provide targeted support and advice. This was established as part of the services' work to meet the increasingly complex needs of different population groups in east London. For example, specialist staff were on-site for clinics that supported men who have sex with men, for patients who used recreational drugs during sexual activity and for vulnerable young people. Staff provided a joint clinical and psychology service for such patients. Service delivery in this area included consideration of the risks to patients. For example modified rooms suitable for young people at risk of self-harm were available. This service had established considerable outreach work to support people's needs and to reduce unnecessary hospital attendances. This included a health promotion bus, staffed by Royal London Hospital sexual health staff, which was set up at music concerts, festivals and public events. This service provided sexual health screening, testing and advice.
- A reduction in funding for HIV and sexual health screening meant senior staff were considering how to support self-testing without compromising patient safety, particularly in view of the variable understanding and English language skills in the local population.
- Two consultants-led pilot projects to increase opportunistic testing for HIV in the emergency department, older people's services and critical care and to increase testing for hepatitis in patients with HIV. Both projects were in response to increased risks of infection in the local population.
- A senior sister was embedded in the endoscopy unit and led a team of four nurses as part of a specialist inflammatory bowel disease screening service. This team provided a service by telephone to patients to prevent unnecessary admissions and were on-call across the hospital to support ward staff.

Access and flow

- Between June 2015 and May 2016, bed occupancy in medical inpatient areas was relatively high, with an average rate of 94% or above reported in 11 out of the 12 months prior to our inspection. This ranged from 90% occupancy in June 2015 to 99% occupancy in October 2015, November 2015 and May 2016.
- Staff recognised the risks associated with unnecessary bed moves and their efforts to move patients only when necessary was reflected in the 81% of patients who stayed in the same bed during their admission between April 2015 and April 2016. This represented an improvement of 2% from the previous year. In the same period, 15% of patients experienced one bed move, 3% experienced two bed moves and less than 1% experienced three or more bed moves. Bed moves

between the hours of 10pm and 7am varied between medical services. For example, between November 2015 and February 2016, an average of 18 patients per month were moved overnight and in older people's services inpatient wards, an average of 14 patients per month were moved overnight.

- Between May 2015 and April 2016, admitted referral to treatment (RTT) times varied between 48% for general medicine and 85% for neurology, with respect to patients being treated within 18 weeks of diagnosis. RTT data collection was in a period of recovery following a suspension of eight months. This meant the trust was working to ensure data were complete and accurate and therefore RTT data presented may not be wholly valid.
- The average length of stay for inpatients between January 2015 and December 2015 was higher than the England average except in nephrology, where it was lower. For example, the average length of stay for non-elective general medicine patients was 8.6 days compared to the England average of 6.3 days and the average length of stay for elective nephrology patients was 4.1 days compared to the England average of 7.7 days. However, the average risk of readmission for elective nephrology patients was significantly higher than the England average.
- The multidisciplinary team that conducted daily board rounds to review patient needs included discharge planning for each patient. We observed positive examples of this on the stroke unit and therapists told us they felt involved in discharge planning from the point of admission.
- Weekend discharges were regularly delayed, particularly on a Sunday and where patients had a social package of care. Staff told us this was because there were no social workers available on a Sunday, who were needed to approve final discharge. However, during our weekend unannounced inspection a social worker was present on the acute admissions unit (AAU) and took part in the multidisciplinary board round.
- Due to a lack of capacity, patients were not always cared for in the specialist area relating to their condition. On one day of our inspection, two neuro-surgery patients, two trauma patients and one neurology patient had been admitted to the stroke unit. The nurse in charge had a good understanding of each patient and knew who their named consultant was. In such cases the patient's consultant visited them at the same frequency as required in their usual specialist area.
- Two patient flow coordinators had been employed for medical services and a third was dedicated to renal patients. This team provided oversight for patients from admission to discharge and worked with the site bed team and discharge team to reduce delays.
- The HIV service provided inpatient care for patients across northeast London and the southeast, with a standard to admit patients from any provider in this area within 48 hours of the decision to admit being made. The service consistently met this target in 100% of cases.
- A GP pathway coordinator and primary care pathway coordinator were dedicated to sexual health services. Staff in these posts delivered training to GPs and helped to ensure patients accessed appropriate services when needed.
- The endoscopy unit offered up to five clinical sessions in two daily sessions, five days a week with a morning session on Saturdays. Between January 2016 and June 2016, the endoscopy unit reported a procedure cancellation rate of 16%, which represented 847 cancellations out of 5255 total procedures. This included a 4% cancellation rate within two weeks of the scheduled procedure. Only six cancellations were made by the hospital; in all other cases cancellation was due to patient's own cancellation, an unexpected hospital admission or the death of the patient. This represented an excellent track record of procedure scheduling and completion.
- An administration team leader in the endoscopy unit reviewed cancellations and missed appointment slots on a daily basis to identify trends. They had identified a problem with the booking system that could result in duplicate appointments being made for the same patient. This system was being upgraded as a result. In addition, the team leader conducted a weekly review of breaches of the two-week wait target.
- Processes for managing medical outliers at weekends were not robust. For example, the site manager was able to trace patients who were outliers but it was not possible to differentiate between surgical and medical patients. This meant there was not a clear record of where patients were being cared for. We visited three wards where outlying patients were documented to be.

None of the nurses we spoke with could tell us if the patients were from surgical or medical services either because senior ward staff were unavailable or because wards were staffed primarily by agency nurses. A senior clinician told us the lack of weekend bed coordination meant beds were routinely left empty in wards whilst patients remained in the AAU or emergency department.

- Waiting times in the Ambrose King centre walk-in clinics were sometimes variable as it was not possible to predict how many patients would attend to be seen. Patients identified waiting time as their main area of concern in the last quarterly survey, with only 30% of patients seen within one hour. To address this, staff were working on improvements to the web-booking system that would allow patients to check-in to the clinic remotely and then be given a time slot to attend. In addition, the service placed a cap on the number of patients who could be seen during a single walk-in clinic and was increasing community-based advice to reduce the need for patients to attend the clinic.
- Staff in the emergency department and AAU used an ambulatory care pathway to make the most appropriate admissions decision. This applied to 22 medical conditions where patients had a low national early warning score and were over the age of 18. This meant decisions about admission could be made safely while reducing pressure on the hospital to find inpatient beds unnecessarily.
- The AAU had established a community liaison service that enabled GPs to speak with a consultant directly between 8am and 9pm, seven days a week. This enabled medical staff to work together to ensure referrals and admissions were clinically appropriate.

Meeting people's individual needs

- Inpatient wards, the endoscopy unit, the Ambrose King centre and the Graham Hayton unit had private, quiet spaces for patients and relatives along with drinks facilities. Wards also had day lounges that patients and their visitors could relax in and were well equipped for personal care, including accessible showers and toilets. The endoscopy unit had two waiting areas for relatives. We noted there were no printed leaflets or information in these areas. However, the majority of procedures were pre-planned and administrative staff sent out printed information in advance to patients. This was confirmed with each patient at least two days before admission by phone. The endoscopy team was working with their colleagues in colorectal services to ensure patients received preparation advice at the point of assessment.
- Hearing loops were fitted throughout the hospital, including at staff base stations in each clinical area.
- Therapies staff who worked with elderly patients and those with dementia had specialist training. Occupational therapists, physiotherapists and speech and language therapists were assigned to specific wards so they could get to know patients and develop their skills in working with people with specific conditions. Staff had access to dementia champions in the hospital, who could support them to provide care for patients with dementia, Alzheimer's disease and memory loss.
- Individual wards did not always adhere to NHS England guidance on the need for same-sex accommodation. For example, we saw male and female patients regularly shared a bed bay on ward 3E. We asked a senior nurse about this who said lack of capacity meant this was unavoidable. Mixed-sex accommodation is most commonly unavoidable in specialist units, such as the hyper acute stroke unit. Same sex accommodation was more readily provided in other areas. For example, the endoscopy unit had two separate recovery bed bays, one for each gender. Both bed bays had dedicated toilets and showers.
- Each inpatient ward implemented a designated period of protected rest time for patients. During this time the lights were dimmed and relatives were discouraged from visiting. We observed this in place on several wards and it worked well, with patients able to sleep and staff working quietly so as not to disturb them. This supported an improved recovery period for patients.
- Therapy staff told us they felt there was room for improvement in the provision of physiotherapy for renal patients. One member of staff said there was little wider recognition that physiotherapy would benefit all renal patients and so only some patients received this.
- Printed information was available for patients that took into account cultural differences. For example, renal patients were usually discharged with a modified diet plan. The team in this area provided leaflets for patients who came from West African and Asian countries on how they could modify their diet safely.
- Not at all staff had formal training in communicating with patients with dementia or learning disabilities. However, we observed staff used appropriate initiative

and show care and patience when communicating. For example, one nurse on the stroke unit showed us the visual aids they could use in patient care plans and said these worked well. Staff also told us speech and language therapists provided on-demand support when they had difficulty with communication.

- A notice above each bed had space for the patient's named nurse and consultant and any nutritional needs. This information was not completed consistently, particularly on older people's services wards. A nurse told us this was because staffing levels were too low and they didn't know the names of agency nurses so it was not always possible to add names. However, we did not observe agency nurses proactively complete this information. There was no consistent use of signage to identify which patients were at risk of falls or who had dementia. Staff were only aware of this if they had read the patient's notes, knew the patient or it had been discussed in handover.
- Link nurses were in post in most areas and were responsible for maintaining an up to date knowledge of specialist areas and communicating this to other staff. For example, the stroke unit had link nurses for nutrition, pressure ulcers, falls and dementia. The renal unit also had link nurses for interventional radiology, medicines management, fire, Deprivation of Liberty Safeguards and student nurses. Nurse-led smoking cessation was undertaken opportunistically in sexual health and HIV services.
- In addition to advocates who worked as needed with medical services and translators that were available on demand, sexual health services and the endoscopy unit had both implemented a female Bengali-speaking client support worker (CSW). Both members of staff worked closely with Bengali-speaking patients, the most prevalent ethnic group in the local area. In sexual health, the CSW provided reception cover and could give one-to-one contraception information to patients. In endoscopy, the CSW proactively contacted patients before their procedure to give them confidence and ensure they understood their procedure.
- Staff in the endoscopy unit had identified a significant number of patients who did not attend scheduled sessions did not speak English. To address this, the service manager ensured a translator called each patient three days before their procedure and confirmed they understand preparation instructions. The service manager told us this had been successful and the number of missed appointments reduced. This service was also rolled out to the colorectal team to reduce the number of missed appointments from patients they referred.
- A team of patient care coordinators led patient information, advice and support in the endoscopy unit and confirmed each patient had an escort to be able to leave the unit safely after their procedure.
- An alcohol and drug liaison team was available on site and sexual health and HIV services had access to a specialist on-call drug liaison team based at Mile End Hospital.
- Staff on each ward established their own visiting hours policy for relatives based on the needs of patients. For example, wards 14E and 14F had open visiting house daily from 9am to 8pm. As a large number of patients on these wards were living with dementia, the open visiting hours meant relatives could visit at the time most appropriate for their family member's needs. In addition, staff on these wards offered a weekly afternoon tea on Thursday afternoons. This was open to patients and relatives and was a social opportunity to improve their overall experience and promote recovery. As some patients spent several weeks in the wards, this was a positive activity to help them feel relaxed.
- Staff on wards 14E and 14F took part in extra activities to promote patient wellbeing, fund new equipment and as an approach to improve staff retention. For example, staff had taken part in a fund-raising marathon and used the proceeds to buy special cardigans for patients, which they could take home with them. These activities were photographed and displayed on the wards, which staff had also decorated with historic images of the east end of London, which helped enabled staff to provide reminiscence activities and helped patients with dementia to feel less anxious and confused.
- The patient-led assessment of the care environment (PLACE) in 2015 found a review of the dementia-friendly nature of patient areas was needed, as well as the installation of hand gel containers accessible to wheelchair users. The trust's facilities team installed hand gel at a lower level at the entrance to medical patient areas and a dementia strategy group was formed to consider improvements in access and the environment.
- A specialist service for men who disclosed they practiced risky sex and who were HIV negative helped to reduce the risks of HIV infection by ensuring they had

access to post-exposure prophlyaxis. This is a course of medicine that research shows is effective in preventing new HIV infections. This service was offered with a community organisation that offered counselling and risk minimisation strategies.

- HIV services offered a 'virtual clinic' for HIV positive patients who were stable and needed a repeat prescription every six months. This involved a visit to have routine blood tests followed by an electronic prescription with home delivery of medicine. This reduced the need for time in the clinic and freed up more appointments.
- Sexual health staff offered a range of services for the local population. This included a partnership with a voluntary organisation to offer sex and relationship education to the under 25s and a programme to improve the mental health of young men through peer education and community engagement. Staff provided targeted support for young women who experienced sexual pain or psychosexual problems, including providing cognitive behaviour therapy.
- Admissions to HIV specialist beds were benchmarked against the 24-hour standard of the British HIV Association. Between March 2014 and November 2015, 95% patients referred from within the trust were admitted within 24 hours and 58% of patients admitted from outside the trust met this target.

Learning from complaints and concerns

- Staff worked with contractors and other providers to resolve complaints in the best interests of patients. For example, senior staff from renal services met weekly with transport managers to address and respond to patient complaints. Where complaints related to multidisciplinary services, senior staff from each department ensured an appropriate investigation took place. For example, the head of therapies had input into any complaint that related to therapies staff on wards or in other clinical areas.
- Sexual health services had received no complaints in the six months prior to our inspection.
- We did not always observe that staff were well-equipped or trained to handle minor complaints or anxious relatives. For example, on ward 14F we observed a visiting relative raise some concerns about the care their family member received with a nurse. The nurse was rude and dismissive and did not answer the relative's concerns. In response to this we looked at staff training records for handling complaints. Nurses undertook this as part of their mandatory training and the trust had a 90% minimum standard for teams to be up to date. Nurses in all medical areas except wards 10E and 11C and the endoscopy unit met or exceeded the trust's target and in the majority of areas 100% of staff had up to date training.

Are medical care services well-led?

Requires improvement

Overall we rated medical care services as requires improvement for well led because:

- The trust had failed to address three significant areas of improvement identified during our last inspection in January 2015. These related to short staffing, poor infection prevention and control practices and inconsistent patient risk assessments. Although the hospital had made significant improvements in other areas, there was little evidence of sustained improvement at ward or hospital level in the areas highlighted.
- Significant risks had been identified that related to the failure of equipment or the need for replacement. Although the funding system used to provide new equipment responded well to urgent needs, it did not allow staff to plan in advance for the routine replacement of equipment. This meant there were unnecessary delays in sourcing equipment despite the work of the clinical and medical engineering team.
- Staff spoke variably about opportunities to meet as part of a team. For example, nurses on wards 3E, 11E and 14F said they were unaware of team meetings and they only found out about changes to practice or procedures by e-mail.
- Although most staff spoke highly of the relationships between clinicians and divisional leads, a number of staff said they felt older people's services had not been effectively supported during a period of on-going short staffing.
- Recruitment, selection and retention human resources services were wholly unfit to provide the robust and consistent support needed by staff in medical care to address short staffing. This included extensive delays

between offering an appointment and a start date. A number of staff raised this as an issue with us and said high levels of continuous stress meant rates of attrition increased.
- Although there was some evidence of positive cultural changes in some areas of the hospital, a number of staff spoke with us about problems with communication, respect and working conditions. This included a number of staff who said they felt the selection process for promotion was biased and senior staff who said the lack of collaborative working between consultants did not facilitate professional relationships.
- Staff engagement was variable. Not all staff were aware of the trust-wide staff survey and others felt their views were not important.

However, we also found areas of good practice:

- In addition to the trust's overarching improvement plans and urgent need to recruit more nurses, individual medical care services developed their own vision and strategy. In many areas this reflected the planned implementation of an electronic patient record system and the expansion of services.
- Services maintained a risk register that highlighted significant risks such as equipment failure and short staffing. Each risk was assigned to a senior member of staff who reviewed them regularly.
- Clinical governance structures in most areas involved a broad range of staff and enabled them to share learning, ideas and support. This included regular whole-team meetings in endoscopy, sexual health and therapies. Governance in infection control and microbiology was robust, consistent and worked to improve standards across services.
- Service managers demonstrated a commitment to service improvement in governance and leadership, including through staff engagement and a review of practice. All of the staff we spoke with were unfailingly positive about their relationships with service managers.
- The trust provided staff with a new package of care and support, which included a 24-hour, seven day a week confidential advice and guardian service.
- Wards demonstrated how they improved services or facilities based on patient feedback, including through the trust's 'I want great care' programme.
- Human resources business partners attached to clinical teams were being established to improve support and morale. This was in an early stage but staff we spoke with said they had seen positive improvements in communication and working relationships as a result.
- Medical care services demonstrated a number of areas of innovation in service improvement and sustainability, including in renal services, endoscopy and sexual health and HIV services. Individual staff and teams, including psychologists and practice development nurses, demonstrated a commitment to developing practice based on research and new training strategies.

Leadership of service

- Staff told us they received excellent care and support from their senior colleagues after incidents of aggression or violence, such as in confused or delirious patients. One nurse had been verbally abused by a patient with dementia and told us the support they received from doctors and other nurses who were present at the time was "second to none."
- Staff in some areas said they did not have regular meetings with colleagues or managers. One member of staff on the stroke unit said a daily safety huddle took place but this was not mandatory and they had only attended it once. They said they were not aware of any team meetings and all communication from senior staff was either ad-hoc when they were on shift or by e-mail. A member of staff on ward 14F said they were supposed to have a team meeting every month but none had taken place in the previous seven months due to low staffing levels. A nurse on the AAU said, "I only knew I was in a team because my name appeared on the list in the staffroom. There are no team meetings or get-togethers. Consequently everyone has a different level of understanding of what is happening on the ward."
- We spoke with staff at all levels about their relationships with managers and their local and divisional leadership team. Most of the staff we spoke with were positive about their relationships with immediate line managers but spoke of a 'disconnect' between their experience of staffing levels and management understanding of this. For example, one senior clinician said they felt older people's services were neglected by senior

management because of the sustained failure to recruit doctors and nurses. They said, "Care of the elderly is definitely not high on the agenda [of the senior team]. We get little support from the clinical director."

- In all cases, staff we spoke with were highly complementary about the support provided by service managers. However, in wards or departments where multiple medical services were combined, the remit of the service manager was extremely broad. For example, a single service manager was responsible for dermatology, rheumatology and sexual health across three trust sites and there was no service manager in post for HIV services. Senior staff we spoke with raised this as a concern along with the vacancies in the senior management and divisional teams. For example, the lack of a general manager for sexual health, HIV, rheumatology and dermatology meant the remit of the divisional manager was significantly increased.
- Managers and senior nurses we spoke with described extensive delays between recruiting staff and completing their pre-employment checks. They told us there were frequently delays of several months, which led to staff offered a post seeking employment elsewhere instead. A senior nurse said, "The human resource processes are very problematic. There is increasing attrition of staff because the staff we have become more and more stressed with the workload while waiting for new colleagues to start. In the meantime the staff we already have leave, which continues the cycle we have of short-staffing." The trust had a rolling programme of nurse recruitment and individual services were able to incentivise staff to stay. However, recruitment and selection processes were not robust enough to address the acute shortage of nurses in some areas.
- We observed specific areas of the hospital where governance and leadership had significantly improved. For example, a new ward manager on ward 11C had addressed the pressures facing staff and facilitated a cultural change in the working environment. We observed a senior nurse meeting on this ward that included a presentation from a divisional analyst. Staff in attendance were enthusiastic, vocal and positive and it was clear that sharing ideas and learning was valued and rewarded.

Vision and strategy for this service

- The trust had an overarching key improvement priority plan in place for 2016/17, within which medical care services were an integral part. This included exploring the benefits of a new trust-wide leadership model and governance arrangements, completing the referral to treatment time data recovery programme and reducing the reliance on temporary staff. Six distinct quality priorities were in place, including a targeted reduction of pressure ulcers of between 50% and 75%, a reduction of the number of falls resulting in harm of 50% and the elimination of MRSA bacteraemia by April 2017.
- The trust's vision, strategy and improvement plans were advertised in the hospital. However, very few staff we spoke with knew what plans were in place or what the trust hoped to achieve in the near future.
- Senior staff in neurology had developed a future strategy to plan the service in three, five and 10 years' time. This included combined medical rotas with another site for different neurology procedures and would enhance the scope of the service.
- The infection prevention and control team planned to implement a new strategy in October 2016 that would deliver a structured approach to reduce infection rates and improve screening strategies.
- The clinical engineering team had successfully secured the support of the trust to implement a new electronic training system. This would enable them to track equipment training competencies amongst staff and prioritise training for staff who were not up to date. At the time of our inspection the project was at the implementation stage and was due for completion by December 2016.
- An electronic patient records system was planned to be implemented across medical inpatient services and endoscopy.
- The endoscopy unit was planning to introduce three additional full-day clinics on Saturdays from October 2016. This was a significant addition to the capacity of the service and would be supported by two locum consultants and a six day on-call rota for consultants.
- Sexual health services were subject to a significant change due to the decommissioning of the Ambrose King centre building by July 2018. In addition sexual health services were being retendered by the local authority, which meant staff had to compete with other providers to receive approval to provide services by commissioners. Although senior staff had to prioritise this in their short-term strategy, they remained

committed to other planned improvements and developments such as the scoping of a needle exchange programme to meet the needs of the local population and to reduce the incidence of hepatitis C.
- The acute admission unit (AAU) planned to introduce more emergency department assistants to improve multidisciplinary working between the two departments and to increase the efficiency of patient flow.

Governance, risk management and quality measurement

- Services at the Royal London Hospital were organised into four overarching divisions. Medical services were present in two of these; medical specialties and urgent and emergency specialties. A divisional director, divisional manager and associate director of nursing led each division, supported by business partners and clinical governance leads. Within each division there were three clinical directorates, led by a clinical director, general manager and senior nurse. Each service or ward was led locally by a service manager and ward manager. This structure had been introduced seven weeks prior to our inspection and as such was new to staff and there were several senior vacancies in the divisional teams. This included a clinical governance lead for emergency care and trauma, a matron for older people's services, a general manager for the rheumatology, dermatology, sexual health and HIV clinical directorate and clinical leads for six services. In addition to the divisional structure, services were overseen by five clinical academic groups (CAGs). A director, deputy head and professional head led each of these.
- The senior team in each CAG and service maintained a risk register, which was used to monitor significant risks to service continuity, staffing or patient safety. At the time of our inspection, there were seven significant risks attributed to medical care services. Two related to short staffing of nurses and consultants in older people's services and another to the lack of availability of specialist registrars to admit patients from the acute admissions unit (AAU). Other risks related to the need to replace flexible bronchoscopes and the lack of capacity for the medical devices team to service high risk equipment in a timely manner. The prescribing software used in HIV services had been highlighted as a risk as it was not compatible with the systems used by any other service. A new, more integrated electronic system was being piloted at the trust's other sites and was due to be implemented at the Royal London site following testing.
- The financial governance structures, through which funding was released to purchase new medical equipment, did not always provide staff with timely access to new equipment. This was because the governance system was risk-based and responded quickly to equipment needs where patient safety was at risk but did not run well as part of a rolling programme of replacement. This led to a number of significant equipment-related risks being identified by staff.
- Therapists attended a monthly team meeting as part of their team governance procedures. This was an opportunity for staff to review specific cases and to share learning and best practice. During this period patients were cared for by therapy assistants. However, not all therapists we spoke with knew how to access the minutes of the meetings and one therapist told us they did not know how to catch up if they missed a meeting.
- The infection control and prevention clinical director held a monthly governance meeting with a microbiologist to review the results of hand hygiene, '5:5' and MRSA screening audits.
- Sexual health and HIV services had a robust information governance system that protected patient's confidentiality, including a stand-alone patient records system and dedicated data teams.
- All staff in the endoscopy unit regardless of grade or role attended a monthly clinical governance meeting in addition to weekly meetings between the clinical lead and service manager. Managers and administration staff had a slot within the monthly meeting in which they could share incidents, discuss issues and resolve complaints with the clinical team. Managers from this unit met with colleagues in the business intelligence unit on a fortnightly basis to optimise patient lists and the management of appointments and capacity.
- Service managers in medical care services met on a monthly basis to review waiting lists, preventable target breaches, patient or staff complaints. This helped to establish a governance culture of problem-solving and idea-sharing.
- It was not clear that clinical governance and oversight for acute medicine worked in the best interests of clinical staff or patients. A consultant said a rapid

expansion in the provision of specialty care meant the team was "fragmented" and said, "This is not a nice place to work. There's a lack of cooperation generally that no-one has addressed."

Culture within the service

- As part of the trust's transformation project to re-engage staff and improve working morale and patient safety, each member of staff had been issued with a pocket card detailing contact details for key departments. This included a range of services provided for staff to speak in confidence when they had problems or concerns. This included a dedicated Speak in Confidence team, an external Guardian Service, a Confidence in Care employee assistance service and a team of Dignity at Work Advocates. This formed a package of care for staff to help them feel supported and valued at work and to avoid concerns reducing the quality of care they provided.
- Although survey results and staff engagement projects indicated an improvement in staff morale, nine members of clinical staff spoke with us about concerns they had with working conditions. One nurse said, "My ward manager is excellent. They help with checklists, medicine and are very approachable. But on nightshift last night I had nine patients to myself, all in different rooms and it was too much. It's why so many of us are leaving. I couldn't care properly for everyone because they [patients] were all bedbound."
- During our focus groups a number of staff raised concerns with us about the working culture of the hospital. In addition, several staff spoke with us on the condition of anonymity about what they felt was a pervasive culture of bullying and harassment in the hospital. We asked all of the staff we interviewed, in every area, about this. None of the staff we spoke with said they had experienced or witnessed bullying and said they would not hesitate to escalate this if it did happen. One clinical member of staff said they felt site managers could be intimidating. They said, "They [site managers] talk down to us. Their attitude is 'I'm giving you orders, you listen to me.' We're scared to speak back, there's a fear we'll lose our jobs if we do. They do the same with the nurse in charge; it's horrible to see your charge nurse spoken to with such disrespect."
- Staff in the endoscopy unit had developed their own set of behavioural guidelines based on the working culture they wanted to be part of. The guidelines were called the 'green rules' and included standards such as showing respect for each other, being helpful and courteous to colleagues and speaking English at all times. Staff we spoke with told us this helped to facilitate a positive and welcoming working atmosphere in which the contribution of each individual was valued.
- Senior divisional staff said they felt the trust had improved working conditions significantly. One clinical director said, "It feels so much better now. The chief executive [officer] is visible and communication between everyone seems better. There's a really nice, new energy in the hospital."
- Some staff said they believed promotion was more difficult for black and minority ethnic staff and others said they believed promotion was open to everyone who could demonstrate the skills needed.
- Consultants spoke with us about a significant disconnect between some services, particularly out of hours. One consultant said, "Consultants as a body are defensive and incredibly unhelpful. The lack of cooperation is astonishing." They said this contributed to problems at weekends when consultant levels were low and there were a lack of specialty doctors to help on wards.

Public engagement

- Each ward or clinical department displayed a 'You said, we did' board at the entrance. This was a new scheme and not all areas had added information yet. Some areas indicated specifically how services had been changed. For example, the board on ward 3E stated new healthy food options were available as a result of patient feedback. The latest results of the survey that indicated how likely people were to recommend the ward were on display in clinical areas. For example, the result for ward 9E in June 2016 was displayed as 82% and the result for the endoscopy unit for May 2016 was 94%.
- The trust implemented a scheme called 'I want great care' that encouraged patients and relatives to give candid, constructive feedback about their experiences. We saw this was widely advertised and promoted in the hospital. Some staff spoke to us about the campaign. One nurse said, "'I want great care' but what does this mean when we're so short staffed? I have no time to get

to know my patients because I'm so busy. I had no personal or social interaction with any of my patients yesterday, the whole day was taken up with paperwork because we're so short staffed."

- Staff in sexual health and HIV services noted that all of the patients who responded to the first survey return identified as White British. As this was not representative of the diversity of patients seen in clinics, staff had the questionnaire translated into the top five languages spoken by patients who used the clinic. This resulted in a broader range of feedback and responses. The 'I want great care' survey was available in a number of different languages in acute services.

Staff engagement

- The trust had engaged staff in a survey to monitor improvements in empowerment and morale following a period of significant change in leadership and governance structures. This formed part of a 'safe and compassionate' improvement plan for staff of all grades and asked 15 questions about how staff felt about working at the trust. At the Royal London Hospital, an increase in the positive responses from staff was recorded in all 15 questions, some with significant improvements. For example, in September 2015 34% of staff agreed that the organisational culture encouraged them to contribute to changes in their team or department. In May 2016, 8% more staff agreed with this. Between the two survey dates, there was an increase of 13% in the number of staff who agreed the hospital's main priority was patient safety and care. This represented an overall improvement in the working culture of the hospital. However, not all staff were aware of the survey or felt the trust engaged with them. One nurse said, "No I don't know anything about a survey, I haven't been asked to take part. Most communication is by e-mail and we just don't have time to read everything that gets sent out." Two healthcare assistants (HCAs) we spoke with said they did not believe this engagement applied to them. One HCA said, "I don't think we're valued that much as a staff group. We get less training and no-one seems that interested when we say we're struggling with the workload. I didn't know there was a survey I could take part in."
- To improve staff engagement and retention, human resources business partners were being embedded into the new divisional structure. This would result in staff in each ward or department being able to contact a named human resources member of staff for guidance and support. This system was being implemented at the time of our inspection and was not fully functioning yet. Senior staff we spoke with were positive about this development but raised concerns about the capacity of business partners to provide support due to workload, with the business partner in one division being responsible for 1000 staff. One senior member of staff said they had seen improvements in their team following the implementation of the business partner. They said the partner had identified some areas of problematic communication and worked with staff to resolve them. They told us, "They've [business partner] done some work with staff about managing expectations and given staff the opportunity for counselling through our occupational health department. Altogether I think things have become much better."
- To address staff need, a programme of accredited conflict resolution training was in the process of delivery by human resources trainers with support from practice development nurses. In addition, a leadership programme was in place offered by the organisational development team. Staff spoke positively about this and said it helped them to build better relationships with colleagues.
- Staff were encouraged to suggest and develop improvements to services. For example, a nurse who completed the renal development pathway helped to develop a quality improvement project for patients that would include an easy-to-read printed resource detailing quality standards, what to expect from care and how to access transport services.
- It was not always evident that all staff groups were listened to in relation to their concerns. For example, a senior clinician had raised concerns about the lack of specialty medical cover on a weekend in light of a series of incidents that involved on-call consultants refusing to attend the site. Registrars and consultants on a weekend were often shared with St Bartholomew's Hospital and there was not a robust policy in place to mitigate the risks associated with this.
- Staff on ward 3E had implemented a philosophy of care. This detailed the standards patients and their relatives could expect and was displayed on the ward.

Innovation, improvement and sustainability

- We spoke with several new members of staff who had previously been students in the hospital. They demonstrated an unwavering enthusiasm for the hospital and its work and were vocal about their hopes to expand their training and research portfolios. One nurse said they were funding their own postgraduate training because their department's budget would not cover it. They said, "It's a shame they won't pay for me to develop because I believe this ward needs research activity to improve its practice. I'm doing my own study outside of here and the ward manager is working with me on how we can apply it to patient care."
- Research nurses were based on the stroke unit and were supported to engage in trials to improve care and patient outcomes. Staff on this ward demonstrated a proactive approach to improving patient experience. Most recently this involved a pilot project for protected meal times. This involved all staff on the ward, including therapists and doctors, being involved in the meal service. Staff received positive feedback from patients during the pilot as it meant their food was served as soon as it arrived and so was hot and fresh. This also meant patients had more social interaction if they wanted it because more staff than usual were free to serve food. Nurses and physiotherapists we spoke with said they found this approach to meal times much better for patients and it had been implemented as a standard policy.
- As a strategy to attract and retain nursing staff, practice development nurses had developed an innovative 'acute fast track programme' in renal services. This enabled nurses to rotate between the renal inpatient wards, dialysis services and the renal high dependency unit as well as in the renal satellite sites. Nurses on the programme engaged in reflective exercises and gave very positive feedback about the experience.
- Staff in sexual health and HIV services were highly research active and used findings from in-house research and collaborative partnerships to drive improvements in care and patient outcomes. For example, the services had taken part in the PROUD (Pre-exposure Option for reducing HIV in the UK) study to assess the efficacy of using pre-exposure prophylaxis (PrEP) to reduce HIV risk. The clinical team were establishing protocols to support participants who successfully completed the trial in light of the NHS England decision to not fund PrEP nationally.
- Sexual health services had developed a 'clinic in a box' model in response to increasing rates of new HIV infections in London. This included community and specific site-based testing and had completed 12,000 tests to date. A refugee service helped people in this population to access services and to minimise on-going risk by providing testing for sexually transmitted infections and HIV. This was an innovative partnership project with Doctors of the World along with safeguarding staff who were specialists in trafficking and modern day slavery.
- Psychologists in sexual health services worked with a hospital religious leader to provide targeted support to young men from ethnic minorities in the local community in preparing them for positive psychosexual health when they got married.
- Staff in the endoscopy unit had visited colleagues at another hospital where the same electronic patient records system planned for the Royal London Hospital had been introduced one year previously. This exercise helped to predict initial problems with the system and to mitigate the risk of this stopping the service.
- The endoscopy unit was piloting a 'straight to test' pathway to help them achieve 18 week time to treatment referral targets. This approach would reduce the need for patients to attend on multiple occasions and was being piloted with three local GP practices.
- A member of staff in the endoscopy unit had received the Barts Health NHS Trust Star Award for their work in supporting patients who did not speak English to engage with the service as well as their volunteer work.

Surgery

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

Information about the service

The Royal London Hospital provides a range of day case, elective and emergency surgical services to a population of patients from East London and West Essex. More than 22,000 surgical procedures were carried out by the hospital in 2015 and the trust was in the top quartile for surgical activity nationally. The Royal London Hospital is used mostly for day case and non-elective surgery, with 55% day case procedures, 25% emergency/non-elective procedures and 20% elective procedures in 2015.

There are 12 main operating theatres at The Royal London Hospital and eight day case theatres (ACAD). Main theatres are used for inpatient surgery and ACAD theatres for short stay and elective procedures. Surgical activity at The Royal London Hospital is managed by two divisions within the trust: Surgery, Peri-Operative Medicine and Critical Care, and Emergency Care and Trauma

We inspected the perioperative care pathway from admissions, through operating theatres and recovery onto surgery wards. We looked at provision for both inpatient and day case patients. During our inspection we visited a sample of operating theatres and nine surgery wards: 3D short stay surgery, 3F Surgical Admissions Unit, 9F Urology Inpatients, 10F Elective Orthopaedics, 12C Emergency Orthopaedic Surgery and Plastics, 12D Trauma, 12E Neurosciences, 13C Vascular and General Surgery and 13D General Surgery.

We spoke with 25 patients and their family members. We observed care and treatment and looked at 15 care records. We also spoke with more than 40 staff members, including allied healthcare professionals, nurses, doctors in training, consultants, ward managers and senior management staff. In addition, we reviewed national data and performance information about the service.

Surgery

Summary of findings

We gave the surgical services at The Royal London Hospital an overall rating of 'requires improvement'. This was because:

- There were a number of serious, cross-cutting risks and issues that were longstanding and unresolved. The service had not adequately addressed some concerns identified at previous CQC inspections.
- There were frequent problems with insufficient availability of sterile equipment in theatres.
- There were high levels of non-medical staff vacancies across wards and theatres, including nurses and theatre practitioners. There was heavy reliance on agency staff to cover gaps and this sometimes resulted in temporary staff without suitable skills or experience. There were not enough recovery staff suitably trained in high dependency support and advanced life support to safely care for patients in theatres at all times.
- There was a high number of never events.
- There were insufficient processes in place to ensure the nutrition needs of all patients were met.
- Patients gave us variable feedback about the quality of care they received, particularly from some agency nurses. We saw some examples where care could be improved. Some patients and their relatives did not feel they were proactively kept informed by hospital staff.
- The flow within the surgery system from admission, through theatres, wards and discharge was not managed effectively. There were serious problems with bed management and bed availability, which caused late theatre start times and frequent short notice cancellations of surgical procedures. There were inefficiencies and under usage of operating theatres and the service was not meeting all of its targets.
- Patients were held in recovery for inappropriate lengths of time and in an unsuitable environment. Patients frequently remained in recovery overnight.
- Some staff told us there remained challenges with the organisational culture of the surgery service. Some staff did not feel well supported by their peers or managers and unprofessional behaviours were still present in some parts of the service.

However,

- There was good compliance with hygiene processes. Medicines were stored securely and managed appropriately. There were effective site-level processes in place for incident reporting, investigation and governance.
- Surgical pathways were delivered in line with referenced national clinical guidance. There was a comprehensive clinical audit programme and this informed service development. There was an effective multidisciplinary working environment.
- There was a trust-wide strategy to improve basic nursing care.
- The service was focused on reducing Referral to Treatment backlogs, which had decreased since February 2016. The surgery service introduced a surgical assessment unit which was preventing long waits in A&E and unnecessary admissions.
- There were appropriate arrangements in place to support patients with learning disabilities and those living with dementia.
- New site level leadership and governance structures were in place across the surgery divisions. This afforded greater focus on site specific challenges, and more manageable and responsive leadership structures for each surgical specialty. The service leadership was committed to quality improvement and there was evidence that some progress had been made since the last CQC inspection.
- There was a very strong record of innovation in the hospital's trauma service.

Surgery

Are surgery services safe?

Requires improvement

We rated the surgical services at The Royal London Hospital as 'requires improvement' for safety. This was because:

- There were frequent problems with insufficient availability of sterile equipment in theatres.
- There was limited evidence of shared learning from incidents across sites within the trust.
- There was a high number of never events.
- There were insufficient numbers of recovery staff with high dependency or advanced life support competencies to safety care for high acuity, high risk patients.
- There were high levels of non-medical staff vacancies across wards and theatres, including nurses and theatre practitioners. There was heavy reliance on agency staff to cover gaps and this sometimes resulted in temporary staff without suitable skills or experience.
- There were some instances of clinical waste not disposed of correctly.
- There was variable awareness amongst staff about major incident plans.

However,

- All of the clinical areas we visited were visibly clean and there was good compliance with hygiene processes.
- Medicines were stored securely and managed appropriately.
- There were effective site-level processes in place for incident reporting, investigation and governance. Learning from incidents within the hospital was shared effectively.
- There was good compliance with the 'five steps to safer surgery' checklist, but debriefings were not well embedded.

Incidents

- The surgery service at The Royal London Hospital reported eight never events between August 2015 and July 2016. Reported never events included incorrectly inserted nasogastric tube, wrong site implant placement, administration of medication, retained object after surgery and wrong tooth extraction. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Each never event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event.
- The surgery service at The Royal London Hospital reported 27 serious incidents to the NHS Strategic Executive Information System (STEIS) between August 2015 and July 2016. Recorded incidents which met SI criteria included: pressure ulcers, treatment delays, medication incidents, sub-optimal care of the deteriorating patient, and surgical/invasive procedure incidents.
- The trust used an online incident reporting system. All surgery staff had individual user login details to access this system. Doctors, nurses, theatre staff and allied health professionals told us they felt able and comfortable to submit incidents to the system. Agency nurses told us they could report incidents and felt encouraged to report incidents. They also attended safety briefings.
- Senior staff told us use of the incident reporting system was actively encouraged and there had been an increase in the number of reported incidents in the months before our inspection. In the year preceding our inspection there were 239 incident reports in the surgery service. In the trust's incident reporting log for surgery we found general themes of lack of central appointments, instrumentation in theatres, falls without harm, pressure ulcers and medication errors.
- There were appropriate incident governance systems in place. Surgery staff attended weekly governance meetings to review incident reporting data across the hospital, including the level of harm. Senior staff told us this meeting had open attendance for all staff, including those from other hospitals in the trust to share learning. The trust clinical effectiveness unit and governance team sent emails after these meetings to share information with staff who were unable to attend.
- There were daily safety huddles in surgery wards and theatres every morning attended by all staff on duty and led by a senior member of staff. The briefing was used

highlight any safety issues of the day's patients including risks of falls, patients subject to Deprivation of Liberty Safeguards (DOLS), security matters, safeguarding, pressure ulcers and staffing. It was also used to provide feedback on recent incidents. We observed two safety huddles and found comprehensive discussion of safety risks. All staff were engaged and raised concerns. The safety huddle used a template agenda to ensure all briefings covered the same topics.

- Senior staff told us outcomes from incident investigations were discussed at monthly staff meetings. They recognised the hospital was good at sharing learning within the site, but there a need to improve shared learning across sites within the trust.
- Paper copies of recorded safety concerns and complaints were available to staff so they could review the outcomes of investigations. These were anonymised to ensure learning could be shared without identifying individuals involved.
- Matrons told us incident investigations were thorough and timely. Investigations included 'round table' meetings with all staff involved in the serious incident within 48 hours of it occurring. The meeting was used to complete the SI reporting pro forma and discuss what happened. The trust governance lead attended the meeting to provide a neutral arbiter and guide staff through the investigation process. There was a weekly SI panel meeting to discuss concerns and decide if a SI required further investigation. Trust processes required a staff member outside of the surgery service to investigate serious incidents and never events.
- There was evidence of learning and changes to practice as a result of serious incidents and never events. The service had sought advice and guidance from nasogastric tube (NG) trainers in the hospital critical care team in response to recent never events in this area. The service had introduced a checklist for using and inserting NG tubes. Nurses told us they knew how to escalate for help with insertion of NG tubes. A number of system changes were evident in response to other never events, including introduction of new protocols for medication administration, and development of new surgery procedure checks and equipment counts as part of the National Safety Standards for Invasive Procedures (NatSSIPs).
- Matrons told us the service had commissioned the Faculty of Dental Surgery to conduct a review following a number of never events and serious incidents. At the time of our inspection the service was in the process of reviewing the Faculty's recommendations for changes.
- Senior staff told us there was high awareness of never events and serious incidents and good cascade of learning to staff. However, there was variable feedback from staff across the service about learning from incidents, particularly from other hospitals within the trust. There was also variable understanding of the term 'never event'. In theatres, some ODPs told us they received timely feedback on incidents, while others were not clear if there had been any never events within the hospital. Some staff were able to articulate recent never events and SIs, while others were unable to recall learning from never events and were unclear what incidents had happened.

Duty of Candour

- There were formal processes in place for ensuring duty of candour responsibilities were exercised appropriately. Senior staff told us the trust's incident reporting section incorporated a section on duty of candour responsibilities to confirm staff had shared information appropriately with patients and their relatives. Incidents could not be closed on the system until this information had been completed. Matrons and staff nurses were responsible for communicating with and apologising to patients and their relatives. Duty of candour cases were recorded on trust systems and were discussed at governance and safety meetings.
- We found senior staff within the surgery service understood their responsibilities for duty of candour and were able to describe giving feedback in an honest and timely way when things have gone wrong.
- The trust covered duty of candour responsibilities for new members of staff during their induction. Howevever, there was a varying degree of understanding of duty of candour amongst more junior staff. Some junior staff were not aware of the term duty of candour, but when questioned were able to articulate how they would respond should a mistake happen. They appreciated the need for openness and honesty in the investigation of incidents. Some staff in main theatres did not understand processes or the meaning of duty of candour and thought it related to patient privacy and dignity.

Safety thermometer

- The NHS Safety Thermometer is an improvement tool to measure patient harm and harm free care. It provides a monthly snapshot audit of the prevalence of avoidable harms in relation to new pressure ulcers, patient falls, venous thromboembolism (VTE) and catheters and associated urinary tract infections (UTIs). The surgery service collected and audited Safety Thermometer data on a monthly basis and the results were made available to wards managers.
- Between April 2015 and April 2016 the trust reported to the Patient Safety Thermometer: 59 pressure ulcers (grades 2, 3 and 4), 37 falls with harm and 24 catheter acquired urinary tract infections. In the same period there was one reported instance of Meticillin-resistant staphylococcus aureus (MRSA) and four reported cases of Clostridium difficile (C Diff) infection across all surgery areas.
- Current safety thermometer results were clearly displayed on ward 'safety cross' boards along with other performance indicators. This meant safety performance information was available to patients and their families. Wards managers advised they feedback on ward performance to staff at handover meetings.

Cleanliness, infection control and hygiene

- All of the clinical areas we visited were visibly clean. The environment across the surgery wards and theatres was clean, tidy, well organised and clutter-free. All floors in corridors were clean. There was no evidence of dust. Infection prevention and control was generally well managed.
- The equipment we reviewed was visibly clean and was labelled as clean and ready for use consistently across all clinical areas. Staff used green 'I am clean' stickers to indicate when equipment had been cleaned. We saw these stickers used on resuscitation trolleys, IV trolleys, ECG machines, hoists and weighing scales. The stickers were also used comprehensively in main and ACAD theatres.
- We observed theatre staff clean equipment between cases. We observed nurses and HCAs using wipes to decontaminate chairs and equipment on wards. All of the 'I am clean' stickers we inspected were dated and current.
- Hand hygiene signs were prominent across surgical areas. There were hand sanitiser points at the entrance to wards and throughout public areas. On some wards, the sanitiser points were placed quite high up on walls, which meant some visitors may not be able to reach it to clean their hands.
- We observed staff using hand gel as they entered wards. Patients and their relatives also told us they saw staff washing their hands and that wards were clean.
- There was appropriate protective personal equipment (PPE) such as gloves and aprons at entrance to bays and side rooms for staff to use to maintain IPC standards. We observed staff wearing PPE appropriately.
- Senior nurses told us they challenged all grades of staff to maintain hygiene standards, such as bare below the elbow. All staff we spoke with were clear on the need to keep wards and theatres safe and free from infection. Matrons conducted twice monthly walk arounds with staff from domestic services.
- The surgery service conducted regular audits of infection prevention and control compliance across wards and theatres. Audit results were prominently displayed on quality and audit boards. Data submitted by the trust from monthly environmental audits demonstrated an overall compliance of 98% across all surgery areas. The lowest performance was in ward 10F elective orthopaedics at 95% compliance. A hand hygiene 10 weekly audit was completed by the trust's clinical governance team. Data from these audits demonstrated an average hand hygiene compliance of 80%% across all surgery areas.
- Patients were screened for infections such as MRSA on admission. Patients with confirmed infections were allocated to a ward side room for isolation purposes to prevent cross-contamination. There were clear notices at the entrance to side rooms indicating infection risks and IPC actions on entry and exit to side rooms. Senior nurses told us side rooms and bays were deep cleaned once patients with infections had vacated them.
- Some wards were 'ring fenced' for elective patients to reduce infection risks. For example, ward 10F was allocated for elective orthopaedic patients only.
- All of the toilet and shower rooms we inspected were clean and tidy.
- The clean and dirty utility rooms we inspected were clean and tidy. Sharps bins were not overfilled. However, we found some instances where clinical waste bags were not labelled with an identification number. In the dirty utility of main theatres we found five clinical waste bags which were unmarked with details such date, case

or theatre number. This meant that staff could not identify the bag contents to ensure it was disposed of correctly. We also found one ripped bag and three overfilled bags which could present an IPC risk should clinical waste fall out.
- We observed instances of doors to ward dirty utility rooms left open and unsupervised. This presented a potential safety risk as there were sharps bins and chemicals stored in the rooms.

Environment and equipment

- Staff in theatres consistently reported problems with the timely supply of complete sterile surgical sets from the trust's external contractor. Surgeons told us that lack of instrumentation was impacting on their ability to treat patients effectively and was leading to cancellations and inefficient running of theatre lists. For example, surgeons reported a recent example where they did not have access to sets for major trauma, orthopaedic, vascular, arterial or neurosurgery for over 12 hours. ODPs told us they did not feel confident the service would be able to respond if there was a major incident.
- Theatre incident reports highlighted unavailable instrumentation as the highest reported incident type. All of the theatre staff we spoke with told us instrument issues were a daily problem and their main cause for concern. They felt that it was not improving, despite it being escalated to service leaders in frequent incident reports. They were concerned it was not being dealt with urgently. Senior service leaders were aware of the concern and it was reported as one of the main risks in the service risk register. The trust's external sterilisation contractor had brought in extra staff to clear a back log of sets. However, during our inspection we observed instances of trays with missing equipment. Surgeons resorted to opening other sets to obtain necessary equipment, but this impacted further down the list as equipment was removed and not replaced.
- All of the clinical areas such as theatres and wards we visited were calm, well organised and quiet. Wards were spacious and well laid out with adequate space to move and no clutter or trip hazards blocking walk ways. Theatre infrastructure across main theatres and the ACAD theatres was well maintained, spacious and clean.
- Patients on the wards told us they were comfortable. They told us it was mostly quiet at night and they managed to rest. Nurses mentioned that moving from the old building to the new building has been a great improvement because there were side rooms with en suite toilet facilities. They felt this was good for the patient experience and for infection control. Wards also had day rooms for patients and their families, however relatives told us they were not particularly comfortable spaces and were clinical and unwelcoming. Senior nurses recognised the day rooms could be improved.
- Store rooms in theatres and on wards were generally neat and well organised which made it straight forward to find supplies. The hospitals store team was developing a colour coded system to make it easier and quicker for staff to find supplies in an emergency.
- Theatre equipment was neatly stored in labelled in drawers. The theatre equipment storeroom was segregated and contained large pieces of equipment that were cleaned and stored away from theatres. There were dedicated bays on ward corridors for the storage of large equipment such as scales and hoists.
- Wards were accessible to patients and visitors with limited mobility. There were disabled toilets and shower facilities and accessibility rails on walls.
- There were fire extinguishers at appropriate points throughout wards and theatres.
- We saw resuscitation equipment available in all clinical areas with security tabs present and intact on each. Systems were followed for checking resuscitation equipment. We saw checklists were completed daily and in full and audit and guidelines documents were present, signed and up to date for all resuscitation trolleys that we checked. All necessary trolley equipment and consumables were present and sealed as appropriate, and in working order. In theatres there were additional dedicated trolleys for managing difficult airways and emergency tracheostomy cases.
- We examined log books for daily anaesthetic machine checks in a sample of theatres. Records were accurately completed and there were no gaps.
- All of the equipment we checked had been serviced and the date of the most recent service was clearly displayed. We did not find any equipment that was overdue its service.
- Staff told us there was no rolling replacement programme for surgical equipment, such as anaesthetic machines and portable ventilators. Senior clinicians told us equipment requests were usually granted by service managers, but procurement processes were slow and staff did not clearly understand them.

- Staff told us there was a shortage of wheelchairs and footplates for patients. Nurses completed incident reports when these equipment were not available.

Medicines

- We found that medicines were stored securely and appropriately. Keys to medicines cupboards, trolleys and patient bedside lockers were held by appropriate staff and medicines trolleys were immobilised (chained to the wall) when not in use. There was restricted access to rooms where medicines were kept.
- All medicines cupboards and fridges inspected were clean and tidy, and fridge temperatures were mostly within the recommended range of 2-8°C.
- Treatment rooms were clean and tidy, with cupboards labelled detailing contents within.
- Keys to the drug cupboards and patients' own drugs (POD) lockers were held by registered nurses and doors to the rooms housing medicines were locked with restricted access.
- Controlled Drugs were audited on a daily basis, with a separate signing sheet seen on 13D. Controlled Drugs were correctly documented in the CD register, with access to them restricted to authorised personnel.
- Room and fridge temperatures were recorded on a daily basis, and were mostly found to be within the recommended range of 2-8 Degrees. When asked what would happen if the normal fridge temperature of 2-8 Degrees went out of range, we found some inconsistencies in response from staff. Some stated they would contact the pharmacist, whilst others stated they would contact the helpdesk. This meant there were inconsistencies in the action taken, which could lead to a risk that medicines within fridges were not stored appropriately.
- There was a policy in place to support the use of PODs and we saw evidence of PODs appropriately stored in lockers beside patient bays.
- There was a policy in place to support the use of Patient Group Directions (PGDs), and we saw evidence of these PGDs that were signed by authorised personnel, in date and appropriately audited.
- Nursing staff we spoke to said they had access to a pharmacist available between 9am-5pm daily Monday to Friday on the ward. They were responsible for screening drug charts, medicines reconciliation, ordering and topping up of drugs from the main pharmacy, ordering the TTO (to take out) medicines for patients and counselling certain patients on specific medicines usage.
- Staff had access to BNFs as well as all policies/ information relating to medicines management (including the antimicrobial formulary).
- Staff competencies for prescribing, dispensing and administrating medicines were assessed by dedicated induction processes provided by the trust, through the intranet portal.
- Staff understood and demonstrated how to report medicines safety incidents. This was then escalated and fed back for learning through various channels, such as daily safety hub meetings, emails and pharmacy feedback.
- Allergies were recorded on the drug charts, alongside other sections such as a VTE risk assessment, medicines reconciliation section and a separate diabetic chart.
- Medicines cupboards were labelled clearly detailing contents within. We found that medicines used for resuscitation and other medical emergencies were available, accessible for immediate use and tamperproof. There were daily checks carried out on the monitoring of these medicines.
- TTO (To take away) medicines were stored appropriately in a lockable medicines cabinet. Pharmacy data provided showed that TTO times to pick up non-urgent medicines were within the trust target of 3 hours. However, nursing staff we spoke to said it was difficult to get discharge medicines in a timely manner, especially out of hours.
- There was no pharmacy input in the pre-admissions unit. Staff felt pharmacy input would be very valuable for medicines reconciliation and prescribing.
- There were some ward based pharmacists. Nurses told us this had improved obtaining TTOs, but there was a need for improved communication with medical teams to ensure more timely decisions on required medications.

Records

- The surgery service used the trust's electronic patient record (CRS) to record and access patients' records. This was available to doctors, nurses and other healthcare professionals. All professionals in the care of a patient recorded information in chronical order in the clinical notes section. We observed nurses and allied health

professional using the CRS and saw they were comfortable and adept at using the system. However, staff told us there were four separate computerised record systems in use across trust, as well as separate paper record keeping for renal and urology services. Staff told us the multitude of systems was problematic for the effective sharing of information.

- We accessed the electronic patient record system with the assistance of a ward nurse. We reviewed 15 patient records and found patient notes were completed in a logical and comprehensive way. The clinical notes provided a good description of care plans, observations and patient progress. Nursing assessments were completed, including vital observations and early warning scores, falls assessments, assessment for pressure areas (Waterlow score), venous thromboembolism (VTE) assessment and nutritional status (Malnutrition Universal Screening Tool - MUST), drug charts, and safeguarding status. Care plans included all identified care needs.
- Paper copies of patients' bedside notes were stored in holders by beds or outside of side rooms. Records were confidentially stored and not left open or on display. The CRS required password access to ensure security. Staff members had unique accounts to ensure professional accountability. Temporary staff were also allocated logins.
- The CRS flagged patients who were at risk of falls, those with MRSA or CDiff. The system also provided an alert for patients with learning disabilities or dementia so all staff were aware of a patient's specific needs.
- Staff were alerted to incomplete record sections by CRS system prompts.
- Information governance was part of the mandatory training programme staff were required to attend. The trust target was 90% of staff having completed the training. Across all surgery service lines, an average of 91% of staff had completed training.
- The surgery service used a comprehensive electronic form for pre-operative assessment. This was stored on the CRS.

Safeguarding

- There was a trust wide policy for safeguarding vulnerable adults and children. The policy and protocol for safeguarding referrals was available for staff to access via the trust's intranet. The trust's Deprivation of Liberties Safeguards policy and process was also available for staff to access on the trust intranet.
- The staff we spoke to were able to explain their understanding of safeguarding and the principles of safeguarding for children and adults. They were clear about the trust's safeguarding escalation process. Doctors in training and nurses were confident to seek safeguarding advice from their line managers.
- Safeguarding information was displayed on posters in wards.
- Staff were able to identify the potential signs of abuse and the process for raising concerns and making a referral. Ward nurses had good recognition of domestic violence and were able to discuss this in a sensitive and way with patients. We were given examples of concerns they had identified and referrals made.
- Patients we spoke with told us they felt safe in the hospital.
- There was a safeguarding link nurse in the surgery service who linked in with other safeguarding leads across the trust to ensure new information and learning was shared appropriately. Ward staff told us the safeguarding lead was accessible and responsive and provided support for referrals when needed.
- There was good completion of mandatory safeguarding training within the surgery service. Safeguarding awareness was included in corporate induction and additional safeguarding training was available to staff depending on their seniority and role. The trust's target was 90% of staff having completed mandatory safeguarding training. Across all surgery service lines, 90% of staff had completed safeguarding vulnerable adults training and 100% of staff had completed safeguarding children training. Training in female genital mutilation awareness was included as part of adult safeguarding level two training.

Mandatory training

- The trust target for staff completion of mandatory and statutory training was 90%. At the time of our inspection, average compliance with mandatory training for all surgery service lines was around 90% for most training modules across all staff groups.
- The mandatory and statutory training programme covered equality and diversity, health and safety, basic life support, infection control, information governance,

adult and child safeguarding, fire safety, manual handling and conflict resolution. Mandatory training included online learning modules and practical teaching sessions. All staff had a 'your clinical statutory and mandatory training' booklet which included all aspects of mandatory training including safeguarding and DOLs.

- Ward managers we spoke with demonstrated the systems they used locally to monitor their staff attendance at mandatory training to ensure it was completed, or refreshed.
- Newly appointed staff were required to complete a corporate induction and a subsequent ward or theatre based induction. The second part of induction included orientation to the clinical area, mental capacity awareness training, using medical devices, moving and handling and medications management.
- Staff told us they could access refresher training and drop in sessions for additional support with mandatory training.

Assessing and responding to patient risk

- Patients' clinical observations were recorded and monitored in line with NICE guidance CG50 'Acutely Ill-Patients in Hospital.' A scoring system known as a national early warning score (NEWS) system was used to measure patients' vital signs and identify patients whose condition was at risk of deteriorating.
- Nurses conducted regular intentional rounding throughout the day to monitor and record patient safety parameter. We saw staff in surgical wards recorded the observations of patient safety parameters such as heart rate, respirations, blood pressure, temperature and pain. These were recorded in patients' notes on the CRS. Patients were assessed for actual and potential risks related to their health and well-being and we saw evidence of these in notes.
- Nurses assessed patients' fluid intake and output multiple times per day. Fluid balance charts were completed in patient records and nurses calculated a patient's daily input/output and total fluid balance.
- Compliance with the trust policy on use of NEWS was audited monthly. Data submitted by the trust for the period January to April 2016 indicated 92% compliance with recording and monitoring of vital signs and identification of deteriorating patients across all surgery wards. There were nominated safety champions on each ward who audited NEWS scoring.
- Nursing staff told us they would call a doctor if they were concerned about a deteriorating patient. There was a clear escalation protocol. Nurses reported a prompt response to emergency calls by doctors and the hospital critical care outreach team. Doctors assessed patients and nurses took over once the patient was stabilised and a care plan was in place. However, some nurses in the surgical assessment unit reported difficulties in getting timely medical input from the trauma and orthopaedics team because of the demands of emergency trauma admissions. Nurses told us trauma doctors were often very busy in theatre which frequently resulted in trauma patients on wards being reviewed and assessed late in the day. They felt this delayed actions and increased length of stay.
- The trust's escalation protocol for unwell patients was clearly displayed in a poster on the wall by staff computer stations. There were also falls prevention posters including information on the post-fall pathway, a bed rails decision making tool, and information on training.
- Doctors in training conducted twice daily ward rounds to review patients and identify any concerns or additional care needs. Consultant surgeons attended ward rounds if required.
- The hospital resuscitation team attended surgery wards following an emergency call to review what happened and conduct a root cause analysis. This information was input to the national cardiac arrest audit. Resuscitation officers also provided life support and resus training to ward nurses.
- The agency nurses we spoke with were aware of policies in place for escalation of deteriorating patients and other policies such prevention and management of pressure ulcers.
- Medical staff in the POA told us identification of high risk patients took place in outpatient clinics or when a nurse assessed a patient. In approximately 90% of cases patients were reviewed for risk factors by a nurse. Surgeons and nurses reported good liaison with clinical nurse specialists and learning disability nurses to support patients with specific needs.
- Before admission all high risk elective patients were assessed using the surgical outcome risk tool (SORT), which identified six preoperative variables, and provides a percentage mortality risk for individuals undergoing surgery. High risk patients were also assessed using physiological and operative severity score for the

enumeration of mortality and morbidity (POSSUM) and cardiopulmonary exercise testing to assess the performance of the heart and lungs. Outpatient clinics were used to identify high risk patients who required a high dependency unit or critical care bed post-operatively.

- We observed anaesthetists provide a comprehensive handover to recovery nurses after a procedure. This was provided according to the handover checklist, including information on the procedure undertaken, any allergies and post-operative care requirements.
- Nursing staff in the main theatre recovery raised concerns about their ability to safely care for high acuity, high risk patients post-operatively with suitably trained recovery nurses at all times. All theatre recovery staff were required to complete immediate life support training and two staff had completed advanced life support training. However, during our inspection we found some shifts did not meet the Association of Anaesthetists of Great Britain and Ireland (AAGBI) requirement for one member of recovery staff to have high dependency or advanced life support competencies to safely and effectively care for some groups of patients post-surgery or respond to serious concerns. Theatre staff told us they relied heavily on HDU anaesthetists and anaesthetic practitioners to provide appropriate support.
- Recovery nurses reported a number of peri-arrests in recovery and told us a patient had died in recovery. They felt there was a lack of clarity about escalation and who to report concerns to.
- Recovery nurses told us that patients classified as high dependency level 3 were sometimes extubated so they could be cared for in recovery while waiting for a high dependency bed to become available. They told us a number of these patients needed to be re-intubated because they were not ready for extubating. Nurses told us in such cases an anaesthetist would remain with the patient before being transferred to the intensive care unit (ITU). In some cases where an ITU or HDU bed was not available, the patient would remain in recovery overnight. In such cases the recovery team requested an agency nurse with a HDU level qualification, but recovery staff told us they were not always available.

Use of the 'five steps to safer surgery' procedure

- The surgery service completed safety checks before, during and after surgery as required by the 'five steps to safer surgery' – the NHS Patient Safety First campaign adaptation of the World Health Organization (WHO) surgical safety checklist. We found evidence of good compliance with the surgical safety checklist, with good completion of the three compulsory elements: sign in, time out and sign out. A daily pre-briefing was held in theatres each morning before lists started, but there was limited evidence of embedded end of list de-briefings to complete the five steps.
- There was a trust framework for the five steps for safer surgery. The trust had implemented a standardised paper checklist which was used in all theatres and procedure rooms. The checklist codified the actions needed to be taken by theatre staff before the list started, before induction of anaesthesia, before skin incision and before the patient leaves the operating theatre. The completed checklist was filed in the patient's notes.
- We followed the patient pathway through a number of different surgical procedures in main theatres and ACAD theatres. In all of the procedures we witnessed staff completed the checklist comprehensively. All staff present were attentive to the process. We observed morning briefings which provided a very comprehensive briefing with full engagement by all team members. Staff demonstrated full interaction with patients during sign-in. There was a full introduction of the entire surgical team and completion of all checks during the time out. Sign out was completed in full with all instrument and swab counts completed in accordance with Association for Perioperative Practice (AfPP) national guidelines. All checks and counts were conducted in full and recorded as required on the theatre count board.
- The surgery service audited surgical safety checklist compliance covering main and ACAD theatres. The service used an audit tool based on guidelines by the Association for Perioperative Practice (AfPP) to benchmark against standards. Audits of compliance submitted by the trust demonstrated very good compliance of 97-100% compliance between June 2015 and May 2016 for all five stages. The annual audit report identified team debriefing as an area for improvement as this had the lowest level of compliance of all stages, across main and ACAD theatres at 97%.
- Theatre staff told us debriefing was mostly a paper exercise which was completed weekly using a team debrief grid document. This included action plans and

named action owners and completion dates. However, there was no formal verbal debrief during our inspection. Staff told us there were some feedback sessions if there were any identified concerns but full team debrief attended by consultant surgeons was not routine.
- Staff in theatres told us the safer surgery checklist was completed in the spirit and manner in which it was intended. They told us they felt confident to challenge poor practice and non-compliance with the principles of the checklist.

Nursing staffing

- Matrons reported an overall 21% uplift in nursing staff establishment in 2016, but there remained high levels of nursing staff vacancies across wards. Some wards such as 10F were at full establishment across all nursing bands, but in other wards there were high levels of vacancies. For example on 3D short stay, 9E renal and urology, and 13C vascular and general surgery there were vacancy rates of 38-50%. This was being managed with use of bank and some long term agency staff to cover shift gaps. There were daily safety huddle meetings to review staffing levels. The trust was also actively recruiting nurses with rolling job adverts and overseas recruitment exercises. There was some recruitment of student nurses who had been on placement at the hospital.
- There were some very established band 5 and 6 nurses on the wards who had worked for the trust for many years. Staff on these wards reported good skill mix and experienced, supportive, self-reliant staff. Nurses were supported by healthcare assistants (HCA).
- Many of the nurses we spoke with told us they worked with regular agency nurses who returned for shifts. These agency nurses had good understanding of the wards and established staff were aware of their competencies. However, they felt the high reliance on agency nurses meant they often worked with nurses who were new to the hospital. This impacted on their workload because some agency nurses required a lot of support and supervision.
- Many nurses reported overwhelming workloads and intense shifts because of the high acuity of patients and many surgical sub-specialty patients being allocated to different wards. They often found it difficult to allocate time to complete paperwork. During our inspection we witnessed a number of nurses from the night shift working up to two hours beyond their allocated shifts. Nurses told us they often wrote up notes after a very busy night shift because they had no time to document the care being given.
- There was a perception amongst most of the clinical staff we spoke with that the staffing establishment did not cover the service requirement. Doctors in training told us the service was usually short of nurses across surgery wards. They felt the reliance on agency nurses sometimes impacted on their own workload. They felt the lack of continuity of staff affected efficacy and delays things. They also felt it impacted on continuity of care.
- ACAD theatres were staffed in accordance with national AfPP recommendations and vacancies were generally well managed. However, there were challenges with non-medical staff vacancies in main theatres. Senior staff told us the staffing establishment in main theatres was recently increased, but at the time of our inspection there were more vacancies than substantive staff. This was particularly prevalent within the band 5 and 6 grade. The service used bank and agency operating department practitioners and anaesthetic assistants on a daily basis to cover rota gaps. Theatre staff told us there were frequently more agency staff than permanent staff and they often had many agency staff who had not worked at the hospital before. This impacted on the efficient running of the main theatres because they did not know the competency or experience of agency staff.
- ODPs told us there were frequent instances of agency staff without specific surgery skills or experience. They told us agency staff who are known to the service are usually requested but occasionally they are not available and unsuitable staff were sent. Sometimes there were applicants without anaesthetic training (eg ward nurses). They felt this put patients with complex needs or high maintenance patients at risk.
- Many theatre staff we spoke with felt vacancies were not being dealt with urgently. Senior managers told us there had been an 'up-banding' exercise to reduce agency costs and improve retention of theatre staff while also using longer term agency cover to mitigate risks. The service offered in house anaesthetics training courses to improve the recruitment offer.
- Many staff reported challenges with trust recruitment systems. They felt that delays and inefficiencies acted a

barrier to recruiting good staff. There were many examples given of candidates waiting six to eight months from accepting a job offer to starting in post, by which time some individuals had taken a job elsewhere.
- We observed nurse handover at the start and end of day shifts. This involved individual handover at the patient bedside followed by a team handover and safety briefing at the nurses' station. Handover was well managed and tasks were delegated appropriately. However, nurses did not apply situation, background, assessment and recommendation (SBAR) technique to effectively communicate key information which meant handovers sometimes took over one hour.

Surgical staffing

- There was a stable cohort of consultant surgeons and anaesthetists working in the surgery service at The Royal London Hospital and many doctors we spoke with had worked at the trust for many years.
- The surgery service had a lower percentage of consultant surgeons compared to the England average, with 36% of medical staff at consultant level compared to a national average of 43%. There was a much higher proportion of higher tier doctors in training (ST1-6 grades) with 54% compared to 35% nationally. There were fewer middle tier and foundation doctors in surgery posts at the trust, with 5% and 6% respectively compared to 10% and 11% nationally.
- Service leaders reported some problems with recruitment and retention of clinicians. The service had agreed priorities to increase the compliment of middle grade surgical doctors based on wards to improve safety during out of hours, support discharges, and help improve the training experience for doctors in training. The surgery service was considering the Royal College of Surgeons International Surgical Training Programme to recruit additional trust grade doctors.
- The surgery service had invested in some innovative options for new models of working and building capacity within the medical rota, such as employing physician assistants to support routine surgical cases. However at the time of our inspection there were no physician assistants in post. Staff in theatres told us physician assistants left because they did not feel adequately supported.
- Arrangements were in place to ensure adequate surgical out of hours and weekend cover. Consultant surgeons were on call out of hours, rather than resident within the hospital. There were resident trauma surgeons on site during weekends. Doctors in training were resident on weekend shifts, including foundation doctors.
- Consultant surgeons reported limited allocated managerial time of 0.5 professional activities in their job plans.
- Doctors in training told us they felt supported by consultants and reported good access to supervision, teaching and advice. They told us the hospital was a busy and often intense working environment because of the complex and high acuity patients. Consultants reported positive feedback from doctors in training and locum doctors.

Major incident awareness and training

- There was a site level major incident plan and policy. There were protocols for deferring elective activity to prioritise unscheduled emergency procedures.
- Emergency planning training was mandatory for all staff. Training completion rate for surgical services was 99% and met the trust's target of 90%. However, senior nurses recognised there was variable awareness amongst staff about major incident plans. This was corroborated amongst the staff we spoke with. Some staff did not know where to access emergency information and there was limited awareness of major incident protocols.
- Senior clinicians confirmed there had been no recent major incident exercise at the hospital.

Are surgery services effective?

Good

We rated the surgery service at The Royal London Hospital as 'good' for effective. This was because:

- Surgical pathways were delivered in line with referenced national clinical guidance.
- There was a comprehensive clinical audit programme and audit activity was used to inform service development.
- There were effective processes in place to ensure patients' pain relief needs were met.

- The trust supported continued professional development of its staff.
- There was an effective multidisciplinary working environment which supported patients' health and wellbeing.

However:

- The surgery service did not use enhanced recovery after surgery protocols to support patients' recovery.
- There were not enough recovery staff suitably trained in high dependency support and advanced life support to safely care for patients at all times.
- Consent for surgery processes did not follow best practice as it was usually taken on the day of the procedure by a doctor in training.
- There were insufficient processes in place to ensure the nutrition needs of all patients were met.

Evidence-based care and treatment

- Surgical pathways were delivered in line with referenced national clinical guidance. Senior service leaders reviewed their service outcome data, such as Patient Reported Outcome Measures and National Joint Registry compliance.
- We reviewed a sample of trust policies for surgery and found appropriate reference to relevant National Institute for Health and Care Excellence (NICE) and Royal College guidelines.
- The trust's policy for recognition of and response to acute illness in adults in surgery services was provided in line with NICE CG50 guidance (see assessing and responding to patient risk in safe section).
- Staff accessed policies and corporate information on the trust's intranet. There were protocols, policies and guidance for clinical and other patient interventions and care on the intranet. Staff could also access paper copies of policies in wards and theatres. For example, AAGBI guidelines for anaphylaxis, malignant hyperthermia, and failed intubation were available for staff to access in day theatres.
- Understanding of and adherence to NICE guidelines was embedded in multidisciplinary working and evidenced through the use of audit programmes to benchmark practice. For example, the therapies audit programme included evaluation of how physiotherapy was managed in patients with a fragility hip fracture when patients moved between the inpatient setting to community services. Therapies staff used this to assess compliance with NICE quality standards. Similarly, the audit and training programme included an evaluation of the management of fractured neck of femurs in line with NICE clinical guidance. This meant therapists who worked daily with patients in rehabilitation could benchmark their work against best practice standards.
- The trust's Clinical Effectiveness Unit (CEU) identified and disseminated new NICE guidelines. New Royal College guidelines were disseminated by the assigned College Tutor for each specialty and regional advisors. There was a rolling audit programme to review gaps and compliance with new guidelines and alerts.
- There was a comprehensive clinical audit programme for 2015/16. Documentation submitted by the trust highlighted nearly 300 different audits, including the surgery service's involvement in local and national audits. Service leaders told us all clinicians were required to conduct at least one audit per year. The trust supported audit activity and clinicians were allocated protected time for audit.
- The trust's Clinical Effectiveness Unit monitored completion of audits across all hospital services to hold clinicians to account.
- Audit activity was used to inform service development. For example, in the hospital's surgical dentistry service, data from audits on the quality of referrals resulted in changes to commissioning guidelines and acceptance criteria which resulted in fewer unnecessary or inappropriate referrals. The orthopaedics service introduced clinics for patients with scaphoid injuries to reduce fractures and breakages and reduce demand for surgery.
- There were regular non-medical quantitative and qualitative audits including: hygiene and infection control, environment and equipment, vital signs recording, microbiology, patient feedback, cancellations and attendances amongst many others. The results of these regular monthly audits were shared at monthly governance meetings.

Pain relief

- There were effective processes in place to ensure patients' pain relief needs were met and pain was well managed in the surgery service.

- The hospital had implemented the Faculty of Pain Medicine's Core Standards for Pain Management (2015) and there was consistent evidence staff followed this in practice.
- Staff on wards did routine intentional rounding throughout the day to ask patients about their comfort, including pain levels. This information was recorded. We witnessed nursing staff regularly asking patients whether their pain was being effectively managed and if they were comfortable. Pain scores were consistently recorded in the patient records we looked at.
- Patients told us nurses were responsive to their pain relief needs. All of the patients we spoke with were aware they could use the call bell to request additional pain relief.
- There was a dedicated acute pain team at the hospital with consultant, nurse and AHP input. They provided a consulting service for chronic and acute pain across the hospital. Nurses told us the pain team was very accessible and helped to review patients on a daily basis. We were told they provided very good guidance and teaching, including updates on pain management.
- Staff in the main theatre recovery area told us anaesthetists were not always immediately available at night time to support pain management post-surgery. They felt this caused some delays to treatment and timely pain relief. Staff recognised that the on call anaesthetist was often very busy in other areas of the hospital.

Nutrition and hydration

- The trust used the Malnutrition Universal Screening Tool (MUST) to monitor patients who were at risk of malnutrition. The accredited screening tool also screened patients at risk of obesity. Where patients were identified as at medium or high risk of malnutrition, food intake was to be recorded, and the patient was to be encouraged and given assistance with meals. Patients identified as at risk of dehydration also had fluid balance charts to monitor fluid intake and output. However, during our inspection some senior nurses were unsure if staff received training in MUST and many of the healthcare assistants we spoke with were not clear about their responsibilities in this area, particularly around recording of leftover food.
- Healthcare assistants were responsible for checking patients' specific dietary needs. Domestic staff told us health care assistants did not always order enough food or plan meal needs appropriately. This meant some patients did not receive the food they requested or needed.
- Patients gave us variable feedback about the quality of food. Some patients told us food often arrived cold. For many this made the food inedible.
- A Health Watch visit in March 2016 to 13D surgery ward found some patients were given incorrect food or food they could not eat. The report recommended a number of areas for improvement including supporting nil by mouth patients, more varied food options, and better communication between consultants and ward staff on patient nutrition needs post-surgery or after coming off nil by mouth. The Health Watch report also found that nurses needed additional training on using MUST, and ensuring all patient information (ie nil by mouth) is properly recorded in the food cart patient sheet and in bedside notices.
- There were regular protected meal times on surgical wards and we saw these were respected by staff and visitors. This meant all non-urgent activities on the ward would stop and patients would be positioned safely and comfortably for their meal and staff would assist patients with their meals as necessary.
- Pre-surgery fasting guidelines were in place to ensure patients were ready for their procedure.
- Dietary plans were included in patient care plans.
- There were specific food menus for different patient groups including those with specific needs, such as patients having renal procedures, those requiring high calorie or low fat diets. There was provision of easy to eat food such as yoghurts and fruit juice for those patients who felt nauseous post-surgery.
- There were dedicated nutrition nurses working in the hospital and they attended surgery wards to support nutrition planning, management of peripherally inserted central catheter feeding, and advice and guidance to nurses on patient suitability for food.

Patient outcomes

- The trust contributed to relevant national patient outcome audits and performance in national and local audit was presented at regular planned audit team meetings.
- The Royal London Hospital performed worse than the England average for five of the six measures in the 2015 national Hip Fracture Audit. Senior managers told us the

service did not meet targets for admission to orthopaedic ward within four hours, surgery within 36 hours of admission, and length of stay. This was seen as a consequence of theatre and bed pressures and limited orthogeriatrican support. The hospital had recruited a locum orthogeriatrician to build capacity.

- In the National Emergency Laparotomy Audit (NELA) 2015 patient report The Royal London Hospital scored within the middle percentage for five questions and in the low percentage for the other five questions.
- The trust had a fair case ascertainment rate in the Bowel cancer Audit 2014/15; 70% compared to the England average of 94%. Data completeness for patients having major surgery were rated as 'fair' meaning the trust scored between 50% -80%. The trust scored 58%, considerably lower than the England average of 80%.
- The Royal London Hospital had a higher risk of readmission compared to the England average for elective otolaryngology and neurosurgery specialties. The overall non-elective risk of readmission was lower than the England average, but neurosurgery was nearly double the England average.
- The trust's Patient Reported Outcome Measures (PROMS) were generally in-line with national results in 2015. PROMs measures health gain in patients undergoing hip replacement, knee replacement, varicose vein and groin hernia surgery in England, based on responses to questionnaires before and after surgery.
- At the time of our inspection the surgery service did not use enhanced recovery after surgery protocols to achieve early recovery after surgical procedures. The key elements of enhanced recovery protocols include pre-operative counselling, optimisation of nutrition and pain relief and early mobilisation. Staff told us the lack of common agreed enhanced recovery pathways resulted in a lack of clarity between surgeons about likely discharge dates. Nurses told us changes to local social services provision had also impacted on their ability to modify packages of care in the time frames required.
- Patients having joint replacement procedures were offered 'joint school' support, but this was not provided directly by the trust. There was limited information regarding enhanced recovery elsewhere in the surgery service. Senior clinicians told us the trust had recruited a perioperative clinical fellow to lead on quality improvement projects in enhanced recovery. There was a clear appetite amongst ward staff for enhanced recovery protocols to improve patient outcomes.

Competent staff

- There was good completion of annual staff performance appraisals in the surgery service. Information provided by the trust for all surgery service lines showed 61% of surgery staff had received an annual appraisal between April 2015 and March 2016, with the lowest level of 27% reported in neurosciences and trauma. Staff told us appraisals were used to review performance, set objectives and identify learning and development needs.
- The trust supported continued professional development of its staff, including formal qualifications, practical training, secondments, team days, mentoring and shadowing opportunities. Nurses told us they were actively encouraged to apply for development opportunities.
- Consultant nurse specialists provided practical training on subjects such as Waterlow scoring, MUST, early warning scores and identification of sepsis. However, at the time of our inspection the hospital did not have any practice development nurses (PDN). Many of the nursing staff we spoke with told us they would benefit from the support provided by PDNs.
- The trust had developed its own physical assessment training course for nurses, which was formally accredited by an external higher education partner.
- There were opportunities for leadership and management, human factors and quality improvement training for senior nurses and clinicians.
- Newly qualified nursing staff reported a supportive learning environment on surgery wards. They were allocated a mentor to help with orientation and competency development. Nurses told us there were opportunities to develop their careers at the trust and to specialise if they wished.
- Specialty doctors in training told us The Royal London Hospital was a good place to work with approachable and supportive consultants, good supervision and good access to practical teaching and learning opportunities.

- There was an annual local teaching programme for doctors in training. This included journal clubs, simulation training and case presentations. However, some doctors in training told us workload pressures sometimes resulted in missed teaching sessions.
- Locum doctors told us they did not attend teaching sessions or grand rounds but were asked to conducted audits.
- As part of a recruitment drive to attract doctors in training to the hospital, the trust funded a free postgraduate degree for junior tier specialty doctors in training in some surgical specialties.
- There were link trainers identified in day theatres for fire safety, safeguarding and infection control. They attended training sessions with other link trainers across the hospital and provided briefings at staff meetings, audit meetings and the morning safety meeting.

Multidisciplinary working

- There was an effective multidisciplinary team (MDT) working environment within the surgery service at The Royal London Hospital. We found evidence of good multidisciplinary relationships supporting patients' health and wellbeing. We observed multidisciplinary input in caring for and interacting with patients on the wards.
- The trust adopted an MDT approach to ward management, allowing allied health professionals (AHP) to be ward managers. Nurses told us this approach facilitated MDT working and improved ward management and the patient experience. For example, by ensuring prompt access to rehabilitation equipment which helped patients recover more quickly.
- Patient records demonstrated input from AHPs including physiotherapy, dieticians, occupational therapists, pharmacists as well as the nursing and medical teams.
- Nurses reported good access to and effective support from physiotherapists and occupational therapists. However some nurses told us there was a need for more timely medical input from doctors and the hospital pharmacy team to support discharge.
- Some nurses felt that hospital discharge protocols were a barrier to effective MDT working because they were required to wait for a doctor to approve patient discharge. They told us this resulted in frequent delays to discharge, with subsequent impact on bed availability.
- We saw multidisciplinary working evident on surgery wards: physiotherapists and occupational therapists were part of daily MDT ward and board rounds on a weekday basis. Nurses told us a discharge coordinator and external community nurses also attended three times per week. However, there was no medical input to these meetings and nurses felt this impacted on the effectiveness of the MDT approach.
- We observed the trauma MDT meeting, which was very constructive and interactive with all grades of staff participating. The meeting covered more than 40 trauma patients with a range of injuries. It was used to prioritise different cases, set dates for procedures and plan ongoing care pathways. Cases were used as a teaching aid for doctors in training, student nurses and AHP trainees.
- There were monthly specialty half day audit meetings for consultant surgeons, doctors in training, nurses and AHPs to discuss clinical performance and share learning from research and audits. Staff told us there was a MDT focus to these meetings, but surgeons and other theatre staff were often unable to attend because of frequent theatre overruns.
- There were surgical care practitioners (SCP) working as members of the extended orthopaedic surgery team. They performed some surgical interventions, and pre-operative and post-operative care under the direction and supervision of a consultant surgeon. They also contributed to the training of doctors in training by supporting surgical skills training sessions. The service was seeking to develop the SCP team across different surgical services.
- SCPs delivered virtual fracture clinics to review all patients with fractures referred by the hospital emergency department. These clinics were attended by an administrator, nurse and consultant surgeon to review x rays, identify fractures and breaks and refer to clinics, general practitioners or physiotherapy services as appropriate.

Seven-day services

- The hospital delivered a full service on six days with on call availability seven day per week, but there was a lower establishment of doctors in training for weekend rotas. Operating theatres were used on Saturdays for elective and priority list patients.

- The surgery service adopted a 'consultant of the week' rota system to ensure continuous consultant cover over seven days. The allocated consultant conducted ward rounds and provided advice and guidance to doctors in training and other clinical staff.
- There were two reserved emergency operating theatres, as recommended by the NCEPOD report (1990). These theatres were available 24 hours per day seven days a week for emergency and trauma cases.

Access to information

- Computer stations with intranet and internet access were available on the surgical wards for staff to use. There were adequate numbers of computers on wheels for staff to access patient information on wards and prevent clashes of need.
- Agency nurses told us they had access to the same ward training documentation, updates and information as permanent members of staff.
- Notice boards along the ward corridors were neatly organised with information for staff and patients, including visiting hours, protected meal times and senior nurse contact details.
- Theatres did not have an electronic system for theatre management to enable a 'real time' view of what procedures were being conducted in all theatres. Theatre staff told us the theatre coordinator was required to physically go from theatre to theatre to establish what activity was happening in each theatre.
- There was a white board in main theatres which displayed all theatre lists, including some sensitive patient details. Theatre staff told us the board was covered when patients walked past to theatre to maintain privacy and data protection, but we observed a patient in front of the board with their escort with the list on display.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients told us staff explained treatment and care and sought consent before proceeding. All patients we spoke with said they had been given information about the benefits and risks of their surgery before they signed the consent form. Consultant surgeons and doctors in training were aware of the concept of shared decision-making with patients.
- The sample of patient records we reviewed demonstrated consent for surgery was completed in full and signed and dated appropriately. However, we found evidence that consent for surgery processes did not follow best practice, with records highlighting that patient consent for surgery was in some cases being taken on the day of the procedure. This meant that some patients did not have a 'cooling off period' in advance of their surgery, should they wish to reconsider their procedure. This approach is suboptimal, although it is widely recognised as a difficult problem to solve unless the patient is seen on a separate occasion.
- Records also indicated that consent was not in all cases taken by the consultant surgeon. Doctors in training confirmed that pre-operative checks and consent taking were usually their responsibility.
- All patients were required to review and sign a mental capacity form when consenting to treatment.
- There was discrete mandatory training for all staff in consent. Records showed that 87% of staff had received this training against a trust target of 90%. Mental health awareness was also included in the trust's corporate induction.
- Staff we spoke with were aware of the requirements of their responsibilities as set out in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), and told us they would refer patients to the trust safeguarding team if patients required a MCA referral. Staff told us they knew who to contact for advice in cases where a patient may require safeguarding support.
- There were posters throughout surgery areas with information on DoLS and what it means for patients and families.

Are surgery services caring?

Requires improvement

Overall we rated the surgery service as 'requires improvement' for caring. This was because:

- Patients gave us variable feedback about the quality of care they received, particularly from some agency nurses. A number of patients told us some agency staff demonstrated a less caring approach.

- We saw some examples where care could be improved, for example, tray tables left out of reach of elderly or immobile patients, and call bells not in an accessible place.
- Some patients and their relatives did not feel they were proactively kept informed by hospital staff.
- There were very few examples of patient literature in the surgery areas of the hospital.

However,

- We observed good interactions by all grades of staff with patients and saw excellent interactions between HCAs and patients and their relatives.
- Friends and Family Test (FFT) results were consistently very good across surgery areas.
- There was a trust-wide strategy to improve basic nursing care.
- Most of the patients we spoke with felt informed about their treatment during pre-assessment and told us staff explained things in an accessible way.

Compassionate care

- The patients we spoke with gave variable feedback about the quality of care they received. Some patients told us nurses were attentive, kind and had positive attitudes. However, some patients told us directly, and reported in the trust's 'I want great care' survey that they could differentiate between the attitude and level of care provided some agency nurses and permanent staff. A number of patients told us some agency staff demonstrated a less caring approach, for example, not introducing themselves to patients. Direct comments from patients that was representative of this feedback included: "the word 'caring' doesn't apply to all nurses here" and "agency staff have a different attitude because they might not be here tomorrow".
- Some ward nurses told us that short staffing and a focus on freeing up beds meant they were often unable to provide patients with the standard of care and compassion they would want to give.
- We observed some instances where care could be improved, for example, tray tables left out of reach of elderly or immobile patients. Some patient's family members told us nurses sometimes forgot to put the table back by the bed or put the call bell in an accessible place. This meant some patients had to stretch or manoeuvre into an uncomfortable position to reach.
- However, we observed good interaction by all grades of staff with patients and saw excellent interactions between HCAs and patients and their relatives. We heard staff speaking to patients politely and in a pleasant manner.
- There was evidence that staff had established good relationships with patients and their relatives. Some patients told us they had developed a good bond with the nurses. They mentioned some individual nurses by name as being exceptionally caring and compassionate.
- The trust collected feedback from patients, families and carers. The service used Friends and Family Test results, the annual NHS inpatient survey, in-house theatre surveys and a survey called 'I Want Great Care'. Documents submitted by the surgery service highlighted many positive comments from patients, but with a number of areas for improvement, notably timely response to call bells.
- Friends and Family Test (FFT) results were consistently very good across surgery areas, with an annual average recommendation score of 96% for the period April 2015 – March 2016. Across surgery wards the average annual FFT response rate was 37%, which was higher than the England average of 30%. However the response rate varied between wards. For example, 9E Renal and Urology Inpatients ward had a 67% response rate compared to 24% in 13D General Surgery ward. Data for the month immediately before our inspection highlighted a drop in the recommendation rate, with an average of 78% across the wards we visited.
- There were paper feedback forms and comments boxes by the nurses' station on surgery wards. Senior nurses told us their aim to embed patient feedback in the culture of ward so all patients are given a form and encouraged to complete it as soon as they have been identified as suitable for discharge.
- Ward staff displayed thank you cards from patients in day rooms. Comments in these cards included "thank you for looking after me so well" and "thank you so much for all your incredible work. You have been awesome and I never thought that being in hospital could be so relaxing".
- Senior surgery nurses told us about the trust-wide strategy to improve basic nursing care, with a focus on

improved understanding of what patients need and want, staff introducing themselves to patients, make it clear who is the nurse in charge, ensuring patients know where to get help, and involving families.

Understanding and involvement of patients and those close to them

- There were very few examples of patient literature in the surgery areas of the hospital, including the theatre admissions area and wards. In the pre-assessment unit there were some leaflets on anaesthesia by the Royal College of Anaesthetists, which explained how anaesthesia worked and what to expect. There were some specialty specific leaflets regarding specific medication and peer support networks, but this was not comprehensive and there was varying degree of availability across wards. Staff in the pre-assessment unit told us other pre-operative information leaflets, such as those by EIDO were turned down by service leaders on financial grounds.
- Most of the patients we spoke with felt informed about their treatment and told us staff explained things to them in an accessible way. However, some patients' family members told us they were not proactively kept informed by hospital staff. For example, one parent told us their child was delayed going into theatre but was not informed of this so felt anxious when their child did not return from theatre at the expected time. Another parent told us staff did not proactively share information about their child's care. Other patients reported that updates were not always willingly offered without prompting.
- Patients on surgery wards told us pre-assessment by consultant surgeons fully explained the risks and benefits of the procedure and provided information about after care and home support. The patients we spoke with felt involved in their care and were given opportunities to ask questions.
- There were clear, easy to understand notice boards and posters for patients, family members and carers located at points on each ward. These included names and photographs of the responsible matron, ward manager and nurses, and contact details for ward staff.
- Patient information boards also included information on condition specific healthy diets and 'let us help you' information on staying safe and leaving hospital.
- There were 'you said we did' posters on wards which demonstrated areas for improvement identified by patients and the service's response. Across wards, a key area for improvement noted by patients was to improve consistency of practice between agency and non-agency nurses.
- In theatres, relatives and carers of children and patients with learning difficulties or specific needs were allowed into the admissions and recovery areas to keep them company and help them feel more secure.
- The trust provided overnight accommodation to patients' families who did not live in the local area so they did not have to travel long distances to see their relatives. Guests were not required to pay for the accommodation and could give a donation instead.

Emotional support

- Some patient groups had access to counselling services, for example, those patients having organ transplant procedures. Counsellors provided emotional support in cases of failed transplants.
- There were staff in the hospital that provided for patients' spiritual needs, including a trust chaplain. The chaplain facilitated links with religious leaders in the local community, such as imams.
- Some of the wards we inspected had information posters on accessing the hospital's spiritual support services.

Are surgery services responsive?

Inadequate

The surgery service at The Royal London Hospital was not responsive to patients' needs and the service had not adequately addressed a number of concerns identified at previous CQC inspections. We rated the service as 'inadequate' because:

- The flow within the surgery system from admission, through theatres, wards and discharge was not managed effectively.
- There were serious problems with bed management and bed availability, which caused late theatre start times and short notice cancellations of surgical procedures.
- There were inefficiencies and under usage of operating theatres. This meant the service was not meeting all of its targets.

- Patients were held in recovery for inappropriate lengths of time and in an unsuitable environment. Patients frequently remained in recovery overnight.
- Ineffective discharge arrangements across surgery wards impacted on bed availability.
- The average length of stay for elective and non-elective surgery admissions was longer than the England average.
- The surgical admissions unit and short stay ward were not fully used for their intended purpose and some staff found the unclear remit and range of patients challenging to manage.
- There was inadequate provision of patient literature in community languages.

However,

- The service was focused on reducing Referral to Treatment backlogs, which had decreased since February 2016.
- The surgery service introduced a surgical assessment unit which was preventing long waits in A&E and unnecessary admissions.
- There were appropriate arrangements in place to support patients with learning disabilities and those living with dementia.

Service planning and delivery to meet the needs of local people

- The Royal London Hospital was a tertiary hospital which provided a wide range of specialist surgical services to patients in east London and south east England. Many patients from Essex, Cambridgeshire, Hertfordshire and Kent were referred to the hospital for investigation and treatment.
- The Royal London Hospital conducted more than 22,000 procedures in 2015 across all surgical specialties. The trust overall was in the top 10% of all hospital trusts nationally for surgical activity and the hospital was the busiest of all four sites within the trust. General surgery, urology and plastic surgery were the hospital's most active specialisms, conducting almost one third of all surgical activity.
- Approximately 55% of all surgical procedures in the hospital were day case, with 25% emergency surgery and 20% elective surgery. The hospital conducted fewer day case procedures than the national average but this may be accounted for by the tertiary, highly specialised nature of some surgical activity at the trust and complex cases.
- There were regular planned lists of surgical procedures on set days each week, including weekend elective lists in main theatres and day case theatres. Most elective lists were delivered over two sessions as a full day of activity. There were some 'three session' days with planned late finishes.
- Service leaders reported constructive working relationships with local commissioning bodies, but recognised a changing local and regional healthcare landscape. This had resulted in some surgical specialties being transferred to other London hospital trusts, for example, cancer surgery. Surgery leaders were investigating options to transfer some surgical activity to other sites within the trust, including colorectal, urology and otolaryngology, to release capacity for more specialist and trauma procedures at the hospital.
- The majority of surgical patients were seen by nurses in the hospital's Pre-operative Assessment Unit (POA), or an anaesthetist if required. Few patients were seen by a consultant surgeon at this stage. POA clinics saw approximately 12,000 patients per year for review before their procedure. Most patients in the POA were having procedures at the Royal London Hospital, but there were also clinics for some high risk patients from other hospitals within the trust. This included breast and ocular oncology, and those patients requiring cardiopulmonary exercise testing to assess performance of the heart and lungs. The Royal London POA unit did not review local anaesthetic cases, paediatric cases, intravenous injection cases or renal surgery cases. There were dedicated local arrangements for these services.
- The POA did not see patients directly from the hospital's outpatient clinics. Senior staff told us there was a need for some 'one-stop shop' POA appointments direct from the outpatients and diagnostics service to coordinate appointments and give patients more time to prepare for surgery. Surgeons told us increased referral to treatment waiting times for elective surgery had resulted in a longer gap between outpatient appointments and date of procedure, which meant some patients were seen in POA clinics too near the

planned date of their procedure. Service leaders reported that recent implementation of co-location of surgical scheduling would result in better liaison and more time between clinic and procedure.
- The pre-operative service was not linked in with local primary care providers to further maximise opportunities to optimise patients' health prior to surgery.
- In the six weeks prior to our inspection the surgery service had opened a Surgical Assessment Unit (SAU) in ward 3F. At the time of our inspection the unit was still in development, but staff told us it was already having a positive impact in avoiding long waits in A&E and unnecessary admissions. Senior leaders told us they wanted to expand this service.
- The SAU was located in an area which was not originally planned for use as an admissions unit, and there was a lack of clarity amongst staff about its function and remit. This resulted in a whole variety of uses which, while playing a useful part in the hospital, gave a sense of unclear purpose. Nearly all patients seen in the SAU were emergency cases, with some pre-operatives elective patients seen for specific purposes. Some medical patients were also admitted in the SAU. We were told the SAU was originally designed as a cardiac catheter suite but cardiac activity was transferred to another site within the trust so it was re-designated for surgical admissions. Some staff in the SAU felt the SAU was used as a "dumping ground". Staff told us they had been sent on additional training to extend their knowledge of dealing with a wider range of patients.
- The SAU had a trolley and treatment area and 18 beds for a variety of patients. Staff in the SAU told us they wanted to take patients directly from GPs to avoid patients having to go to A&E. The SAU was not open overnight, but beds were nursed 24/7. Patients were supposed to be short stay (less than 48 hours) but during our inspection many of the patients had been there over one week.
- There was minor procedures area in the SAU which relieved capacity in the emergency department. It was used for abscess removal procedures and abdominal pain treatment.
- The short stay ward (3D) was a 46 bed ward designed to take post-operative patients for up to 48 hours, but we found it was used mostly for other purposes. Staff told us patients frequently stayed beyond 48 hours, which impacted on bed availability and subsequently hampered the ability to start surgery on time every day. During our inspection we found it was used as a 'step down' area for other areas of the hospital, particularly trauma. It also took pre-operative emergency patients for later operation and discharge. There were emergencies and elective procedure patients from most surgical specialties, including interventional radiology.

Access and flow

- The flow within the surgery system from admission, through theatres, wards and discharge was not managed effectively at The Royal London Hospital. There were serious challenges with theatre utilisation and bed management which led to high levels of cancelled procedures.
- Most patients attended the ACAD surgical admissions unit on arrival at hospital for their surgical procedure. Some patients having orthopaedic surgery went directly to a ward pre-operatively. Some patients who were not from the local area were invited to stay in local hostel accommodation the night before their procedure.
- There were 12 main theatres and eight ACAD theatres. Main theatres were used for inpatient and trauma surgery, and ACAD theatres were used for used short stay and elective procedures. One of the ACAD theatres was used for interventional radiology.
- Trust data on theatre utilisation for the period of February to April 2016 showed under-use of both main and ACAD theatres, at 47% and 42% respectively. However, utilisation had improved to 65% (main theatres) and 68% (ACAD theatres) in July 2017. Senior staff and clinicians accounted for the low usage figures as a consequence of late starts to operating lists. Late starts were caused by bed unavailability and unavailable complete sterile instrument sets. Theatre staff told us lists were timed to start at 08:30 but often started at 11:30 while waiting for beds to become available. This meant there were frequent three hour overruns and staff often left work beyond their allocated shift.
- Staff told us theatre inefficiencies meant the service was not meeting all of its targets, such as ensuring all fractured neck of femur cases were operated on within 36 hours as per national guidelines, and not completing spinal and orthopaedics lists within allocated slots.

- The information board in main theatres displayed late start statistics and reasons. The most reason for delays was stated as 'surgeon late' and 'anaesthetist late', followed by 'morning overrun' and 'no ward beds'.
- Senior perioperative leaders told us there were weekly theatre productivity meetings with mandated attendance of theatre leadership. These meetings reviewed fallow sessions to improve utilisation. The service was working to change its scheduling protocol, using data from each of the different surgical specialties to identify where theatre performance could be improved. The service had also worked with external management consultants to identify a range of efficiency measures such as extending theatre working hours, putting more minor cases at the start of lists to get lists started, and devolving appointments bookings to individual services
- Some day case patients were treated in main theatres but were then discharged to day surgery. To be moved there, hospital policy required the surgeon to complete a discharge summary for the patient. Theatre staff told us surgeons often refused to discharge patients in this way because the patient was not being discharged from the hospital. We were told this often resulted in patients having to remain in the recovery area unnecessarily for several hours.
- Ward and theatre staff, across grades and professions reported serious problems with bed management within the hospital. Theatre practitioners and clinicians told this was an "issue every day of the week", which was "very stressful and a constant source of frustration".
- There were hospital-wide bed management meetings at 08:00 and 10:30 each day attended by divisional managers, matrons, scheduling teams, and theatre staff. However staff told us communication about bed availability was difficult because there was no shared IT system to provide an overview on bed availability across the hospital. Ward nurses told us matrons spent considerable amounts of time organising beds and negotiating where patients should be allocated.
- During our inspection we witnessed the impact of bed unavailability, including a number of procedures cancelled on the day. There were frequent cancellations of surgical procedures for non-clinical reasons. Trust data showed 1,182 surgical procedures (1.6% of all surgical activity) were cancelled on the day between July 2015 and July 2016. Of this, 24% were because of unavailable ward or HDU beds. Trust data for the same period showed almost 88% of cancelled procedures were rebooked for treatment within 28 days. Clinicians reported that patients were prioritised to ensure cancellations did not cause adverse clinical outcomes, but they recognised the psychological impact and inconvenience of cancellations on patients. We observed clinicians informing patients that there may be a long wait for their procedure and warn of potential cancellations. Cancellations were audited weekly and reasons for cancellations and how they might have been avoided were shared at daily team briefings.
- The trust suspended monthly mandatory 18-weeks referral to treatment time (RTT) reporting from September 2014 onwards. This followed the identification of significant data quality concerns about data accuracy. Since this suspension the trust has implemented a full RTT recovery programme, which included the extraction of 4.2m pathways from the patient administration system followed by the application of national and local (NHS IST approved) rules as well as a continuing validation programme. Unvalidated data submitted by the trust for the period May 2015 – April 2016 highlighted 18 week RTT performance for different surgical specialties. The highest performing specialties were ophthalmology at 88%, urology at 72% and plastic surgery at 67%. The lowest performing specialties was trauma and orthopaedics at 33%. Other specialties performed within a range of 49-62%.
- Senior surgery managers told us reducing RTT backlogs were a priority area for the hospital. Surgical specialties conducted clinical reviews to check there were no negative outcomes as a result of delayed treatment times. Service Managers told us backlogs and breaches had reduced since February 2016. Senior leaders of the hospital told us a number of specialties have treated all patients waiting over 52 weeks and were sustaining this performance. However, there remained a small number of surgical specialties where patients were still waiting over 52 weeks for treatment. There were weekly performance meetings to review RTT and sub-divisions received a validated position every four weeks.
- At trust level the percentage of patients whose operations were cancelled and not treated within 28 days were worse than the England average within the three year period of April 2013 to March 2016. Between

January-March 2015 around 30% of patients whose operations were cancelled were not treated within 28 days. This has improved to around 10% in January-March 2016. The England average is 8%.

- Most patients for all-day lists were admitted early in the morning. This meant many patients had a long wait between arrival at hospital and having their procedure. During our inspection we found some patients arrived at 7am but were then cancelled late in the day.
- Bed unavailability led to late theatre start times and overruns and patients being held in recovery for inappropriate lengths of time and in an unsuitable environment. Staff in the main theatres recovery area told us they felt they were used as an extension of the hospital's HDU.
- Trust data showed 60 patients were held in the recovery overnight in the 12 months preceding our inspection. Most days there are patients in recovery overnight. In June 2016, 16 patients stayed overnight and staff told us there were occasions when some patients stayed in recovery for more than one night (2-3 days). During our inspection there were patients in recovery overnight.
- The recovery area did not provide a suitable space for patients to remain overnight as many post-operative patients required level two or level three high dependency care. Recovery staff told us it was often difficult to access timely HDU/critical care nurses and doctors to support care and provide patients with the level of care they needed. Recovery staff told us they had to order patients' food from the hospital kitchen using a voucher system as there were no allocated domestic staff in theatres. They found this time consuming and unpleasant for newly admitted patients to have to smell food as they emerge from anaesthesia. Patients also did not have direct access to toilet facilities in recovery. It was also difficult for patients to receive visitors as visitors were required to report to the theatre reception and be escorted to recovery and escorted to leave. Relatives were not always able to visit as it was not acceptable for unconscious recovering patients to be in the same room as other patients' relatives.
- There were few medical outlier patients on surgery wards. Surgery nurses told us medical patients were occasionally allocated to surgery wards if there were bed shortages elsewhere in the hospital. Although there were few medical patients allocated to surgery wards, nurses told us they frequently cared for surgical patients from outside of the allocated ward for a particular specialty, for example trauma or orthopaedic patients on general surgery wards. Nurses told us 'ring fenced' beds for each specialty would alleviate some pressures and enable more effective bed management.
- Ineffective discharge arrangements across surgery wards impacted on bed availability. In most cases patient discharge was doctor-led, and nurses were not allowed to discharge patients. This meant patients frequently had to wait for a doctor to become available to complete their discharge. Nurses were allowed to discharge some patients in the 3D short stay ward, but not in other areas. We found that the hospital's discharge lounge was not used effectively as most patients were discharged directly from the wards. Staff told us discharge processes had improved as a result of the 'consultant of the week' rounding model, but there was a need for ward-based discharge coordinators and pharmacists to support the process.
- The average length of stay for elective surgery admissions was one day longer at The Royal London Hospital than the England average, and for non-elective stays this increased to two and half days longer. Senior staff accounted for the longer stays, which were seen as a consequence of complex case patients, particularly in trauma and orthopaedics, and limited local rehabilitation facilities. Some practitioners told us length of stay was impacted by no enhanced recovery pathways and a lack of discharge coordinators.
- There were hospital wide processes for management of non-attendance by patients. Staff would telephone patients in cases of a missed appointment to ascertain reasons for non-attendance. Patients who missed two appointments were discharged from the service.

Meeting people's individual needs

- The surgery service responded to specific individual needs, including patients with complex needs and cultural and religious requirements.
- The trust used a 'hospital passport' system for all patients with learning difficulties to ensure effective and timely information sharing for patients with complex individual needs. The hospital passport included detailed information such as next of kin contact details and the patient's likes and dislikes. There was a lead clinical nurse specialist (CNS) for patients with learning

difficulties. Nurses told us the CNS provided guidance and support for patients and carers at meetings with practitioners and supported the development of support package for care at home.

- In theatres staff reviewed the needs of patients with learning difficulties two weeks before their planned procedure to ensure suitable provisions were in place. A learning difficulty trained nurse attended the patient at each stage of their pathway through theatres. Relatives of patients with learning difficulties were allowed to accompany patients in the anaesthetic room and recovery area when required.
- There were appropriate arrangements in place to support patients living with dementia. The hospital used the abbreviated mental test score (AMTS) to assess elderly patients for dementia and others if concerns arose during the POA interview. Specific information relating to the patient's needs was recorded in patient notes to enable clinicians to prepare in advance. Ward managers told us they could book extra support workers to ensure patients were cared for properly. We observed ward managers highlight specific needs of patients to staff in morning handover meetings. Patients living with learning difficulties and dementia were asked about their wishes and needs and if they would prefer their families to support them.
- The hospital provided services to a diverse local population, with approximately 32% of patients from the local Bengali community, plus many other black and minority ethnic groups. Translation and advocacy services were available for clinical decision making and most staff were familiar with the process for booking an interpreter for patients who did not speak English as a first language. Translation services were provided via telephone and face-to-face interpreters. Translation and advocacy requirements were assessed at the time of booking POA appointments and suitable arrangements made.
- Many hospital staff spoke community languages. Some theatre staff were used as translators in the recovery area. Some ward nurses told us they sometimes relied on family members to translate on wards.
- Staff told us they could request trust leaflets in other languages, however during our inspection we did not find any patient literature in languages other than English in any of the surgery areas.
- Patients told us nurses were observant of specific cultural and religious needs, for example, religious compliant dietary needs were addressed appropriately. We witnessed theatre ODPs explain cultural and religious sensibilities to senior staff in support of a patient who wished to keep their bracelets on during surgery as part of their religious observations.
- Equality and diversity awareness was part of mandatory training for all staff.
- There were posters with information on the trust chaperone policy should patients or relatives wish to be supported by a chaperone.
- We observed theatre staff maintain the privacy and dignity of patients at all times throughout their procedures, including ensuring patients were appropriately covered by gowns. However, there were some challenges with privacy and dignity in other areas of the surgery service. There were insufficient measures in place for patients to change into gowns before surgery. Staff told us wards lacked a dedicated space for patients to change their clothes. To get around this, nurses used a treatment room to ensure dignity and privacy but they told us there was often a wait for these rooms if practitioners were using it. Patients with a bed allocated on arrival were able to change behind curtains in the bed area. We also observed breaches of single sex accommodation, with mixed sex bays in the neuroscience ward (12E) which did not allow for adequate levels of dignity.

Learning from complaints and concerns

- There were posters on each surgery ward which provide information on how to contact trust's patient advice and liaison service (PALS) and how to make a formal complaint.
- Trust data from May 2015 to April 2016 demonstrated that there were 111 formal complaints to the surgery service at the Royal London Hospital. Of this, 61% of complaints were responded to within the trust wide timeframe of 25 working days. 19 complaints were fully upheld, 23 were partially upheld, and seven were not upheld.
- Matrons told us there were some themes within complaints, particularly regarding the attitude of agency nurses. Other reported complaints regarded procedure cancellations, waiting times and discharge.
- Nurses told us ward managers were proactive in preventing formal complaints and most concerns were

addressed informally and directly. Ward managers conducted daily ward rounds to speak to each patient to identify any specific concerns and act on them. Matrons told us this has resulted in fewer complaints.

- There was evidence of learning from complaints. Patient experience boards on each ward were introduced as a result of feedback which displayed reported concerns and actions taken to address them. Matrons were seeking to recruit more permanent staff and had worked with nursing staff to raise awareness of attitude. The service had introduced mini white boards on patient lockers to record the name of their lead nurse and HCA for the day and to record targets/actions for the day.

Are surgery services well-led?

Requires improvement

The surgery service at The Royal London Hospital was mostly well-led, but some areas required improvement. This was because:

- There were a number of serious, cross-cutting risks and issues that were longstanding and unresolved. A number of fundamental issues identified at previous CQC inspections had not been fully addressed.
- Some staff told us there remained challenges with the organisational culture of the surgery service. A number of staff told us unprofessional behaviours were still present in some parts of the service.
- Some staff told us there was a lack of communication between surgery wards, theatres and site managers, which resulted in information not always being shared effectively.
- Some staff did not feel particularly well supported by their peers or managers.

However,

- New site level leadership and governance structures were in place across the surgery divisions. This afforded greater focus on site specific challenges and more manageable and responsive leadership structures for each surgical specialty. There was a positive attitude to improvement and some progress had been made since the last CQC inspection.
- There was a very strong record of innovation in the hospital's trauma service.

Leadership of service

- A site based leadership model was put into place for The Royal London Hospital in September 2015. In May 2016, four Divisions were formed to further enhance the site management structure.
- Surgical activity at the hospital was led by two of these divisions: Surgery, Peri-Operative Medicine and Critical Care and Emergency Care and Trauma. The divisional leadership teams comprised a Divisional Director, Divisional Manager and an Associate Director of Nursing to form a clinical management triumvirate. There were sub-divisions which delivered different surgical specialties. The second tier of leadership for each sub-division included a clinical director, general manager and senior nurse. Many staff in leadership positions had worked at the trust for a long time, but were newly appointed to their respective posts.
- Senior managers and clinicians felt that the site based and divisional leadership model afforded greater focus on site specific challenges and areas for development. They felt it created a more manageable and responsive leadership structure for each surgical specialty, with clearer lines of escalation and responsibility. They saw the new structures as stable and sustainable.
- Matrons and senior nurses reported supportive general and service managers. They felt that the tripartite model afforded good clinical and managerial balance. There was a perception that the tripartite were interchangeable in terms of their understanding of clinical, managerial and performance matters.
- Clinical leaders within the surgery service reported good access to and response from the trust executive and board members. This access had enabled surgery teams to seek funding for the purchase new equipment to use in major incidents.
- Clinical Network Directors supported cross site working within different surgical specialties and shared learning between sites.
- Some ward staff told us they did not feel supported or listened to by senior managers. They felt there was too much focus on metrics at the expense of caring. They felt this sometimes resulted in allocation of patients to

the incorrect ward (for example, trauma patients on elective wards) and patients being discharged before they were ready because managers needed to free up beds.
- At the time of our inspection wards 10F, 12c and the pre-admissions unit were without a matron for six months. As an interim measure ward managers reported to an allocated ADON. However, some ward managers felt this arrangement had restricted opportunities to book agency staff because a matron would usually be responsible for this.
- In the ACAD theatres some staff reported limited support from band 6 staff to more junior staff, including band 5s and HCAs.

Vision and strategy for this service

- There was an annual business plan for the Surgery, Peri-operative Medicine and Critical Care division which was aligned with the site priorities for the Royal London Hospital. Overarching divisional priorities for 2016/17 included embedding governance processes, improving theatre productivity and wait list management, improving staff fill rate and reducing the number of staff leaving. There were also sub-division priorities. For General Surgery these were reducing referral to treatment backlogs, improving the financial position, improving flow from theatres to wards to discharge, and better use of the monitored vascular unit to reduce critical care usage.
- There was a service redesign plan for the Trauma and Orthopaedics and Plastic Surgery division which focused on improving T&O patient pathways for prevention, treatment and rehabilitation.
- Service leaders told us the focus for leadership teams in the nine months preceding our inspection had been on reorganising services into site based divisions with new local level governance and management structures. They reported that after a period of flux the new structures were now embedded with key leadership staff in place. Strategic planning for the surgery services was therefore a new priority and they planned to agree clinical directorate priorities in forthcoming service line performance reviews.
- The business plans and service redesign documents were well evidenced and thorough, however it was not clear if there was a collective vision and strategy for the whole of the surgery services across the different divisions.
- Surgery matrons told us the priorities for their services was to improve staffing to reduce vacancies and build capacity, with a focus on developing training and education packages for nurses and theatre staff. There was a desire to upskill staff across wards and theatres.
- There were varying degrees of awareness of the trust vision and strategy amongst the ward and theatre staff we spoke with. This was particularly the case amongst more junior level staff.

Governance, risk management and quality measurement

- There was clear identification of divisional risks and priorities in the service risk registers, however, at the time of our inspection there were a number of serious, cross-cutting risks and issues that were longstanding, ongoing and yet be fully rectified. This included concerns identified at previous CQC inspections. Top risks included: staff vacancies and reliance on agency staff, availability of sterile theatre instrumentation, flow of patients through theatres, wards and discharge, theatre productivity and cancellations. Although there were action plans and mitigation in place to address these risks and issues, clinical staff across all areas of the service told us that risks were not being managed effectively and many of the issues were long-standing without being adequately resolved. We witnessed directly the impact of instrumentation unavailability, problems with bed management and inefficient theatre productivity on the patient experience and flow through the system. Many of the staff we spoke with were very frustrated by these issues, which impacted on their day to day work.
- New site level clinical governance structures were in place across the surgery divisions and staff felt they were effective. Each service held regular planned governance meetings. There were forums and meetings for staff to monitor quality, review performance information and to hold service managers and leaders to account.
- Some surgery sub-divisions operated a cross-site governance model to review performance and manage risks in theatres across hospitals within the trust. This included the perioperative, ophthalmology and dental/ OMFS teams. Governance arrangements for other surgical specialties were at site level only.
- Senior managers told us governance processes were being embedded to ensure consistency, including

topics for discussion in meetings, frequency of meetings, quality of minutes, and agreed learning outcomes. The surgery divisions were aiming to standardise agendas and processes for governance meetings across sub-divisions.
- Sub-division governance meetings were held fortnightly. There were monthly meetings for ward managers and monthly performance review meetings. There was a senior sisters' forum for ward managers and senior nurses to discuss incidents, reflections and learning.
- We reviewed the minutes of governance meetings and saw there was good attendance from the multidisciplinary teams including managers, nurses and doctors to ensure cross-discipline representation. Adverse incidents, performance indicators, patient feedback and complaints were reviewed at these meetings.
- Senior managers provided feedback from governance meetings to their respective teams in team meetings and emails. They shared performance dashboards to all staff in their sub-divisions. Performance dashboards were standardised across sub-divisions to enable comparison between teams.
- There were governance information boards in some area of the surgery service. For example, in ACAD theatres the governance and safety board displayed the local risk register.

Culture within the service

- We found, for the most part, an inclusive and constructive working culture within the surgery service. Most of the staff we spoke with felt that the hospital was a good place to work and had improved considerably since the last CQC inspection with changes in the senior leadership team.
- Most nurses and doctors reported approachable and supportive colleagues. Senior staff were proud of their teams.
- Surgery leaders told us they wanted to be more innovative and not just focus on fixing things. They wanted to embed good practice and consistent standards, but they needed a period of stability to deliver on this. There was an acceptance and willingness to change and improve amongst the senior leaders we met.
- Staff told us their "pride was coming back" and there was a "can do attitude" which made the hospital feel like a positive place to work. Senior leaders of the service told us the organisational culture had become more positive in the past seven months. They reported a shift change in the nursing culture, particularly in theatres, with matrons on each floor of theatres to improve leadership and visibility. Senior staff told us the surgical teams were dynamic and open, and nurses told us "people smile more". Consultant anaesthetists, clinical fellows and senior doctors in training told us they enjoyed working at the hospital and they enjoyed their jobs. Healthcare assistants told us they felt valued by their colleagues and staff were caring. Many staff recommended the hospital as a place to work.
- However, some ward based staff told us the considerable number of bank and agency nurses employed by the service impacted on ward culture. They told us there was limited sense of connection to the ward.
- There were some reports of a reluctance to change amongst pockets of established members of staff. These entrenched behaviours were seen by some staff as a cultural barrier to improvement.
- Some staff told us there was a lack of communication between surgery wards, theatres and site managers, which resulted in information not always being shared effectively.
- The trust had commissioned an external review into bullying and harassment across the trust after the last CQC inspection. However, a number of staff told us unprofessional behaviours were still present in some parts of the service. Theatre staff report some instances of bullying behaviours including verbal abuse from staff in front of patients. This had resulted in some staff leaving because they felt it was not being adequately addressed. There was a sense that unprofessional behaviours went on behind sight of managers and went unnoticed.
- Senior leaders of the service recognised that capacity pressures may have impacted on unprofessional behaviours, particularly in oral maxilio-facial (OMFS) and plastic surgery. The trust had commissioned a Royal College of Surgeons England review of OMFS, the report of which identified some behavioural issues.
- Some staff on wards (particularly newly recruited staff) told us they did not feel particularly well supported. The General Medical Council national training survey 2016 also highlight that foundation year doctors did not feel adequately supported in their roles.

- Some main theatres staff told us there was a lack of trust from the senior nursing level, which resulted in controlling behaviours and lack of delegation.
- Staff in the pre-operative assessment were not aware of any bullying or harassment in the team and it was described as a "happy family" and a good place to work.

Public and staff engagement

- The surgery service participated in the trust-wide Listening into Action programme to improve staff engagement. This included staff surveys and daily feedback emails. Most of the staff we spoke with told us the initiative was very popular and they felt empowered to raise concerns or share their frustrations. However, some staff told us the content of the daily emails was often repetitive which diminished its value.
- Surgery matrons reported improved networking opportunities for matrons across services as part of the Listening into Action programme. Matrons told us they felt they had a greater voice in contributing to decision making.
- There were daily trust briefing emails from the senior leadership team to share local and cross-site news.
- Ward nurses reported good communications from their managers about changes within the service. Other clinicians reported good weekly communications from the trust executive team such as the chief executive and chief nurse. We were told that chief nurse had visited main theatres and met with staff, and the trust medical director spoke with staff at a NATSIPS event.
- Individual wards and theatres held daily briefings for staff to share important information, including trust-wide news.
- Senior surgery leaders acknowledged a need for more widespread consultant engagement to make sure surgeons felt represented and that the management and governance structures effectively represented the voice of surgeons.
- The surgery service collected patient feedback using the 'I want great care' survey as well as Friends and Family Test results and direct feedback. Senior surgery leaders recognised the need to introduce more forums to improvement engagement with patients.
- The pre-operative assessment unit conducted a patient satisfaction survey in January 2016. Feedback obtained from the survey resulted in the development of a new leaflet explaining what the pre-operative assessment unit did and what to expect. This was sent to all patients in advance of their procedure to help them understand and manage expectations.
- Surgery service leaders told us they were investigating plans to introduce Patient Reported Outcome Measures (PROMs) for all surgical patients across divisions to assess the quality of care. At the time of our inspection PROMs covered four clinical procedures: hip replacements, knee replacements, groin hernia and varicose veins.

Innovation, improvement and sustainability

- There was a very strong record of innovation in the hospital's comprehensive roadside to resuscitation to reconstruction to recovery trauma service. Barts Health was internationally recognised as an innovator and leader in research in this field. The Royal London Hospital was the first designated Major Trauma Centre (MTC) in the UK, and the busiest MTC in the UK and one of the busiest in the world (2000+ patients per year). There was a multispecialty multidisciplinary trauma workforce embedded throughout the hospital, including dedicated trauma neurosurgery and trauma plastic surgery services and an injury prevention service.
- The trust provided support for teams undertaking quality improvement projects with training and access to improvement coaches.
- The Headway East London Brain Injury Drop-In at the Royal London Hospital was an early intervention project based at the hospital, supporting families of patients with head injuries and other acquired brain injuries. Experienced Headway East London staff held weekly drop-in sessions at the hospital, providing advice and information to families in the early stages following their accident/injury. These sessions acted as a peer support network for those experiencing similar issues.
- The trust supported an internet-based resource for trauma patients called After Trauma to provide opportunities for peer support and information exchange.
- The trust hosted personnel from the Defence Medical Services on placement in civilian trauma centres as part of the live training during an exercise period (LIVEX). Trauma staff in the hospital provided refresher trainer in trauma, resuscitation and crisis resource management skills.

Surgery

- One of the surgery ward managers had developed a patient safety culture resource poster for staff in the hospital. The poster contained clear and accessible evidence-based information on the systems and principles needed to maintain high levels of safety.

Critical care

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

Information about the service

The Adult Critical Care Unit (ACCU) provided both specialist and general critical care support for the local population, as well as tertiary services including trauma, neurosciences, maxillofacial and ENT, vascular, renal, hepato-bilary medicine and surgery. Between April 2015 and March 2016 the service had 2,816 patients. There were 44 beds on the unit which were arranged to provide 22 beds for patients requiring level three care (advanced respiratory support alone or basic respiratory support with support of two other organ systems), as well as 22 beds for patients requiring level two care (more detailed observation and higher levels of care such as those receiving basic respiratory support or with single organ failure). Patients requiring level 3 care had one-to-one nursing and those requiring level 2 had a ratio of one nurse to two patients. There was a Critical Care Outreach Team (CCOT) who assisted in the management of critically ill patients on wards across the hospital.

The Renal High Dependency Unit had four level 2 beds and provided specialist care to patients with renal disorders or undergoing renal transplant.

We visited all areas of critical care over the course of three announced inspection dates and one unannounced inspection day. During our inspection, we spoke with 64 members of staff including doctors, nurses and allied health professionals and ancillary staff. We also spoke with the directorate leadership team, six patients and 13 relatives. We checked five patient records and many pieces of equipment.

Summary of findings

We rated the service as good because:

- We saw good evidence of learning from incidents and varied methods of disseminating learning points, including the daily 3pm safety huddle and regular communication with staff. Learning from serious incidents at other hospital sites was shared with the staff.
- Suitable processes and development opportunities were in place to ensure nursing staff were competent such as regular skills stations for all staff to attend.
- Patient and relative feedback was very positive about the care provided on the unit and staff were frequently described as caring and professional. Patients and relatives were provided with information in a format they could understand and said staff were always available to answer any questions they might have.
- Intensive Care National Audit and Research Centre (ICNARC) data demonstrated the ACCU was performing better than similar trusts with regards to readmissions within 48 hours following discharge.
- ICNARC data demonstrated that mortality and morbidity within ACCU was about the same as similar services.
- Clinical practice was benchmarked against national guidance form organisations such as the National Institute for Health and Care Excellence (NICE) and Royal College guidelines.

Critical care

- The leadership team had identified access and flow on the unit as one of their main challenges and were taken steps to improve the issue, such as working with the neuro team.
- Staff knowledge of safeguarding and Deprivation of Liberty Safeguards (DoLS) was good which ensured safe practice embedded.

However:

- We found drug cupboards unlocked in a room that was accessible by all staff working on the ACCU who had swipe card access. This meant both clinical and non-clinical staff could access medication that should be stored securely. This was not documented on the services risk register.
- Ward information and signs were only available in English which could make navigation difficult if English was not the first language.
- The unit was just below the recommended 50% of nursing staff with a post registration award in critical care nursing.
- There were high numbers of delayed discharges due to bed flow problems within the hospital. Bed occupancy was also high which could limit the services ability to provide a bed in the event of an emergency.

Are critical care services safe?

Good

We rated safe as good because:

- There was a good incident reporting culture and learning from incident investigations was disseminated to staff in a timely fashion. Staff were able to tell us about improvements in practice that had occurred as a result.
- Staff understood their roles and responsibilities with regards to safeguarding and could tell us how they would escalate any concerns.
- The environment was fit for purpose and we observed staff complying with infection control and prevention guidelines. The unit had infection prevention and control link nurses to ensure compliances improved.
- There was a major incident link nurse who had helped run the two major incident simulation exercises. The unit had developed number action cards so staff knew what their roles were during an event.
- We found good completion of records and prescription charts.

However:

- Medicines were not stored safely and securely. Drug cupboards were left unlocked and all staff with a swipe card (clinical and non-clinical) could access the medications room and therefore the drugs cupboards.
- The replacement of capital equipment was on the services risk register, as equipment was not being replaced in a timely way.

Incidents

- The trust reported to the Strategic Executive Information System (STEIS), which records Serious Incidents and Never Events.
- The service reported no never events for the12 months prior to our inspection. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Each never event has the potential to cause

serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurring for that incident to be categorised as a never event
- Incidents were reported via online forms that could be accessed by all staff and completed on any trust computer.
- Between May 2015 and April 2016 ACCU reported 615 incidents and an average of 51 per month. [This was slightly more than other similar sized units who reported approximately 25-45 incidents each month.
- Of the 615 incidents 453 (73.7%) were reported as no harm, 151 (24.6%) low harm, nine (1.5%) moderate harm and two (0.3%) severe harm. We reviewed the incidents log and found the most common themes were medication related incidents (20%), pressure ulcers (18%), and continence management (14%).
- Serious incidents (SI) are those that require investigation. Between June 2015 and May 2016, the service reported two serious incidents (SI). One incident was a pressure ulcer meeting the SI criteria and the second was sub-optimal care of the deteriorating patient meeting the SI. We saw evidence of investigation reports and root cause analysis (RCA), including action points. There was evidence of duty of candour around the investigation and findings.
- Staff across critical care were able to identify how to report incidents and the types of situations that should trigger incident-reporting completion, including near miss situations.
- Staff told us they received feedback and learning points from incidents, including those that occurred in other units within the hospital and other sites within the trust. Learning was shared via a range of methods including to critical care staff directly via email or in meetings and during the daily safety briefings and safety huddles. The critical care multidisciplinary team also attended monthly clinical governance meetings for additional information and feedback. Band 6 nurses were invited by the matron to attend clinical governance meetings so information could be cascaded to staff on the ward.
- During the daily safety huddle, learning from serious incidents within the trust was shared with staff by the matrons.
- Staff were able to describe action points from incidents. For example, staff told us there had been a number of never events and serious incidents around nasogastric (NG) feeding within the trust. NG feeding is where a thin tube is inserted through the nostril, down the oesophagus and into a patient's stomach to delivery key nutrients and medication. The ACCU had introduced some additional training around the safe insertion of NG tubes in response to incidents within the trust. The service had developed a bespoke competency packages and all staff were assessed before being able to insert NG tubes.
- The ACCU also embedded learning from serious incidents into simulation training.
- Weekly morbidity and mortality (M&M) meetings were held and staff were encouraged to attend if possible. Cases were discussed and recommendations were made and actions assigned. However, review of M&M minutes did not clearly demonstrate evidence of actions being completed.
- The ACCU had conducted a quality improvement project to increase learning from clinical incidents to improve patient safety and prevent re-occurrence of incident themes. This set out a number of action points for the service to achieve including ensuring there were daily safety briefings and safety huddles, link learning from incidents to practice development and ensuring dissemination across the team.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with had variable knowledge of duty of candour; however, senior staff were very clear about the requirement of this.

Safety thermometer

- The ACCU participated in the NHS Safety Thermometer scheme. The NHS safety thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to patients, such as new pressure ulcers, catheter and urinary tract infections (CUTI and UTIs), falls with harm to patients over 70 and Venous Thromboembolism (VTE) incidence.
- There were 10 unit acquired pressure ulcers reported within critical care between April 2015 and April 2016. During our inspection, we saw patients' risk of developing a pressure ulcer was assessed using Waterlow pressure ulcer prevention score. There were

staff identified as pressure ulcer prevention link nurses across the ACCU who were available to provide support to their colleagues. Tissue viability nurses were available Monday to Friday from 9am to 5pm
- There were zero falls reported between April 2015 and April 2016. We saw evidence of patient mobility assessments by physiotherapists and patient risk assessments completed when appropriate.
- Catheter care bundles were used by staff throughout critical care and there had only been two instances of catheter associated urinary tract infections (CUTI) between April 2015 and April 2016.
- Venous Thromboembolism (VTE) risk assessment was recorded on the patients' record and completed on a daily basis. Hospital audit data showed compliance with this assessment was consistently at 100% across critical care between July 2015 and June 2016.
- Whilst the trust was collecting safety thermometer information, it was not displayed at the entrances of the ward.
- However, the safety cross was displayed at each critical care entrance. The safety cross is a tool used to display key information about the safety of the ward, which is completed daily. Each number on the cross represents a day and date for the month.
- The safety cross displayed information about the number of cardiac arrests, pressure ulcers, acquired infection, staffing levels and falls for the current month.

Cleanliness, infection control and hygiene

- There were dedicated housekeeping staff for cleaning the ACCU. Housekeepers worked from 7.30am to 4pm each day. For out of hours a team was available on call. Cleaning staff understood cleaning frequency and standards and said they felt part of the team.
- We reviewed patient areas on the ACCU and renal HDU as well as sluices and treatment rooms. All areas were visibly clean and free from dust. Patients and relatives were satisfied with the level of cleanliness on the wards.
- Green 'I am clean' stickers were used to identify which equipment had been cleaned by staff and was ready to be reused, such as commodes. We saw stickers had been marked with the date the item had been cleaned and observed staff replacing stickers once they returned the clean equipment.
- We inspected various pieces of equipment such as commodes and arterial blood gas machines and found a good level of cleanliness.
- Infection prevention and control mandatory training had been completed by 98% of staff which met the trust target of 90%.
- There was easy access to personal protective equipment (PPE) in all areas we inspected and staff used PPE during their activities as required.
- Staff were 'bare below the elbow' and adhered to infection control precautions throughout our inspection such as cleaning hands when entering and exiting the unit and bed spaces, and wearing PPE when caring for patients .
- Side rooms had signs displaying presence of infection which meant staff and visitors were aware of the need to wear suitable PPE prior to entering the patient area. We observed staff adhering to these protocols and doors remained closed. We observed one nurse challenging another member of staff to wear the appropriate level for PPE before entering a side room to see a patient.
- Alcohol hand gels were readily available at the entrances to the critical care unit and at each bedside. We observed staff and visitors decontaminating their hands when entering and leaving the unit. We observed staff challenging staff from other areas of the hospital to wash their hands and use hand gel when entering and leaving clinical areas.
- We observed bed space curtains were labelled and dated when they were last changed.
- Safety thermometer information showed it had been 13 days since the last unit acquired case of methicillin-resistant staphylococcus aureusis (MRSA). It had been 750 days since the last MRSA bacterium (where bacteria enter the bloodstream) and 155 days since the last case of Clostridium Difficile (C-Diff). MRSA and C.Diff are both healthcare-associated infections (HCAIs) that can develop either as a direct result of healthcare interventions such as medical or surgical treatment, or from being in contact with a healthcare setting.
- Patients were swabbed for MRSA and gram negative bacteria on admission. MRSA screening compliance between October 2015 and April 2016 varied between 80% and 100%.
- Data from the Adult Critical Care Specialised Service Quality Dashboard 2015/2016 showed the rate of unit-acquired infection in blood per 1000 bed days was below the national mean for both Ward 4E and 4F (0.3 for 4E and 0 for 4F, compared to national mean of 1.4).

- The unit was auditing ventilator acquired pneumonia (VAP) and Central Venous Catheter (CVC) infection rates.
- The unit has designated infection control and prevention (IPC) link nurses and a monthly infection prevention and control (IPC) newsletter.
- Cleanliness within ACCU was on the risk register due to established cleaning standards not being met on the unit, which could pose a risk to patient harm. We found that, as on our last inspection the risks were addressed by weekly environmental audits.
- Between May 2015 and June 2016, hand hygiene audits demonstrated between 66% and 100% compliance. Following the month where the unit achieved 66%, there was evidence of an agreed action plan with the local IPC link nurses and the IPC team. Between March and April 2016, the unit had an IPC awareness month. Staff were educated around appropriate hand hygiene techniques and this included use of an ultraviolet (UV) light box. The UV light box was used as a tool for educating and improving practice

Environment and equipment

- There was an electronic swipe card entry system for staff and a buzzer entry system at the entrance to the ACCU which was used by visitors. This meant staff could control who accessed the ACCU when the door was secured.
- The ACCU was a purpose built bright and spacious unit and there was appropriate levels of storage. Most of the areas had natural light and space between beds was in line with Intensive Care Society standards. The unit demonstrated compliance with most of the Health Building Note (HBN040) recommendations. Side rooms had decontamination lobbies in line with best practice guidance.
- Resuscitation trollies were located at appropriate intervals throughout the ACCU. We saw the contents of the trollies were checked daily by nursing staff and were tagged and sealed.
- Both the HDU and ICU side of ACCU had access to a 'difficult airway' intubation trolley, which contained equipment to help staff intubate patients with challenging anatomy. The content of the trollies met recommendations from the Difficult Airway Society (DAS) 2013. DAS guidelines were also attached to the trolley providing information on what to do if there was an unanticipated difficult tracheal intubation.
- There were 'chest drain' trollies available on the two sides of the unit. All the equipment within the trolley was in date.
- Needle sharp bins were available at each bed space and within the medication preparation area. All bins we inspected were correctly labelled and none were filled above the maximum fill line.
- Dirty utility rooms contained facilities for disposing of clinical waste and cleaning equipment.
- Staff told us they were able to access equipment required to care for patients and each bed space had a computer terminal to allow staff to readily access pathology results and other policies and guidelines on the staff shared drive.
- We checked various and numerous equipment during the inspection and found it all to be safety tested. We reviewed service records and found them to be up to date.
- We observed spare consumables and other equipment were appropriately stored.
- The unit had a team of critical care technicians who all had biomedical backgrounds. The technicians' role involved checking equipment such as blood analysers, cleaning and resetting ventilators and troubleshooting equipment issues. The team also assisted on patient transfers to scans and were involved in the capital equipment replacement projects.
- Staff told us they felt very well supported whilst working in the side rooms on the ACCU. However, we had some concerns regarding the placement of the emergency buzzer in each room. The buzzer was located on one side of the patient bed. Therefore, if staff members were stood on the other side of the bed and required assistance the buzzer would be difficult to access. One staff member told us on one occasion they had to let go of a patient who was pulling at a tube to walk around the bed and reach the buzzer. This could leave patients at risk and there was no risk assessment in place for this. We also found no lone working risk assessment in place for staff who were working in these side rooms throughout the day. We raised this with the units' matrons who recognised the need to implement this.
- Faculty of Intensive Care Medical Core Standards for Intensive Care Units recommends there must be a programme in place for the routine replacement of capital equipment. Trust data showed that ACCU is not

fully compliant with this due to limited planned maintenance of equipment for clinical engineering supported devices. Equipment was not routinely being replaced and this was on the services risk register.

Medicines

- During the latest three month data available (Q1 2016-17), the ACCU maintained the governance of Controlled Drug (CD) audits that were undertaken by the Pharmacy department. We saw evidence of second signatures, total balances maintained accurately when being moved from page to page and the appropriate storage of these medicines. Any issues that arose were discussed at the daily safety huddle to highlight the importance to staff of adhering to trust policy.
- We saw that procedures have been put in place to record patients' own CD in a separate CD book and stored in plastic containers within the locked cupboard. Keys to the drug cupboards and POD lockers were held by registered nurses.
- We saw the unit used medicines reconciliation process which meant that when patients were admitted to hospital the medicines they are prescribed on admission correspond to those they were taking before admission. There was evidence of clear records of previous medicines in the notes from the pharmacist and on two of the prescription charts we reviewed.
- We reviewed 11 prescription charts and saw they were fully completed. Allergies were clearly documented and allergy stickers were applied to patients' records.
- All staff had access to British National Formulary (BNF) as well as policies and information relating to medicines management, including the antimicrobial formulary.
- Some medicines were stored in fridges and we observed that staff were checking and recording fridge temperatures on a daily basis,
- Information provided by the hospital indicated there were two whole time equivalent (WTE) ICU pharmacists to cover the ACCU. Recommendations from the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units identify there should be 3.6 WTE pharmacist for the number of critical care beds provided. We found that although the level of pharmacy staff was below that required by the department, this had no detrimental effect on patient care. Staff we spoke to said they had access to the on-call pharmacist when required out of hours and did not experience delays in receiving discharge medicines.
- The unit was also not meeting the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units recommendations around pharmacy technical support. There was no technical support available on the ACCU
- Pharmacists attended ward rounds where staffing levels could permit this. Therefore, the service was not guaranteed to be provided five days a week (Monday to Friday). On weekends the trust aimed to offer a basic ward visit but staff were not always appropriately trained in critical care. This was not compliant with recommendations from the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units.
- There was a storage room for all medicines which was accessed by a swipe card system. This was accessible to all members of staff, including non-clinical staff. This meant that there was a risk that medicines could be accessed by anyone with a swipe care and therefore this did not adhere to trust policy
- We found that the fridges and cupboards within the room storing the medicines were unlocked during the inspection. Staff told us that this was due to how the department operated and that certain medicines needed to be easily accessible in an emergency. All staff who worked on the unit could access this room, including non-clinical staff. We raised this concern with the matrons and were told that there had been a risk assessment for this, but could not find it on the trust or services risk register.
- During an unannounced visit in August 2016, we found all staff (clinical and non-clinical) were still able to access the medications rooms via the swipe card access. Therefore, all staff could access medication in the unlocked cupboards. We spoke with the matron regarding this concern and were told it was being looked into with the hospital's security.

Records

- Paper based medical notes were used to record medical interventions and involvement from the multidisciplinary team. These notes were kept at the end of each patient's bed for easy access. We reviewed five sets of patients' records and found they were legible, signed and fully completed.
- Patient observations and assessments were recorded on the daily record sheet which was kept at the end of

the patients' bed. Nursing documents were clear and concise and care plans fully completed. This included information such as regular observations, fluid balance and pain scores.
- We reviewed 11 prescription charts and found there was good completion. VTE prophylaxis regimes were consistently prescribed and administered.
- Of ACCU staff, 99.53% had completed information governance training, against a trust target of 90%.
- A documentation audit between September 2015 and December 2015 found good performance with regards to the recording of patient name, record number, respiratory rates, blood pressure, heart rate and temperature. However, found poorer compliance with regards to nurses' signature, NG at nose position recorded and line removal. The matron said that the ACCU were working with clinical effectiveness to develop an electronic tool for the ACCU so they can regularly audit nursing documentation.

Safeguarding

- Staff we spoke with were aware of their responsibilities in relation to safeguarding vulnerable adults and could locate and describe the trust safeguarding policy.
- Nursing staff were able to give examples of what would constitute a safeguarding concern and told us they would seek advice from senior staff members and the trust safeguarding team if they had any concerns.
- All staff we spoke with knew the safeguarding team and could identify where to find their contact details if required.
- Safeguarding adults training was completed by staff as part of the trust's mandatory training. All staff were required to attend this training and 100% of staff had completed safeguarding adults level one and 83.3% of staff had attended safeguarding adults level two. The ACCU was performing below the trusts target of 90%for safeguarding level two training.

Mandatory training

- Key aspects of mandatory training such as information governance and fire safety were undertaken as part of the induction process for new starters. Additional mandatory training were undertaken as e-learning modules and further classroom based sessions.
- Senior staff told us a trust-wide compliance target of 90% was set for mandatory topics and we noted this target was met for almost all the mandatory training subjects. The overall percentage for the ACCU was 97.6%.
- Patient-handling practical training was 86.8% which was below the trust target of 90%.
- Basic life support training was mandatory for clinical staff. Training had been completed by 86.83% of staff, which was below the trust target of 90%.
- The service offered Intermediate Life Support (ILS) training to all band 7 shift leaders. Training had been completed by 100% of band 7 nurses. Band 6 nurses were offered the opportunity to attend ILS as identified as part of their appraisals or practice development. ILS had been completed by 53.5% of band 6 nurses.

Assessing and responding to patient risk

- The ACCU used the 'Richmond Agitation-Sedation Scale' (RASS) to score the level of sedation for each patient receiving sedative medicines. We found evidence this assessment was being completed in patients' records.
- Patients were evaluated using the Confusion Assessment Method for ITU (CAM_ICU) flowchart to determine whether delirium was evident, in line with best practice guidance from the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units. We saw evidence this assessment was completed with appropriate patients during the inspection.
- Patients were monitored using recognised observational tools and monitors. The frequency of observations was dependent on the acuity of the patient.
- There was a written escalation procedure that identified the criteria for the management of emergency admissions to ACCU. All patients requiring emergency admission were referred to the critical care consultant on duty.
- There was a well-established Critical Care Outreach Team (CCOT), staffed by a nurse consultant, critical care nurses and a physiotherapist. The CCOT team deliver level zero to level three critical care to non-critical care areas. CCOT worked seven days a week from 8am to 8.30pm and handed over to the hospital at night team to ensure a twenty four seven strategy for the review and care of sick and deteriorating patients.
- The National Early Warning Scores (NEWS) was used throughout the hospital wards to enable early

identification of deteriorating patients. This was in line with guidance from the Royal College of Physicians and complaint with the NICE 50 guideline. Hospital documentation identified that a referral to CCOT should be made when the NEWS reached a score of five or above or if a person had any single score of three.
- Staff told us the sepsis pathway which helped them identify sepsis earlier. The screening and management performa allowed staff to follow a flow chart when a patient was deteriorating. This incorporated the sepsis six which are six things staff should be monitoring with patients who are at risk.

Nursing staffing

- There were 220.06 WTE members of qualified nursing staff who worked across critical care including 28.78 WTE vacancies (13%), as of August 2016.We were told a number of staff had been recruited which would reduce the vacancy rate to around 6.5%.
- Staff told us of difficulties recruiting band 6 critical care nurses and service leads were focusing on the recruitment and retention of staff. The unit had been proactive in the recruitment of nurses from overseas.
- On each clinical shift the unit was subdivided into three teams called A, B and C. The normal funded establishment was 38 WTE nurses per shift, included within this were three nurses in charge of allocated teams and three clinical support nurses. Staff worked shifts from 8am to 8pm and night shifts from 8pm to 8am, with nursing handover taking place at the start of each shift.
- Nursing handover incorporated a safety briefing and discussion about any relevant information that needed to be shared. This handover was brief and was followed by a more detailed bedside handover once staff were allocated a patient.
- The unit had two matrons who shared responsibility for the nursing elements of the service.
- The trust used the Shelford safer Nursing Care Tool (SNCT) to assess levels of acuity and dependency of inpatients. ACCU collated the SNCT data but staffing levels were based on the Faculty of Intensive Care Medical Core Standards for Intensive Care Units. This states that all ventilated patients (level three) are required to have a registered nurses to patient ratio of a minimum of 1:1 to deliver direct care, and for level two patients a ratio of 1:2. Patient allocation records demonstrated critical care complied with the required staffing levels. Patients with additional care needs would be nursed by two nurses.
- New staff completed a period of supernumerary working supported by a mentor and were allocated a mentor to support them during the induction period. There were specific competencies in place that had to be signed off by their mentor before the staff member was able to work independently.
- Best practice guidance suggests no more than 20% agency usage per shift. Nursing staff rotas we reviewed and our observation of nursing staff in duty during our inspection demonstrated the unit did not always comply with this standard. Data provided by the trust indicated between for June 2016 the bank and agency was 26.9% (16.3% bank and 10.6% agency%). For July the fill rate was 21.2% (12.5% bank and 8.7% agency).
- The unit had a link administrator who coordinated agency and bank bookings. All new agency staff were given an induction and went through an orientation checklist before working on the ward. This set out clear expectations and standards for working on the ward.
- The CCOT worked seven days a week from 8am to 8.30pm. This was led by a nurse consultant and staffed with a clinical specialist physiotherapist, three band 7 sisters or in-charge nurses and a band 6 rotational post from the ACCU.
- The unit had 3.21 WTE clinical nurse educators responsible for coordinating education, training and the CPD framework. At the time of the inspection only 1.61 WTE of the clinical nurse educators had a postgraduate certificate in education or equivalent. This does not meet the Faculty of Intensive Care Medical Core Standards for Intensive Care Units recommendations. We were told that a further clinical nurse educator (0.8 WTE) was in the process of gaining this qualification.

Medical staffing

- A total of 17 WTE consultants were in post across the critical care units. In line with recommendations from the Faculty of Intensive Care Medical Core Standards for Intensive Care Units, 100% of consultants were Faculty of Intensive Care Medicine accredited or had suitable equivalent qualifications.
- Consultant cover for ACCU was split into three teams designated A, B and C. Each team was led by a consultant Monday to Friday between 8am and 6pm.

This was in line with the Faculty of Intensive Care Medical Core Standards for Intensive Care Units recommendations that the consultant to patient ratio of between 1:8 and 1:15. However, at weekends this was only two consultants and therefore not meeting the recommendations.

- At 6pm, the team A and B consultants then took over for the team C consultant until 10pm.
- Overnight the ACCU had two on-call consultants available to attend the unit. Which means between 6pm and 8am the service is not meeting the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units. This recommends a minimum of 1:15 consultant to patient ratio, therefore the unit would need three consultants twenty four hours a day.
- There were four junior doctors working on the wards, two of which were airway trained.
- Consultants across the ACCU were supported by a varying number of registrars, specialist trainees and foundation year doctors. There were 30 WTE slots for junior doctors who worked a hybrid shift rota to cover the ACCU. The rota allowed for regular fixed teaching sessions on Tuesdays and Wednesdays.
- Junior doctors were well supported and reported good access to clinical supervision and training. They said they were supported to develop and said medical staffing levels were good.
- Consultant ward rounds took place twice a day at 9.30am and again at 5.30pm.
- Senior leaders told us there were regular gaps in the rota due to a lack of applications to both anaesthetic and intensive care training programmes. The unit had made use of locums to cover essential shifts during the past 12 months.
- There were no staff grade doctors on ACCU.

Major incident awareness and training

- There was a hospital wide major incident plan, which included intensive care and anaesthetics response. The ACCU had allocated a major incident link nurses who helped review the major incident policy to make it easier to read.
- The major incident plan was kept in the nurse's station on each ward. Staff we spoke with could identify where this was kept.
- The ACCU had developed action cards for staff so they knew what to do in the event of a major incident. Cards described the role of different professionals such as nurses and pharmacy.
- The ACCU had done two preparation exercises in the past 12 months and one had involved a virtual experience on the real time bed state.

Please include additional subheadings if needed.

Are critical care services effective?

Good

We rated effective as good because:

- Patients were cared for by competent medical and nursing staff who followed evidence based guidelines for care and treatment.
- Multidisciplinary working was effective and access to diagnostic imaging was good.
- Intensive Care National Audit and Research centre (ICNARC) data demonstrated that patient readmission rates were better than other similar units, mortality was as expected.
- There were suitable processes and developmental opportunities in place to ensure nursing staff working on the unit were competent. Patients were cared for by appropriately qualified nursing staff who had received an induction to the unit and achieved specific competencies before caring for patients.
- Medical staffing had good access to educational opportunities and felt well supported.
- Staff were aware of the need to obtain consent, taking into account mental capacity principles. Knowledge of deprivation of liberty safeguards was good.

However:

- The provision of physiotherapists, pharmacists, occupational therapists (OT), speech and language therapists (SALT) and dieticians was not sufficient to meet recommended standards. This meant physiotherapists and pharmacists were not attending ward rounds on a daily basis. OT, SALT and dieticians were not available over the weekend.
- Patients were not receiving the recommended number of rehabilitation sessions per week.

Evidence based care and treatment

- Policies and procedures were available on the critical care shared computer drive. Intensive care specific policies and procedures were up to date and referenced to current best practice from a combination of national and international guidance. This included National Institute for Health and Care Excellence (NICE), Royal Collage guidelines and Intensive Care Society recommendations.
- We were told by senior management that quick read copies of policies and guidelines were being developed for staff to improve access.
- Staff told us the education nurses updated them regarding any changes to national guidance and evidence based practice. Staff were also updated during the 3pm safety huddle.
- The Adult Critical Care Unit (ACCU) contributed to the Intensive Care National Audit and Research Centre (ICNARC) database for England, Wales and Northern Ireland. This meant care delivered and patient outcomes were benchmarked against similar units nationally.
- An evidence-based ventilator-associated pneumonia (VAP) prevention care bundle was in use throughout the ACCU. Hospital data between November 2015 and May 2016 showed variable compliance with VAP care bundles. Compliance varied between 90% and 100%.
- We observed patients were risk assessed for VTE at appropriate intervals (on admission and after 24 hours) and that suitable VTE prophylaxis was in place. This was in line with NICE quality standard 3.Hospital data between April 2015 and April 2016 showed 100% of patients were assessed for risk of VTE.
- There was a local audit programme in place to ensure certain audits were completed monthly such as infection control, pressure ulcer prevention, Saving Lives and Safety Thermometer. There was a formal Critical Care audit programme in place co-ordinated with the clinical effectiveness unit. The service participated in a number of quality improvement projects to ensure compliance with national guidance. For example, projects looking at NICE Delirium assessment and treatment, Nutrition support in ICU, Critical Care rehabilitation, End of life care, Managing Acutely Ill patients, VTE assessing and reducing risk, prevention, diagnosis and management. The service had also established a formal on going rolling audit of tracheostomy care in line with 'On the right Trach' as recommended by NCEPOD 2014.
- Patients undergoing rehabilitation received three sessions of physiotherapy per week which does not meet the Faculty of Intensive Care Medicine Core Standards for Intensive Care Medicine. This recommends a minimum of 45 minutes of each active therapy, for a minimum of five days a week.

Pain relief

- Pain was assessed on an hourly basis as part of basic observations using a formal patient reported scoring system. Patients were asked to score their pain on a scale of one to four. If a patient was unconscious, staff would look for signs of pain such as facial expressions and grimacing.
- Some patients had Patient Controlled Analgesia (PCA) devices, which is a method of pain control that allows patients the power to control their pain. Other patients told us staff asked them about their pain on a regular basis. All patients we spoke with were happy with their access to pain relief medication and said it was managed well.
- Support for patients with pain issues could be obtained from the ACCU pain link nurses and the hospital pain team who were available via a bleep system. The pain team were available from 8am to 7pm Monday to Friday, outside of these hours an on-call service operated.
- We saw a physiotherapist give a patient a 30 minute reminder before their session to allow the patient to use their PCA if required. This allowed the patient time to use pain relief before the physiotherapy session took place.
- Senior management told us all staff had to do epidural and PDA training.

Nutrition and hydration

- There were 1.4 WTE dieticians provided to the ACCU. This provision was not compliant with the British Dietetic Association recommended numbers for WTE dieticians for the number of critical care beds that were available, this should be 2.2 WTE. We were told due to some vacancies in the dietician team some patients were not reviewed on admission.
- Patients on ACCU were reviewed by a dietician Monday to Friday between 8.30am and 5pm, there was no access to assessments over the weekend.
- We reviewed five patient records and saw evidence of comprehensive fluid balance monitoring on the daily care charts. However, Malnutrition Universal Screening

Tool (MUST) scores were not documented for every patient. MUST scores can be used to establish nutritional risk and staff were aware recording of this needed to be improved.

- The ACCU had an enteral feeding protocol to assess the nutritional needs of patients, based on height, weight and body mass index. The nurses implemented the feeding protocol when patients were admitted to the unit. Enteral feeding refers to the delivery of a nutritionally complete feed, containing protein, carbohydrate, fat, water, minerals and vitamins, directly into the stomach.
- Parenteral nutrition (PN) was started upon agreement of the ICU medical team. PN could be started out of hours or at weekends by critical care staff. Parenteral nutrition(PN) is the feeding of a person intravenously, bypassing the usual process of eating and digestion. The person receives nutritional formulae that contain nutrients such as glucose, salts, amino acids, lipids and added vitamins and dietary minerals. Dieticians were not available over the weekend, so if a patient was admitted on a Friday they would be unable to have a dietician assessment till the Monday.
- The ACCU conducted a quality improvement project in September 2015 to improve nutrition on the ACCU. The service collected feedback from patients and relatives, spoke with dieticians and catering staff at the hospital and had a food tasting session. This had resulted in a new menu being introduced and snacks made available for patients admitted out of hours. Staff also told us the unit had recently had an oven fitted on the unit which means patients can have oven cooked meals.
- Patients who were able to eat told us they were happy with the food choices available on the unit.

Patient outcomes

- The critical care service contributed data to the ICNARC database for England, Wales and Northern Ireland. This meant care delivered and patient outcomes were benchmarked against similar units nationally. The ACCU submitted ICNARC data for both the intensive care unit (ICU) and the high dependency unit (HDU). ICNARC data quoted relates to the period from April 2015 to March 2016.
- ICNARC data showed there were 30 deaths on the HDU and 243 deaths on the ICU. This represented a unit mortality rate of 2.2% on the HDU and 19.2% on the ICU, which was in line with the expected mortality rate for each unit.
- The mean length of stay on HDU reported by ICNARC was 89 hours which was more than the average for comparable units (80 hours). For ICU the mean length of stay was 166 hours which was more than other similar units (128 hours).
- Patients discharged 'out of hours' between 10pm and 7am were associated with worse outcomes and ICNARC data demonstrated the HDU unit was performing about the same (3%) as other similar units (3.1%). The ICU was performing slightly worse (5.2%) than other similar units (2.6%).
- ICNARC data showed there were four unplanned readmissions to the HDU within 48 hours of discharge, which represented 0.3% of patients admitted to the unit in this period. This was better when compared to other similar units (1.2%). There were five unplanned readmissions to the ICU within 48 hours of discharge, which represented 0.9% of patients admitted to the unit in this period. This was slightly better when compared to other similar units (1.2%).
- The units contributed to the local critical care network which enabled further outcome and quality benchmarking, specifically against other local critical care units.
- The ACCU had conducted a quality improvement project to reduce the number of pressure ulcers. The ACCU had designated pressure ulcer prevention link nurses, staff had pressure ulcer prevention training and information was shared during safety briefings and huddles. Since 2014 the unit had saw a reduction in the number of unit acquired pressure ulcers on heels and buttocks. In 2014, the unit had 55 and in 2015 the unit had 22 pressure ulcers. The unit has also worked on reducing the number of equipment related pressure ulcers by using new NG taping methods, new softer nasal cannula and ensuring regular skin assessments.

Competent staff

Nursing Staff

- The ACCU had a practice nurse development team that supported staff and facilitated a continual professional development programme for staff.

- All new nurses working in critical care were allocated a period of supernumerary practice, during which they were expected to complete a series of competencies which had to be signed off prior to independent working. New staff were given a 'New Staff Passport' which was a record of progress for individuals to update their training and achievements during their supernumerary period.
- When staff completed the New Staff Passport, they progressed to the National Competency Framework for Critical Care Nurses – Step one. This is a competency-based programme for staff to develop core skills in caring for critically ill patients under supervision from a mentor or practice development nurse. Staff were very positive about the learning and level of support they received during this.
- The Core Standards for Intensive Care Units (2013) recommend that a minimum of 50% of registered nurses should be in possession of a post registration course in critical care. At the time of the inspection, the unit was achieving 49% for this standard. We was told by the matron a number of staff were currently on this course, and once completed the unit would be meeting the standard.
- Allocated link nurses were in place for a number of key themes within the critical care area such as pressure ulcer, infection control and major incidents. This allocation meant nurses on the units could seek guidance from their colleagues around specific issues. Staff told us this system worked well.
- The ACCU ran skills stations which were weekly teaching sessions for staff on topics such as NG tube insertion, respiratory assessments and wound dressing. Skills stations were attended by a variety of staff including nurses, students, technicians and physiotherapists.
- We spoke to some student nurses during focus groups for the inspection who gave very positive feedback about the ACCU. Student nurses told us they were given detailed information packs when they started and was always able to ask questions and learn. Students were able to attend the ACCU skills stations even when this was above their role and said they were always encouraged to develop.
- Appraisals had been completed within the previous 12 months for 90.20% of staff.

Medical Staffing

- All new doctors were provided with a comprehensive booklet and 'survival guide' outlining various important points about working on the unit, including timing of key activities and expectations relating to their role.
- Medical staff told us they received full formal inductions to the unit. We reviewed induction records and it showed doctors received their induction in a timely way.
- Doctors received structured teaching two days a week including a weekly journal club. We spoke to a number of doctors during the inspection who told us they were very happy with the training on the ACCU.
- Junior staff told us they were supported to develop and learn and they enjoyed the simulation courses that were available to them.

Multidisciplinary working

- The critical care outreach team (CCOT) was responsible for reviewing patients in other areas of the hospital to determine their need for admission to critical care. There were written guidelines which advised when patients should be escalated to the CCOT, for example those with a NEWS score of five or more.
- There was a weekly multidisciplinary team (MDT) meeting to discuss long term patients (patients who had been on the ACCU for longer than seven days).
- Every Tuesday there was a MDT tracheostomy ward round where all patients who had a tracheostomy were discussed. A tracheostomy is an opening created at the front of the neck so a tube can be inserted into the windpipe to help patients breathe. The CCOT physiotherapist oversaw and reviewed the care and directed the weaning programme for patients with tracheostomy.
- ACCU staff reported good links with the specialist nurses in organ donations team.
- All staff we spoke with said there was good MDT working between nursing, doctors and therapists. Therapists worked closely with ward staff to implement rehabilitation plans for each patient and we saw nursing staff and therapists working together to complete patient tasks and rehabilitation during the inspection.
- Physiotherapy and pharmacy staff could not always attend the daily ward rounds due to staffing numbers. The ACCU was funded for 3.5 WTE physiotherapists, which does not meet the Intensive Care Society (ICS) recommendations. The ICS recommends a minimum ratio of one physiotherapist to four patients, meaning the ACCU should have 8 WTE physiotherapists.

- There ACCU had 0.3 WTE funded occupational therapy (OT) which was below the ICS recommendation of 0.22 WTE OTs per level three bed.
- The Faculty of Intensive Care Medicine states that patients should have access to SALT staff with critical care experience. However, we were told SALT was only provided on a limited basis.

Seven-day services

- Consultants covered the ward seven days a week and completed twice daily ward rounds, including over weekends.
- Physiotherapy services were available seven days a week from 8am to 6pm by a dedicated physiotherapist's team; an on-call physiotherapist was available out of hours.
- The ACCU was funded for 2 WTE pharmacists which was below the recommended 3.6 WTE for the number of beds provided. Only one of the pharmacy team had a suitable post graduate qualification for critical care pharmacy.
- Physiotherapy and pharmacy were not able to attend daily ward rounds due to staffing issues, which was not compliant with Guidelines for the Provision of Intensive Care Services.
- Dieticians and occupation therapy were available five days per week Monday to Friday, there was no access to these services over the weekend.
- The CCOT team was available seven days a week from 8am to 8pm to assess and provide support for deteriorating patients on wards. Outside of these times, the hospital at night team was available to provide support.
- Patients could access investigations such as blood tests, x-rays and CT scans 24 hours per day, seven days per week. Staff reported there was no difficulties for accessing this type of support services and told us urgent investigations for critical care patients were prioritised.

Access to information

- Staff obtained most of their in-house information via the hospitals intranet and shared drive. This included policies and procedures, mandatory training, and emails from matrons. Computer terminals were available in patient bed spaces, which allowed access to information.
- When patients were admitted to ACCU, a verbal handover was provided to the medical and nursing staff as well as written information in the patient records.
- Patient investigation results, including blood tests and diagnostic imaging, were available electronically.
- Staff said some of the computers were quite old and sometimes accessing information was difficult as the computers were slow. The shared folders were difficult to navigate which could limit agency staff access to key policies and procedures.
- During the inspection senior staff told us they were trying to develop one page summaries for all policies so that information was more accessible and quick to read.
- The ACCU had developed the 'ACCU Booklet' which condensed several things such as blood results, care bundles, MRSA screening and microbiology surveillance. Staff told us this meant they were not duplicating information which saved time.

Consent and Mental Capacity Act (include Deprivation of Liberty Safeguards if appropriate)

- All staff we spoke with understood the need to obtain consent from patients before performing care talks, investigations of giving medications. Where staff could not obtain consent, for example unconscious patients, staff explained they provided care in the patients best interests.
- We observed staff seeking consent from patients throughout critical care, including explaining the rationale behind each procedure being performed. We observed staff explaining what they were doing to unconscious patients.
- We reviewed five patient records and found completed consent forms in each of them.
- Staff completed Mental Capacity Assessments for people who they believed may lack the capacity to consent. Key information about mental capacity protocols and Deprivation of Liberty Safeguards (DoLS) were available on the shared drive. There was also information about DoLS displayed on a notice board in the staff room.
- Staffs knowledge of DoLS was good. Staff could explain the principles behind DoLS and were clear how this was applicable in a critical care setting. For example, staff knew to use hand mitts a DoLS assessment needed to

be completed. We reviewed some patients' records and found evidence of a DoLS checklist which was in place for a patient requiring mittens. This checklist was appropriately completed.
- Senior staff told us they submitted around three DoLS assessments per week.
- Staff were unsure about the use of independent mental capacity advocates (IMCAs) and told us they would seek support from the matrons.

Are critical care services caring?

Outstanding ☆

We rated caring as outstanding because:

- Patients were positive about care across the service and we observed compassionate and courteous interactions between staff and patients.
- Relatives told us the staff were respectful and helpful and gave them regular updates and felt suitably involved in patient care
- Observations of care showed staff maintained patient privacy and dignity and staff gave full explanations when providing information, allowing patients and relatives to ask questions.
- Staff provided emotional support to patients and relatives and could signpost to services within the organisations as well as external organisations for additional support.

Compassionate care

- All the patients we spoke with were extremely positive about the care and treatment they received on the unit. Patients said things like: "I am very happy with the care I have been given", "The care is very good here, the nurses work hard", "It's been amazing I am so grateful", "It's fantastic here and so friendly and open, they meet my needs".
- We observed staff chatting with patients and asking them questions about their interests. Patients told us staff made them feel comfortable.
- Relatives told us they were confident that patients were safe whilst staying on the ACCU and were confident in the care being provided. They told us doctors, nurses and other staff were caring, compassionate and responded quickly to their needs. We were told staff were transparent and honest.
- We observed staff maintaining patients' privacy and dignity at all times by keeping them covered and drawing curtains for washes. Staff took extra care to ensure curtains were fully closed during ward rounds and when discussing care with patients.
- We observed several interactions between staff and patients, saw staff speaking to patients in a calm and reassuring manner, and listened to what patients had to say.
- All staff treated patients in a compassionate and courteous manner. Staff were friendly and approachable but always remained professional.
- We observed medical staff during ward rounds and found they interacted appropriately with patients. Staff took extra time to explain care and treatment options and answered any questions the patients had. Staff reassured patients around any concerns and empowered patients by telling them how well they were doing despite any setbacks. Patients told us staff always made time to answer their questions even if they were busy.
- We observed physiotherapists encouraging patients with their rehabilitation in a supportive and positive way. One physiotherapist had made time to come to the ward 30 minutes before the appointment to inform the patient they were coming and give them time to take some pain medication.
- We observed many thank you cards and letters expressing gratitude and compliments from previous patients about the care they received.
- During the inspection, we saw the staff had put up a 'happy birthday' sign for a patient with some floral decorations. Staff told us if patients were able to eat then cake could be provided.
- The majority of relatives were very positive about the unit and staff and said things like: "The staff are fantastic", "They do small things that make a difference like offering to get me a chair and asking how I am", "All the nurses are superb and super attentive", "I feel my relative is not a burden on them, they always have time", "I am very happy I know my relative is safe here", "Everything is perfect, it couldn't be any better. It is an excellent service with sensitive and supporting staff".
- The ACCU was participating in the 'I want great care' patient survey to obtain patient feedback on the service to make improvements. We reviewed some of the comments of this and they were very positive such as

"Dedication of the staff is second to none, wonderful in every way". In April 88.9% of patients and relatives said they would recommend the service to others, and the service was rated 4.75 out of five stars.

Understanding and involvement of patients and those close to them

- We saw nurses, doctors and therapists introducing themselves to patients and families at all times.
- We observed doctors on ward rounds offering patients and relatives the opportunity to ask questions and to clarify anything they were unsure of. Patients said they were given opportunities to ask questions and these were answered by staff. Patients and relatives told us staff would always explain things in a language they could understand. They considered staff talked to them at an appropriate level of understanding and valued the fact that staff listened to their views.
- Patients told us they were always kept informed of the treatment plans and staff explained any test they were due to have.
- We observed staff interacting with patients and involving them in decisions about their care, for example one patient discussed dietary requirements and when they felt they would be ready to move to eating solid foods again.
- We saw one patient who had pictures within their bed space.
- Staff ensured patients were fully informed before completing any intervention. For example, we observed a physiotherapist explaining some exercises to a patient.
- When patients were thought to have brain stem death or if there was a plan to withdraw life-sustaining treatment, the possibility of organ donation was discussed with the patients' next of kin. The ACCU and the specialist nurse for organ donation did this collaboratively where possible.
- The unit had a 'you said, we did' board which gave feedback on changes that have been made as a result of patient and relative feedback. For example, after feedback about food the unit had introduced an oven so patients could have oven cooked meals and warm desserts. The service had also started using proper plates and cutlery rather than plastic ones.

Emotional support

- A multi-faith spiritual team was available to provide support within the hospital. There were information leaflets available on the ward informing patients and relatives how they could access this.
- Feedback from patients and relatives was positive and they told us staff were supportive and had been reassuring and comforting during difficult times. Staff demonstrated an understanding of the patients and relatives situation and worked well to lower peoples anxiety. We observed all patients were spoken to in a kind and empathetic manner.
- ACCU had support from a psychologist who worked with patients and relatives. There was a follow up clinic for ACCU patients, which was led by a consultant and supported by band 6 nurses for rehabilitation post admission to ACCU. The psychologist told us this gave patients the opportunity to discuss their scans and care and treatment. Patients were also able to visit the ward.
- The psychologist directed patients and relatives to external support organisations.
- Relatives were offered hair cuttings and handprints.
- There was an annual memorial service held for attendance by relatives and staff to remember patients who passed away within critical care.

Are critical care services responsive?

Requires improvement

We rated responsive as requires improvement because:

- Occupancy rates were greater than the Royal College of Anaesthetists recommendation of 70% critical care occupancy. This could limit the unit's ability to take emergency admissions due to a lack of bed space availability.
- A considerable number of discharges were delayed, although the service were doing a lot of work around this to try improve flow.
- Despite a diverse local population signs and information leaflets were only available in English.
- The ICU side of the ACCU had more out of hours discharges than other similar units.

However:

- Flexible visiting was available for patients relatives on request and there was accommodation nearby should relatives wish to stay over.
- The service did not receive many complaints and there was evidence of learning from the complaints that they did receive. Learning was shared with staff in the daily safety huddle.

Service planning and delivery to meet the needs of local people

- ACCU served a combination of specialities, including post-operative patients and medical patients. Patients could be admitted after elective or emergency operations or after becoming medically unwell, either in the community or on hospital wards.
- Staff told us the number of elective surgery cancelled because of a lack of ACCU beds had decreased over the past three years. We reviewed an ACCU surgical bed order and saw since May 2014 there had been a steady decrease in the number of cancellations. So far in 2016 seven procedures were cancelled due to lack of critical care bed available, which accounted for 5% of all cancellations.
- The ACCU could flex patient distribution to respond to patient need. For example, ACCU was intended to care for 22 level two patients and 22 level three patients. Staff told us they were able to increase the number of level three beds as required.
- ICNARC data from April 2015 and March 2016 showed the HDU primarily admitted non-surgical admissions (52.3%). Elective surgery represented 39.4% of admissions and emergency surgical admissions were 8.3%. The ICU primarily admitted non-surgical admissions 65.2%. Elective surgery represented 11.6% of admissions and emergency surgical admissions were 23.2%. Non-surgical admissions meant patients came from emergency departments, other wards or hospitals and other critical care units.
- Unplanned admissions to the ACCU were referred to the consultant on duty who was responsible for deciding whether patients should be admitted for care.
- Patients admitted to the ACCU for four days or more were invited to attend a follow-up clinic once they had been discharged from the hospital. The follow-up clinic was run by a consultant, nurses and the unit's psychologist. Staff told us this gave patients the opportunity to discuss their time on the ACCU, for example going over scans. The psychologist also used this time to discuss mental well-being and made referrals to local support groups.

Meeting people's individual needs

- Visiting times on the ACCU were between 2pm and 8pm each day and we saw signs informing patients to contact the nurse in charge should they require visiting outside of these hours. Staff across the ACCU told us there was flexibility with visiting times if needed, which relatives confirmed. For example, one relative worked shifts and was able to visit the unit earlier in the day.
- There was information about the leadership team available at the entrance to the unit, which included a photo board.
- There were three rooms available which relatives could use should they require any quiet time. These rooms could also be used for difficult or confidential conversations with relatives.
- There was accommodation available on site for relatives who lived a significant distance away or who had difficulty accessing the hospital whilst patients were admitted. Relatives told us staff had offered them use of this room.
- A translation service was available for patients and their visitors. Staff told us they could book both telephone and face-to-face consultations and told us services were available in a range of different languages.
- Vending machines were available on the unit for relatives to buy snacks and drinks.
- The unit was able to issue death certificates to speed up the release of the body to meet the needs of certain religions.
- Relatives and patients had access to a multi-faith service and information on how to access this was displayed on the unit.
- There was a DVD library available for patients who wished to watch a film.
- At the time of the inspection there were no patients on the ward with learning disabilities. Staff told us if there was a patient with a learning disability, they would link with the safeguarding team and learning disability nurse within the trust. The unit could access agency carers for additional support.

- Dementia awareness training was a mandatory topic for all trust staff and had been completed by 99.53% of ACCU staff. Staff we spoke with were unable to identify any specific mechanisms in place to support patients with dementia.
- A designated psychologist was available to support relatives. We saw signs posted around the unit informing relatives how to access this support.
- Some information leaflets were available in the waiting areas of the unit and at the reception desks. However, these were only available in English.
- Feedback from relatives had led to the service improving the use of signs, however all signs were in English. This could make it difficult for relatives to navigate their way from the main reception to the ward if English was not their first language.
- We were told younger children are discouraged from visiting due to infection control concerns and we saw no toys available in the waiting area for young children. However, during the inspection we saw one child had been allowed to visit a patient at the request of the relative.

Access and flow

- The critical care unit had a clear admission policy and admission to critical care was usually agreed by the consultant on shift. Admissions were coordinated Monday to Friday by the designated bed manager for ACCU.
- Between April 2016 and June 2016 the average bed occupancy on ACCU was 89.9%. Between January 2016 and March 2016 the HDU had a bed occupancy rate of 98.7% and the ICU 99.1%. These occupancy rates were greater than the Royal College of Anaesthetists recommendation of 70% critical care occupancy. The recommended occupancy rates allow units to be able to take in more patients should there be an emergency. If a unit is at higher occupancy it may be unable to respond to emergency admissions and may be required to step down patients too early. Delay of critical care admission was on the risk register.
- We reviewed five patient records and found unplanned admissions were admitted within four hours of the decision to admit being made.
- Recommendations form the Faculty of Intensive Care medicine Core Standards for Intensive Care Units identify that patients should not be transferred to other units for non-clinical reasons. ICNARC data from April 2015 to March 2016 showed there were no patient transfers out of the unit for non-clinical reasons on the HDU side of ACCU. Six patients were transferred out of the ICU for non-clinical reasons during this period, which was in line with other similar units.
- Trust data showed us there had been one serious incident in May 2015 where a patient had deteriorated whilst waiting for transfer to the ACCU. There had been seven incidents over the past 12 months reported due to a lack of bed availability on ACCU.
- Between April 2016 and June 2016, the ACCU had delayed discharges to wards of greater than four hours for 76.6% of their patients. Both the HDU (10.8) and ICU (4.35) parts of ACCU were performing worse than the national average for mean number of a patients using critical care beds for more than 24 hours after the decision to discharge, which was 3.6.
- Staff told us they experienced difficulties in discharging patients from critical care due to a lack of bed availability in the rest of the hospital. Delayed discharges can have a knock on effect such as blocking beds for new admissions to the ACCU.
- Trust data showed us the main reason for delayed discharges on ACCU were availability of ward beds to receive ACCU step down patients due to competing demand for ward beds for patients in the emergency department, as well as same day elective surgery. There were also issues in repatriation of neuro-trauma patients from key step down wards including the neuro-monitored unit and neuro and trauma wards.
- Senior staff worked with the ACCU on a daily basis to improve the flow issues and prioritise the use of beds. There were two site meetings a day to discuss bed and flow issues. Significant problems were regularly escalated to the hospital management and trust.
- The unit reported 169 mixed-sex accommodation breaches between August 2015 and July 2016. A mixed-sex accommodation breach occurs in a critical care unit when there are male and female patients in the same unit and one or more of them no longer needs that level of critical care and becomes ready to be transferred to a level one unit, but there is no available bed for transfer. We were told patients breach at 10pm at night if they have not left the ACCU on the day in which the patient was considered fit for discharge or step down from the ACCU. NHS England states that it is not acceptable to set a time limit before recording a breach as the breach occurs the moment the patient is

places in the mixed-sex accommodation. Once the patient no longer needs that level of critical care, they become an unjustified breach and should be recorded both locally and nationally.
- Patients discharged from critical care 'out of hours' between 10pm and 7am are nationally associated with worse outcomes. ICNARC data from April 2015 and March 2016 showed the HDU had 36 patients which was in line with national performance. The ICU had 30 patients discharged out of hours which was worse than national performance.

Learning from complaints and concerns

- The ACCU had received four formal complaints within the past 12 months. We reviewed letters that had been sent to relatives, which offered an explanation and apology.
- Information about how to make a complaint was available in the ACCU reception. Staff told us they tried to manage complaints at a ward level to try offer an immediate solution.
- One complaint had been around the lack of signage on the unit, this had been escalated to the safety huddle and improved signage had been installed on the unit in response.

Are critical care services well-led?

Good

We rated well led as good because:

- There was a robust governance structure within the critical care team. The management team had a good oversight of the risks within the service and any mitigating plans were in place. Staff received timely feedback where necessary.
- We saw examples where concerns from critical care were escalated appropriately within the trust, for example delayed discharges and bed flow.
- We saw good leadership within the unit and this was reflected in the conversations we had with staff. There was a positive culture across the service and staff spoke positively about the leadership team.
- There was evidence of staff and public engagement and changes being made as a result of feedback.
- Senior leaders had a good understanding of the access and flow difficulties within the service. A report had been produced to highlight what the main challenges were and a number of actions were being taken to improve this. There were regular meetings with bed management and concerns were escalated to the trust.

However:

- The risk register did not fully document all risks identified across the unit, for example the unlocked medication cupboards.

Leadership of service

- Clinical leadership was the responsibility of the divisional director who worked closely with the clinical lead consultant and matrons for critical care.
- Two matrons shared responsibility for the leadership of the critical care unit and were supported by the service manager and clinical lead. Matrons jointly held responsibility for the ACCU and were responsible for all aspects of nursing provision within the unit.
- During our inspection we noticed senior staff were visible on the wards and knew ward staff across the service. Staff across critical care spoke positively about the senior leaders, praising their supportive attitudes and open approach to management. We were told they were readily available and approachable.
- Three supernumerary shift coordinators were allocated to each nursing team to provide immediate leadership and support. Staff felt well supported by the shift coordinators and said they had regular contact throughout the shifts.
- The nursing and medical clinical leadership teams worked collaboratively to plan and deliver a safe and responsive critical care service. We saw good evidence of communication and a good relationship between the teams was evident.
- Staff at all levels, including senior nurses and ward clerks, told us their roles were valued and they felt the management team cared about them and their well-being.

Vision and strategy for this service

- There was evidence of a local strategic document, which outlined key areas for improvement and the leadership team's vision for the service. This included ensuring that 'the right patient was in the right place at the right time' and each patient had immediate access to critical care services as needed.

- The leadership team were clear in their vision to harmonise clinical guidance and practice across the four sites and improve cross-site working. The focus was on building a strong internal network within the trust to enhance sharing of best practice and learning.
- The educational strategy was to deliver a sustainable development programme for all nurses and healthcare support workers. The focus was on combining and offering opportunities in three domains; professional development, academic accreditation in post graduate qualification and clinical governance. The educational strategy was reviewed on an annual basis to see what had been delivered and what the forthcoming educational priorities were for the ACCU.
- Staffing was an ongoing issue for the service and senior leaders told us the strategy around workforce was to work towards being fully established. The ACCU had rolling adverts and the unit was recruiting from overseas. We saw evidence of work going on around retention including staff questionnaires and exit interviews. Staff told us they received regular updates from senior leaders around recruitment and retention.
- Staff knew how their work contributed to the wider vision of the trust and were aware of the trust values. Staff told us values were discussed during the trust induction and were embedded in their practice.

Governance, risk management and quality measurement

- Clinical governance and risk management meetings were held monthly and were attended by a range of senior staff members including the service manager, matrons and lead governance. There were also representatives from ward level staff such as band 6 nurses. We reviewed minutes from clinical governance meetings which showed a comprehensive review of incidents and on-going issues. Senior staff told us key information from these minutes was disseminated to ward staff via the band 6 meeting, clinical governance newsletter and daily safety huddle.
- We attended one of the governance meetings and noted it was attended by a range of clinicians. The meeting was medically led but there was good evidence of challenge and discussion between professions.
- We reviewed minutes from the band 6 meeting and saw key issues were discussed and clinical governance information was fed back.
- Staff received frequent feedback about incidents and cross-site learning was disseminated during the daily safety huddles. The daily safety huddle ensured staff were aware of any quality improvement strategies and changes.
- Senior leaders told us they were happy with the governance framework for the ACCU. There were monthly performance reviews for the division and regular meetings with commissioners regarding CQUIN targets.
- The ACCU had weekly morbidity and mortality (M&M) meetings which was led by ACCU consultants.
- There were regular meetings with the ACCU bed manager to discuss difficulties with flow. Senior leaders were aware of the issues with flow and this was discussed at a trust level.
- The ACCU had a rolling programme of audit presentations combined with anaesthesia which included one half day fully dedicated to critical care every 6 months. The ACCU participated in 10 audit half days per year in line with the Trust Audit calendar. The programme and presentations were shared with other departments for eight out of these 10 days. Results from both local and national audits were fed back at audit meetings, governance meetings and senior staff meetings as well as local service meetings depending on the topic.
- Senior critical care staff, including the matrons were responsible for overseeing risk management, including the maintenance of the relevant risk register. Senior staff were aware of the risks on the register and who was responsible for maintaining the document. There were a total of nine risks listed on the register and these appropriately reflected concerns regarding critical care. However, unlocked cupboards in the medication room were not documented.

Culture within the service

- There was an open door culture encouraged on critical care and staff told us they would feel comfortable raising any issues with the ACCU matrons.
- Staff commented there was a culture of 'no blame' should things go wrong. Everyone was encouraged to learn from incidents that occurred both within the ward and across the trust.
- Staff told us there were good levels of support and opportunities to develop. There were good

arrangements for mentoring and staff training. We saw staff were keen to share their knowledge with each other and observed staff asking questions and seeking guidance
- Staff at all levels were proud to work of the service and told us they had good working relationships with each other and morale was good. We observed staff work together to complete tasks and ensure suitable patient care took place. Staff told us they organised social events for outside work.
- Compliments and feedback from the 'I want great care' feedback forms were communicated to staff via email and the safety huddle.
- Senior management valued the ward staff and told us "we focus on looking after the staff", this was mirrored by the staff themselves.
- Staff understood the important of being open and honest when things went wrong. However not all staff knew what duty of candour was and there had been no training on duty of candour.

Public and staff engagement

- There were regular team away days held on the unit to develop staff skills, knowledge and improve teamwork.
- The ACCU encouraged patients and relatives to complete the 'I want great care' feedback forms. These were available in each of the reception areas and were available in different languages. Feedback was emailed to staff and used to improve the service.
- Clinical governance information was communicated to staff via a monthly newsletter and also during the daily safety huddle.
- The ACCU had a monthly critical care recognition award for all staff, including ward clerks. Staff were recognised for good work and rewarded with a voucher.
- There was a 'what you have said, what we have done' board on display at the entrance to the ACCU. This displayed what improvements the unit had made as a result of feedback from patients and relatives. For example, feedback about the quality of food had led to a project to improve food and nutrition. Both staff and members of the public were involved in the food tasting session looking at the quality of meals.
- Matrons had done a staff questionnaire to find out what contributed to a positive working environment. This was part of a project looking at staff retention and what contributed to good levels of support.

Innovation, improvement and sustainability

- The ACCU had developed a Stimulation Training and Inter-professional Teambuilding for Critical care Health workers (STITCH) programme. This was an in-house simulation programme developed to ensure best practice and improve patient care for a frequently changing medical workforce. We were told STITCH allows staff to work together which improves team working and better communication. The training used national guidance, such as 'on the right trach' to write simulation scenarios. Sessions were spaced to ensure all critical care staff were exposed to the training over the year. STITCH won an award for best simulations education award from the British Association of Critical Care Nurses (BACCN).
- A critical care consultant had developed a smart phone application called 'iCU Notes'. This was a free application for critical care practitioners. The application provided guidance to both patient management and organ support. It also aimed to stimulate thought about underlying patient pathology and potential complications specific to critical care. The application included management guidelines specific to the ACCU such as sepsis and post cardiac arrest care and liver failure. Senior staff said the application could help standardise treatment across the different sites. Staff told us they had found the mobile phone application very helpful.
- The ACCU was involved in a project called 'Regional Citrate Anticoagulation for Continuous Renal Replacement Therapy in Critically Ill Patients: New Innovations for Old Machines'. The ACCU had helped develop software and hardware upgrades to the Aquarius system to bring it in line with current recommended practice. The Aquarius system delivers Continuous Renal Replacement Therapy for patients in critical care who develop acute kidney injury.
- To address recruitment difficulties the ward matrons had conducted staff surveys looking at retention. Feedback from staff highlighted a theme of 'good support' and further work had been done to identify what good support looked like. This led to changes in the way handovers were conducted.
- The ACCU was a finalist for the student placement of the year award.

Critical care

- Senior staff told us the trust had been placed into financial special measures and said despite this the focus was very much on the patient and providing good care. No staff highlighted concerns with access to training due to financial constraints.

Maternity and gynaecology

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

Information about the service

The Royal London Hospital (RLH) is part of Barts Health Trust. It provides maternity and gynaecology services to the population of Tower Hamlets in East London. The hospital also provides specialist maternity services to women from other hospitals within the Barts Health NHS Trust, and fetal medicine to women from a wider geographical area. The unit delivers over 5,000 babies every year, and numbers are increasing each year.

The maternity unit has a 31 bedded delivery suite, two obstetric theatres, and an obstetric high dependency unit on the 6th floor. The postnatal ward on the 8th floor has 31 beds and cots. The antenatal clinics are also on this floor.The maternity unit is supported by a Level 3 neonatal unit.

The Barkantine birth centre is located on the Isle of Dogs. It is a stand-alone unit run by a midwives and has five rooms. Women can also choose a home birth supported by community midwives. 7.7% of women give birth in the birth centre or at home.

All women attend the hospital for their first antenatal appointment and ultrasound scans, and most then attend antenatal clinics run by community midwives in health centres and GP surgeries. Specialist antenatal clinics at the hospital are run for women whose health conditions need additional specialist input for example those with mental health concerns, heart, kidney or neurological conditions. Postnatal clinics are run in the community and at the birth centre.

Gynaecology services include inpatient beds for up to 20 patients, day case procedures and outpatient services. RLH is a specialist endometriosis centre. There are clinics for general gynaecology, rapid access clinics, colposcopy, hysteroscopy, uro-gynaecology menstrual disorders and a combined colorectal and gynaecology clinic. An emergency gynaecology unit, for women with early pregnancy concerns referred by their GP, or from A&E, is open on weekdays and Saturday mornings.

Termination of pregnancy services (TOP) are provided for a small number of women with complex medical problems, who are not suitable for Silvia Pankhurst Health Centre at Mile End Hospital. The service also provides a mid-trimester termination of pregnancy for women between 14-19 weeks under Clause 4 and 5 of the Abortion Act 1967.

We inspected all the maternity and gynaecology areas including the freestanding birth centre. We spoke with over 60 members of staff, some on an individual basis and others in joint meetings. These included midwives, obstetricians and gynaecologists, nurses, maternity support workers, senior managers, administrators, receptionists and domestic staff. We spoke with 17 women and five family members. We observed patient care, staff interactions, the availability of equipment and the environment. We reviewed written information provided by the trust in advance of the inspection and afterwards. We considered formal arrangements for audit and the management of risk to evaluate the governance arrangements.

We did not inspect the gynae-oncology service.

Maternity and gynaecology

Summary of findings

Part of the purpose of the inspection had been to follow up concerns about the maternity services identified at the previous inspection in January 2014.

Overall we rated the maternity service was inadequate, although we did not have significant concerns about the gynaecology service:

- Insufficient progress had been made in response to concerns raised in the inspection in January 2015 in respect of staffing, capacity and security.
- We found in September that the key concerns about baby security that we raised on inspection in July, had not been promptly addressed and careful checking had lapsed only two months later.
- There were not enough midwives on wards, day or night. Numbers of clinical midwives were significantly below establishment and staffing levels in the previous year. This slowed down processes on the delivery suite and the postnatal ward and prevented some women from getting timely care.
- Only 92% of women had 1:1 care in labour which is recommended by the Department of Health.
- The delivery suite coordinator was not supernumerary and therefore unable to have the constant oversight of the delivery suite necessary to support staff and manage capacity.
- Processes for ensuring baby security were weak. Not all mothers or babies were wearing name bands and midwives were not checking that babies had labels. There was no local or central guidance on making appropriate checks when baby labels were missing.
- The infant abduction policy had not been promulgated to staff. However the policy itself was deficient as it assumed the use of an electronic baby tagging system which was not in use in the hospital.
- The system of dual risk registers for site and cross site risks was confusing and did not provide clarity and transparency to managers around service risks.
- The level of consultant cover on the delivery suite was 71.5 hours a week which falls far short of the Royal College of Obstetricians and Gynaecologist recommendations.
- Women we spoke with had inconsistent experiences, some very poor, of the maternity services, and some women and partners reported a lack of respect from midwives.
- There was unwillingness among some midwives to adopt new processes: the morning safety briefing and the use of a second person to review fetal heart rate patterns at regular intervals were examples.
- Record keeping was not consistent and accurate, particularly of handover of care from the delivery suite to the postnatal ward.
- Midwifery leaders were out of touch with morale of midwives which had deteriorated since the previous inspection.
- The maternity service did not demonstrate care for its own staff, rosters were late, approval of annual leave was slow, midwives felt their concerns were not listened to and morale was low.

However

- Improvements had been made since January 2015 in assessing and monitoring the service.
- Clinicians planned and managed care in line with current evidence-based guidance, standards and best practice.
- Additional capacity for midwife led birthing was due to open in November 2016, which would release more space for postnatal women.
- Secure archiving for ultrasound scans was being rolled out and already used in some areas. It would be available throughout maternity and gynaecology service in autumn 2016.
- Incidents were being investigated and closed in a timely way
- Gynaecology services were well managed and provided a responsive service to women.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Inadequate

We rated the maternity services as inadequate for safety, although this rating did not apply to the gynaecology service. The rating for maternity was because:

- There were not enough midwives on the delivery suite to provide safe cover for all women. Numbers of midwives working clinically were below the numbers in the previous year and, due to vacancies, well below the funded establishment of 1:28 which had been agreed to reflect the acuity of women. There were daily gaps in shifts on the delivery suite. Midwives felt the impact of tight staffing more acutely at night when there were fewer other staff in the unit. Staff shortages were more marked at night. Although the funded establishment had improved since the last inspection, numbers of midwives working clinically had not. Staff told us the actual ratio of midwives to births was closer to 1:36.
- The delivery suite coordinator was not supernumerary and therefore unable to have the constant oversight of the delivery suite necessary to support staff, particularly new staff and manage capacity.
- The level of consultant cover on the delivery suite was 71.5 hours a week which falls far short of the Royal College of Obstetricians and Gynaecologist recommendations for the size of the unit, and the number of births was increasing each year. This had not changed since the last CQC inspection.
- A number of babies on the postnatal ward had no identification labels. There was no systematic checking of babies' labels, creating a risk that a baby might receive medication intended for another baby, and mother might leave the unit with the wrong baby.
- The trust infant abduction policy, revised after the previous CQC inspection, had not been promulgated to staff. However the policy itself was deficient in that it assumed the use of an electronic baby tagging system not in use in the hospital. No interim abduction arrangements had been drawn up which indicated safety was not a sufficient priority.
- Women's and babies' notes were inconsistently completed, particularly the handover to postnatal care and notes on the postnatal ward.
- Although improvements had been made in physical security since January 2015, through swipe card access and receptionists on the postnatal ward and the delivery suite, this was not fully effective in restricting visitor access to the delivery suite and postnatal ward. Midwives felt they were at risk at night on the delivery suite.
- There was pressure on bed capacity for postnatal care. The anticipated opening of the hospital's low risk delivery unit to increase birth capacity, and release rooms on the 6th floor for postnatal beds, had been delayed. It was due to open in November 2016.
- Midwives reported that there was not always enough equipment on the delivery suite.
- Staff were not attentive to the details of checking and cleaning clinical items such as resuscitaires (routine warming and baby resuscitation equipment for the delivery room).
- There was little awareness among staff about major incident plans.

However:

- We did not have safety concerns about the gynaecology service.
- The hospital had effective systems for reporting, investigating and acting on incidents and serious adverse events.
- All the clinical areas we visited were visibly clean and well-maintained with display boards detailing cleanliness and safety information.
- The observation of women's vital signs on wards was carried out systematically and there was a clear escalation process for deteriorating women.
- Sepsis management had been reviewed and new protocols were in place.

Incidents

- RLH had reported no never events in the maternity and gynaecology services between June 2015 and May 2016. Never Events are serious incidents that are wholly preventable as national guidance or safety recommendations that provide strong systemic protective barriers are available. There was a clear framework for investigating never events.
- All the senior team in maternity and gynaecology received copies of potential serious incidents (SIs) to ensure that there was wide awareness among managers.

Maternity and gynaecology

Maternity

- Between June 2015 and May 2016 18 serious incidents were reported in maternity. We saw SIs were discussed at a weekly multidisciplinary risk meeting, recorded on a standard template and escalated within 48 hours to the Chief Medical Officer (CMO) and the Chief Nurse (CN).
- A computer based incident reporting system (Datix™) was used to report incidents. When an incident was designated an SI, two people were responsible for investigating the incident, using a standard format comprehensive investigation report. The local SI panel co-opted other professionals as necessary. There was external scrutiny, in round table quality assurance, at the end of the investigation process, to ensure quality and avoid bias in the most serious cases. We looked in detail at three serious incident investigation reports. The process was in line with Safer Childbirth requirements and the Serious Incident Framework, March 2015.
- Learning points, recommendations and action plans were drawn up following investigation of serious incidents: 'Sharing the Learning' slides were developed, as well as leaflets reflecting lessons from incidents. For example, we saw a leaflet on risk management of cardiotocography (CTG) in second stage of Labour (June 2016). Learning was disseminated through safety briefings, e-mail, newsletter, team meetings and direct feedback. We saw copies of a quarterly governance newsletter summarising incidents, complaints and claims, including a trend analysis. Memes and pictorials were used to make a point memorable for staff with humour or photos, such as the 'Don't be a Grumpy cat' reminder for MEOWS charts for all women admitted in labour.
- The hospital shared learning more widely, in relevant cases, through NHS England, the pan-London obstetric network and through the Supervisors of Midwives network.
- In response to an SI relating to 50 missing screening results, the organisation had responded effectively by introducing processes to minimise risk, such as daily checking of clinic lists, telephoning women for whom there were no blood test results, and ensuring the Emergency Gynaecology Unit (EGU) notified the maternity unit of women who had miscarriages. However, staff turnover meant that some clinic midwives were unaware of the reason for this process.
- Another SI had involved poor checking of resuscitaires. The standard of resuscitaire checking had not improved since the incident as we saw several that were not clean.
- We asked if the trust could assure itself that doctors including consultant had SIs and complaints linked with their appraisals. We were told there was no trust wide process for this. It would depend on the clinical director.
- The level of incident reporting was high which indicated a good reporting culture. Between April 2015 and March 2016, 991 clinical and non-clinical obstetric incidents were reported. Clinicians said they received feedback. The top five incidents themes were communication, obstetric haemorrhage, staffing, delays in care and unanticipated admissions to NICU.
- Anaesthetic incidents were displayed on the wall of the anaesthetic office as 'Learning Points of the Week'. These were mentioned in the daily safety briefing which covered new protocols and new equipment. We saw evidence of follow up of obstetric anaesthetic episodes. An example of change in response to an incident was that when it had been found staff opened sets of surgical instruments to obtain sponge forceps (blunt-tipped forceps used to grasp swabs and gauzes) it was decided to use disposable sponge forceps to prevent this occurring. There was also a teaching programme about not removing instruments from trays. The problem had been resolved.
- We saw some high quality presentations presented to mortality and morbidity meetings (M&M), but it was unclear how the learning from these meetings was disseminated more widely.
- Staff told us that managers had recently discouraged midwives from reporting staffing shortages as incidents. We thought this unhelpful because so many medical staff as well as midwives told us there were not enough midwives, and we saw this for ourselves. In this situation, reporting was the correct route to highlight the issue to management. We recognised that the funded establishment had increased and recruitment was in progress, but this was not yet providing enough staff on the ground. The numbers on the delivery suite were generally below establishment which left staff feeling stressed and often unable to take breaks.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires health service providers to notify patients about certain notifiable safety incidents and provide reasonable support to the person affected.
- There were formal processes in place for ensuring duty of candour responsibilities were carried out appropriately and we saw evidence that this had occurred. Senior staff were responsible for communicating with and apologising to patients and their relatives. Women and families were seen immediately, and timely letters were issued. Families were advised of the 'being open' process and offered resolution meetings. A clinician was named as the point of contact for the family to keep them in touch with progress of the investigation.
- The incident reporting template included a section on duty of candour to confirm staff had shared information appropriately with patients and their relatives. Incidents could not be closed on the system until this information had been completed.
- Although midwifery managers told us Duty of Candour was well embedded into the maternity service, many clinical midwives did not recognise the term and said they had not had any training. However, they clearly understood the principles of openness with women and families when mistakes occurred.

Gynaecology

- For gynaecology (including fertility which we did not inspect), there were 75 reported incidents in the year to end March 2015. This was a far lower number of incidents reported than in maternity. Analysis showed the top themes were communication both verbal and written, medication, treatment, including actions not carried out, and side effects of treatment.
- Gynaecology nurses told us they had feedback from incidents and that incidents were discussed at team meetings.

Safety thermometer

- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing harm free care. The hospital used its own variant of this. Current safety thermometer results were displayed on ward 'safety cross' boards along with other performance indicators. This meant safety performance information was available to patients and their families.

Maternity

- Information displayed at the entrance to the delivery suite showed cardiac arrests, pressures ulcers, infection control, 1:1 midwifery care and staffing levels. Staffing records showed there was more than one member of staff missing every day in July although 1:1 care for women in established labour had been achieved that month.
- The NHS maternity safety thermometer, designed for use in maternity care, was not used. This meant that women did not readily see the harms specifically associated with maternity care: perineal or abdominal trauma, post partum haemorrhage, infection, separation from baby and psychological safety.
- The maternity dashboard was on display on the postnatal ward. While it was helpful to make this data publicly available, this tool was primarily designed for professionals and was not easy for women to understand, especially those who did not speak English as a first language.

Gynaecology

- The gynaecology ward's safety display showed mainly harm free care since April 2016. There had been two patient falls up to July 2016: a 50% improvement on the previous year.

Cleanliness, infection control and hygiene

- We inspected all areas of the maternity and gynaecology services, including the obstetric theatres. All the clinical areas were visibly clean and well-maintained. The ward environment was clean, tidy, well organised and clutter-free. The floors in corridors were clean.
- There was evidence of domestic staff following guidance on required cleaning standards, practices and frequency of cleaning. Environment scores for cleaning were 100% for inpatient wards. The Patient-Led Assessments of the Care Environment (PLACE) reports for 2015 also concluded the cleanliness of the environment supported good care.
- We observed that staff adhered to the trust's 'bare below the elbow' policy, and there was ready access to personal protective equipment, such as gloves and aprons, which were disposed of appropriately.

Maternity and gynaecology

Maternity

- Hand sanitising gel was placed on reception desks rather than at the entrance to clinics or wards. We saw staff remind some women and visitors to use gel, but there were no signs encouraging people to use it. The bottles were not always placed in positions to make their use obvious. We saw that although hand hygiene audits had not been carried out regularly in the past, these were now being done and showing high scores, above the trust target of 90%.
- Maternity staff we spoke with knew the birth pool cleaning procedures.
- There had been incidents of sepsis in maternity, and the hospital had been identified as an outlier by CQC. In response to this we saw that the trust had run a Know your Sepsis Six campaign. (Sepsis six is the name given to a bundle of medical therapies designed to reduce the mortality of people with sepsis.) The Obstetric Infection guideline acted as the maternity sepsis guideline. The aim of this policy was to facilitate early identification of infection and initiation of appropriate and timely antimicrobial therapy to prevent sepsis and adverse maternal and fetal /neonatal outcomes. The maternity wards, including the maternity HDU had sepsis trolleys containing folders with guidance on recognition and a management proforma, which meant that everything needed to treat sepsis promptly was readily available . Trust policy was that patients with signs of sepsis should have senior review, and those with severe sepsis should have a critical care review.
- Not all the clinical equipment we reviewed was visibly clean even when labelled as clean and ready for use. On the delivery suite we observed poor standards of checking and cleaning clinical equipment, particularly resuscitaires. We saw blood spillage in the drawer of one machine and others were visibly dusty. The policy of daily checking was not being complied with. One resuscitaire had been checked once in 7 days, two others on 2 out of 7 days and 3 had no checking information recorded. This was a concern as there had been an SI in December 2015 in which three resuscitaires were found not to have been working.
- The trolleys used for obstetric emergencies were visibly dusty even though displaying an 'I am clean' sticker with the current day's date. A dusty suction unit had a note saying last tested 27/10/14. A cot in 6F was visibly dusty with a sticker showing it was clean 3 days before.
- We saw a chair stuck together with sticky tape in the birth centre. The tape would have made it impossible to clean the chair properly.

Gynaecology

- The gynaeocology ward and clinical areas were clean and well-maintained. Infection prevention and control was well managed.
- There had been no incidences of clostridium difficile or methicillin-resistant Staphylococcus aureus in the period April 2016 to March 2016.

Environment and equipment

- Wards were accessible to patients and visitors with limited mobility. There were disabled toilets and shower facilities and accessibility rails on walls.
- There were fire extinguishers at appropriate points throughout wards and theatres, checked and in date.

Maternity

- The delivery suite had 31 rooms which were all equipped for women to give birth. Many of the rooms were not used for delivery. Some were used for women and babies after birth as an extension of the postnatal ward and others for antenatal women. The unit was divided into a midwife led low risk (6E) and an obstetric led high risk end (6F).
- The midwife led area had 14 beds which included two triage rooms, an early labour lounge and four rooms for induction of labour (IoL). On one day (27/7/16) the ward was full and midwives told us there were women waiting at home to be admitted for IoL. Midwives offered women the choice of going to another Barts Heath hospital but the uptake of this was low. Women in this situation were asked to attend the day assessment unit to have a CTG and for staff to make a treatment plan.
- The high risk area (6F) adjoined the two obstetric theatres.
- The obstetric theatres were large and well equipped. There was a replacement system for capital equipment as needed. All equipment had in-date evidence of electrical testing and stickers showing that equipment had been serviced by the clinical engineering department or manufacturer. Service records were kept on a database. If equipment was broken it was replaced from the equipment library, or by a loan from the manufacturer pending replacement.

- Midwives reported that there was not always enough equipment on the delivery suite – blood pressure monitoring equipment and digital thermometers were in short supply.
- The obstetric theatre space was cluttered by a lot of extra equipment. One theatre contained nine stools and chairs, a large rack of obstetric cushions, two duckboards, an extra oxygen cylinder, three large sharps bins and, in addition to a well-stocked fluid trolley, another box of IV fluids.
- The trust had 16 sets of caesarean section instruments with a good flow for decontamination. Once used, the sets were collected hourly from the sluice room between 7am and 10pm and decontaminated within 10 hours. The labour ward coordinator discussed expected requirements for the day with the theatre equipment manager, and if necessary some sets could be put on a 5 hour, 'fast track,' turnaround.
- The High Dependency Unit was located next to the anaesthetic office. It had one recovery bed and three beds for women needing a higher level of nursing care. A single recovery bed was not sufficient for the number of women giving birth in the unit, so most women were recovered in delivery suite rooms, which all had outlets for suction, oxygen and air. Staffing levels meant that women could not always be cared for in line with the National Institute for Health and Clinical Excellence (NICE) guidelines requiring one to one care by properly trained staff until a woman had regained airway control and cardio-respiratory stability.
- The postnatal ward had four 4-bedded bays and 14 individual rooms. Three four bedded bays were identified as transitional care bays. The 13 single rooms are used for women with babies in SCBU/NICU, vulnerable women and as amenity rooms.
- Capacity in the delivery suite and postnatal ward had been a challenge at the previous inspection. This was still the case. Staff told us the unit reached capacity often and diversion of women to other hospitals in the trust was frequently discussed. Lack of post natal beds also led to closure or diversion, when the flow of women to the postnatal ward prevented transfer because they ran out of rooms and staff to care for postnatal women. There had been two closures during the week before our inspection. There had been five other closures between April 2016 and July 2016.
- We were told the imminent opening of the midwife led delivery unit (AMU) would increase postnatal capacity by freeing up rooms on the delivery suite. The AMU would have four birth rooms, three side rooms and three triage rooms. When we inspected in September we found the opening would not be until November 2016.
- On our last inspection, checking procedures for emergency trolleys had been weak. We reviewed records over the past 4 months and saw there was now good compliance on checking resuscitation trolleys, neonatal resuscitation trolleys, the hypoglycaemia kit, sepsis trolley and haemorrhage kit. The adult trolley on the delivery suite had missed checks on only three days in July. The two neonatal resuscitation trolleys on the delivery suite had been checked and signed every day.
- The antenatal unit and the fetal medicine unit shared a counselling room. Staff told us this often meant staff had to discuss sensitive scan results with women in the scanning room itself, which was not an ideal space for difficult conversations.

Gynaecology

- The gynaecology clinics had ten examination rooms, where two or three consultant led clinics were held each day. There was also a diagnostic suite of rooms where outpatient hysteroscopy and colposcopy took place.
- The emergency gynaecology unit (EGU) had four side rooms, a treatment room and a recovery room with six couches for recovery after manual vacuum aspiration curettage(MVA). MVA is a procedure for managing miscarriage. There was a separate counselling room.
- The gynaecology ward had 19 funded beds and one other bed. Three of the beds were normally step-down beds and staff said there were six gynae-oncology and 10 gynaecology beds. Many gynaecology patients were treated as day patients and did not come to this ward. There was no day room for patients or a staff room.
- Gynaecology staff were aware that they were not using their theatre capacity fully which they needed to improve to keep up with demand.
- The fetal medicine department had modern ultrasound machines with capability for 3D scanning. The scanner generated the written report. These had replaced old scanners that had been on the risk register because of image quality.
- We had noted on our previous inspection that there was no facility for electronic storage of anomaly scans. The department had started archiving fetal medicine scans electronically within the last two months. Staff said they

could now retrieve all images easily for MDT and teaching purposes. This facility was not yet available for obstetric and early pregnancy scans which were, at the time of inspection, printed on thermal paper and put in patient notes. On the gynaecology ward and EPU we saw a few scans in patient notes without patient names. None were in envelopes to preserve picture quality and prevent fading. This was a significant risk to the service and remained on the risk register. However, improvements in scan image storage for all areas of maternity and gynaecology were due be implemented in autumn 2016, which would remove this risk.

- At the birth centre we noted that the home birth equipment had not been checked daily. We noted two episodes of more than three consecutive days where checks had not been carried out.
- The birth centre had welcoming individual rooms with balconies, and double beds so partners could stay overnight.

Medicines

- We checked the drugs cupboard on the delivery suite. Drugs were stored in locked cupboards. Controlled drugs (CDs) were securely stored in accordance with legal requirements. A separate key was held by authorised staff and daily checks were done on the balances of these medicines in the CD register. There was evidence that pharmacy carried out quarterly audits.
- On the delivery suite the clinical clean utility room, where all drugs and IV fluids were stored, was seen left open on a number of occasions. When we raised this with staff the door was then closed and not seen open again on inspection.
- Temperatures of medicine fridges were checked daily. However, on the postnatal ward (8F) records showed temperatures well outside the recommended range of 2C and 8C for more than four days on two occasions. Staff explained the process of informing pharmacy ,but there was no written evidence that any action had been taken when the temperatures had been high. If corrective action was not taken soon enough to resolve temperature deviations, then medicines may need to be destroyed as they would have been damaged by heat.
- Staff had access to the British National Formulary as well as all policies and information relating to medicines management (including the antimicrobial formulary).
- Staff recorded allergies on the drug charts, alongside other risks such as a VTE risk assessment. Women wore wrist bands to indicate their allergy.
- Medicines supplied and administered under Midwives Exemptions under the Medicines Act, as well as those issued under a Patient Group Direction, were appropriate.
- We saw evidence of consistent twice daily checking of pethidine at the birth centre. Drugs and fluids were stored appropriately in a locked room. Fridge temperatures were checked and recorded, and were within normal ranges.
- We found some medicines not properly secured: antibiotics left unattended in the treatment room on the postnatal ward; saline unlocked on IV trolleys in a delivery room, lidocaine ampoules in two delivery rooms and Vitamin K unlocked on a resuscitaire.
- Wards had access to a pharmacist between 9am to 5pm daily Monday to Friday. They were responsible for screening drug charts, medicines reconciliation, ordering and topping up of drugs from the main pharmacy, ordering the TTO (to take out) medicines for patients and advising relevant patients on specific medicines usage.

Records

Maternity

- At the previous CQC inspection we had concerns about the standard of record keeping. We saw that there had been improvements in record keeping and greater adherence to The Nursing and Midwifery Council (NMC) rules. We saw evidence of intensive training in January 2016 on documentation and record keeping using videos, scrutiny of notes and role plays for senior staff. There was now an on-going record keeping audit. However, despite this training, we still found some gaps in records.
- Staff in the antenatal clinic told us folders for new sets of notes were held in the clinic. All these notes had pre-printed schedules of care and other locality specific information inserted, so that when women left their booking appointment, they would have the correct contact information. They also had a schedule of visits for their type of pregnancy, for example if this was their first child, if they were expecting more than one child or they had a medical condition such as diabetes. Four maternity support workers helped with records. Active

notes were stored by the medical records department. Full hospital notes were available for all bookings so that all relevant information from previous pregnancies, and other aspects of women's medical history were available for review.

- We looked at six sets of notes on the delivery suite and saw they were legible, signed and dated. They recorded demographic data, multi-disciplinary care planning and appropriate documentation by medical team when they had reviewed women. Some women's antenatal notes did not record blood test results at booking, and there were inconsistencies in recording antenatal VTE assessment.
- We reviewed in detail 10 sets of notes of both mothers and babies on the postnatal ward. These notes were stored in a drawer – not in bed order. Some loose sheets were evident so we could not be assured all information was in women's files. These notes were not all complete. Three did not document the handover of care of mother and baby from the labour ward to the postnatal ward, birth summaries were not consistently completed, lacking baby details and swab count records. For one baby that was having observations recorded on a NEWS chart, no care plan had been made. Another baby's notes contained an observation chart with no name or ID. For two babies there were no postnatal stickers and no record of any check of the baby's name. Where women did not speak English there was not always information about preferred language or interpreter requirements. There was good compliance to recording maternity early warning scores on these notes.
- The maternity unit's current IT infrastructure did not support good record keeping. Although clinical information such as scan results could be accessed through the computer system, this was not easy to use. Staff often relied on the woman to communicate information about their pregnancy and care plans when they contacted the labour ward team. Community midwives could not access all women's test results remotely.
- We were told that funding had been secured to move to an electronic system to capture patient information during childbirth and in the postnatal period, including CTGs, partograms, all labour events and outcome information in real time to improve patient care and reduce human error. This was not yet in place.
- For women planning to give birth in the birth centre, a back-up copy of the most important information in women's notes was kept in folders.

Gynaecology

- The trust had an electronic patient record system. The system flagged patients at risk of falls and any with MRSA or CDiff. The system also provided an alert for patients with learning disabilities or dementia. The system required password access to ensure security. Staff members had unique accounts to ensure professional accountability.
- Nursing assessments recorded vital signs observations and early warning scores, falls assessments, assessment for pressure areas (Waterlow score), venous thromboembolism (VTE) assessment and nutritional status (Malnutrition Universal Screening Tool – MUST).
- Patients' paper bedside notes were stored in holders by beds. The main records were stored in lockable cabinets.
- Patient notes had been completed with relevant clinical information and signed and dated in accordance with guidelines.
- Data protection was part of the staff mandatory training programme.
- In the EGU we looked at five sets of women's notes. There were all stored as temporary files loosely held in a folder.

Safeguarding

Maternity

- We saw guidelines for safeguarding vulnerable women to support the service in reducing harm to the mother, the unborn or new-born baby, and any other children in the family. There was a dedicated team of specialist community midwives: the Gateway team. Midwives said they were vigilant when women booked late in pregnancy or missed appointments and could arrange follow up when women did not attend an appointment. The Gateway team offer midwifery care to women with complex social needs – this includes young mothers, those disclosing domestic abuse, FGM, severe and enduring mental health illness, substance misuse, child protection concerns, women with learning disabilities, asylum seekers and refugees.. Midwives followed multi agency guidelines on women with FGM which corresponded with statutory guidance.

- Each midwife in the Gateway team had a case load and one safeguarding midwife was always on call at weekends. The midwives reported excellent support from site- based social workers, but lacked administrative support. They considered that such support would increase their effectiveness.
- Staff we spoke with showed an understanding of the trust's safeguarding procedures and the reporting process.
- Midwives and medical staff were required to attend level 3 safeguarding children updates in line with the intercollegiate document 2015. Compliance with training updates on child safeguarding was 93%.
- We reviewed the trust infant abduction policy dated 19 March 2015. This assumed electronic baby tagging was in place, which it was not. Not only did babies not have electronic tags, some babies on the postnatal ward had no ID labels at all which was unsafe. (see section on security). The head of midwifery at RLH was not aware that there was a trust wide infant abduction policy and therefore had not promulgated the policy to midwives. The infant abduction policy said it should be tested either as a desktop exercise or in practice,
- The managing abuse and violence policy of 2014 referenced Working Together to Safeguard Children (1999), not the 2015 version of Working Together.
- Midwives were aware of the policy to ensure they asked women about mental health, including depression and anxiety, at booking. However, midwives were less assured that all women were asked about their mental health at later stages of pregnancy. Staff said a guideline was needed for this.
- There were clear guidelines for acceptance of women referred to the MH pathway which offered psychological support for women with perinatal/postnatal mental health.

Gynaecology

- There was a trust wide policy for safeguarding vulnerable adults. The policy and protocol for safeguarding referrals was available for staff to access via the trust's intranet. Staff we spoke with were able to explain potential signs of abuse, including domestic violence, the process for raising concerns and making a referral.
- There was good completion of mandatory safeguarding training.
- Safeguarding awareness was included in corporate induction.

Security in maternity

- At the last inspection CQC asked for urgent improvement in security in the maternity services. We saw that there had been a reduction in unsecured entry and exit points on the wards. Access to most areas of the maternity and gynaecology wards was now restricted by use of swipe cards, although the head of midwifery told us there were still some unlocked entrances**.**
- Baby identification was a risk. We saw lax practice on checking babies' name bands on the postnatal ward to ensure babies were paired with the right mothers, and to ensure the right baby received the right medicines. On one day of our inspection two babies were in the treatment room, about to have drugs administered, neither of which had name bands attached to their ankles in line with trust policy. The name bands were in the cots. This was not safe practice as staff could not be confident that the name bands in the cot belonged to that baby. Inspection of five more babies revealed that none of them had name bands attached to their ankles: one baby's name bands were on the mother's locker; one baby, whose mother was not on the ward at the time of checking, had no name bands at all; two babies' name bands were in the cot, one visible and for the other baby, down the side of the cot mattress; another baby had no labels and the mother said she had put them in a carrier bag, but on looking could not find them. When asked, mothers said they had not been told to report to staff if their babies name bands had fallen off.
- Staff did not routinely check babies' identification labels. When we raised concerns, the midwives' response was not safe. No member of staff referred to any guideline of what to do if baby labels were missing. We saw a nursery put nurse replace baby labels without checking them against the mother's identification label. Other babies had new labels printed, again without checking this label against the mother's name band.
- Staff told us there was a sticker for both mother and baby that was completed each day. The baby sticker had a checklist specifically for baby checking. We checked seven baby records and the results were poor: the stickers were not always used and where they were used they were not always completed daily.

- Staff on the postnatal ward were unaware of the trust policy on patient identification that included babies. We escalated our concerns to the head of midwifery on the day of inspection, who said she would expect trust processes to be followed.
- When we returned on an unannounced inspection, all babies we checked had labels and mothers were aware that they should report a label that had come off. However, CQC inspected again on 27 September 2016 to see whether the maternity was responding appropriately to CQC's concerns about baby identification. We checked 13 babies and all had labels, but two babies only had one label contrary to trust policy. None of the 12 mothers with babies, some in transitional care, that we spoke to had been advised to tell midwives if the label came off their baby.
- There was little documentary evidence to show that midwives were checking baby labels daily. The notes of one baby who had been in 11 days showed label checks had been recorded on only four days. Although we weretold the ward had started to audit baby labelling, our spot check revealed that the audit design was falsely reassuring managers about systematic checking. One mother told us her baby had only had one label for more than a day, yet the documentation recorded the midwife had checked and signed that the baby had two labels at 6am. The mother said this was not accurate.
- Postnatal women and babies in the delivery suite, where we found one baby with a single label and no documented label checks, were not part of the unit's attempt to audit the checking of baby labels.
- Although our escalation of concerns about babies in transitional care not having ID labels in July had led the maternity unit to note this as an incident they had not considered it needed a serious investigation. They had not added baby identification to the risk register, nor drafted guidelines for staff to follow in the event that a baby was found to have no ID labels.
- We had been told in July that a business case for baby tagging had been approved and would be implemented by autumn 2016. However, we found in September that electronic tagging had been deferred until the next financial year. Baby security across all the maternity sites was on the risk register – rated 12. However, baby tagging would only be effective if all babies wore ID labels, which was not the case during our inspection.
- Not all inpatient mothers were wearing name bands either. Staff on the delivery suite said these were often not put on women who needed emergency procedures and we observed on our inspection a delay in taking a woman to theatre because staff could not find any name bands.
- The reception desk on the postnatal ward was meant to be manned for 24 hours each day. This was put in place after concerns that CQC raised in the January 2015 inspection. Midwives said there was not always a ward clerk available and there were no arrangements to cover breaks. There was secure entry to the ward via a buzzer and electronic door release system, with a small screen for the receptionist to see who was coming in. Reception staff did not ask visitors who they had come to visit, so there was no cross check that the woman was an inpatient, how many visitors she had already,or whether a woman had any restrictions on her visitors, for example for safeguarding reasons. When there was no receptionist midwives had to admit visitors, as well as caring for mothers and babies, which made ensuring control over visitors difficult.
- On our previous inspection we had identified 'tailgating' as a problem. This had reduced. Staff entering and leaving used their swipe card and appeared more alert to not letting people into secure areas.
- We saw that visiting policy had been reviewed. In theory there was a maximum of two adult visitors per bedside. There was no security guard present at visiting times to support enforcement of the policy and we saw visiting times were not consistently enforced by staff, including the end of visiting time. A mother told us her partner had been asked to leave at 1am although visiting for partners ended at 10pm. Staff described getting visitors to leave as 'game of cat and mouse'.
- Staff told us visitors often phoned friends already on the ward to let them in.
- We saw signs saying that children of postnatal mothers were welcomed on the postnatal ward, but several parents told us that staff had been obstructive about this.
- Midwives told us of concerns about their own safety on the delivery suite at night. They had been told a security presence was not affordable. There was a night security guard at the free standing birth centre.

Gynaecology

- There were no security concerns in gynaecology.

Maternity and gynaecology

Mandatory training

- Mandatory training was a combination of e-learning modules and practical teaching sessions. training. Staff said they received reminders when training was due and could book online. Managers followed up to ensure staff attended training. Capability procedures were used in extreme circumstances.
- The mandatory and statutory training programme covered equality and diversity, health and safety, basic life support, infection control, information governance, adult and child safeguarding, fire safety, manual handling and conflict resolution.
- Specific maternity mandatory training was based on the PROMPT (Practical Obstetric Multi-Professional Training) RCOG model. Training included Multidisciplinary Obstetrics Team Training, CTG updates, neonatal resuscitation and promoting normality. Clinical staff told us they had regular skills and drills training for managing obstetric emergencies. Staff told us an eclampsia emergency had been tested a week before the inspection.
- The target for mandatory training completion was 90% and in almost all areas in maternity and gynaecology it was 100%.

Assessing and responding to patient risk

Maternity

- Women using the maternity services had their initial appointment (booking clinic) before 12 weeks and a detailed risk assessment was carried out. The risk assessment was repeated at 36 weeks of pregnancy.
- An antenatal and newborn screening coordinator was responsible for antenatal and newborn screening. NHS England collects data on screening assessments. The service dashboard consistently showed red in relation to meeting the standard of achieving sickle cell and thalassaemia screening by 10 weeks of pregnancy.The service was able to demonstrate that women have access to screening. If screening is positive, partner screening is offered and subsequent diagnostic testing offered if both parents are positive. The possibility of this being delayed does not stop women accessing both screening and diagnostic testing.
- The fetal growth assessment protocol (GAP) had been introduced in October 2015 to help identify babies who were not growing as well as expected.
- At the previous inspection we found Modified Early Warning Scores (MEOWS) charts, to monitor women in labour and detect the unwell or deteriorating patient, were not always completed. There had been improvement in this, demonstrated by an audit and by our observations. In a 2015 audit only 75% of charts had shown MEOWS calculations, and for only 34% of women were there clear instructions on frequency of observations. This had been re-audited in May 2016 with much improved results. Staff were confident MEOWS were being used well now and all the charts we looked at were properly completed.
- There was bespoke documentation for the HDU staff to monitor the health of patients with appropriate criteria for escalation. We looked at notes of two women in HDU which were appropriately completed.
- A daily safety huddle had recently been introduced on the delivery suite including staff from the postnatal ward, the antenatal clinic and the community. The purpose was to identify any staffing, operational or capacity issues. No manager was present to oversee planning. We were told that if, for example, the postnatal ward was full, then joint discussions would take place between paediatricians, obstetricians and midwifery staff to see if any women could be discharged more quickly. However, we did not see local follow up action taking place after the huddle we attended.
- A site-wide nursing safety huddle happened each day at 0930 hrs on the 10th floor. This was attended by representatives from all areas of the hospital, including midwives. It was an opportunity for the senior management teams to get an overview of staffing and capacity issues as well as clinical alerts such as infections, pressure ulcers and recent clinical incidents. Issues were followed up at a three site teleconference at 11am each weekday to share operational and staffing issues and capacity concerns. At this meeting decisions were made about offering care to women on an alternative site when capacity was compromised.
- Another recent initiative to mitigate risk was the introduction of a short safety briefing at handover. However, the proforma completed at the safety huddle showed this briefing had only happened on 12 out of 28 days. No safety briefing took place on the postnatal ward on the day we observed handover, even though midwives had been reminded to do it.

- There was a tolerance of staffing levels well below establishment. Midwives were moved to the delivery suite to ensure minimum staffing standards were met but agency staff were not used to bring staffing to the 1:28 agreed funded establishment.
- The governance managers and lead for governance reviewed the maternity dashboards monthly so they could take action on any developing concerns,
- The Newborn and Infant Physical Examination (NIPE)checks before babies went home were carried out by midwives where criteria permitted. A NIPE midwife was on duty seven days a week. Criteria for midwife checking excluded any Neonatal Unit (NNU) babies, babies on antibiotics, babies with hyperthyroidism and pre-term babies (those born before 37 weeks). All new-borns had oxygen levels checked using pulse oximetry between 4 and 24 hours to ensure there were no respiratory problems. One room on the postnatal ward was designated as a baby discharge clinic. Babies were offered a hearing check. 98% of babies were screened within 4 weeks.
- VTE assessments were audited. Results from the most recent audit showed 96% of women were having their risk of blood clots assessed. However, the scoring system for VTE on the computer was different from that on the new VTE stickers in HDU and different from the RCOG guidelines which meant different assessment standards were being used by different clinicians.
- Staff in theatres completed safety checks before, during and after surgery as required by the 'five steps to safer surgery' – the NHS Patient Safety First campaign adaptation of the World Health Organisation (WHO) surgical safety checklist. We found evidence of good compliance with the surgical safety checklist in obstetrics and gynaecology procedures, with 100% completion of the three compulsory elements: sign in, time out and sign out. The team brief scores were 94%, time out 96% and the debriefing score was 97%. The completed WHO checklist was filed in women's notes.
- In the obstetric theatres, the surgical safety checklist and the guidelines of the Obstetric Anaesthetists' Association and Difficult Airway Society were displayed on the wall as a reminder to staff.
- Women had risk assessments at their initial appointment for raised body mass index, BMI, (height to weight ratio), diabetes and pre-eclampsia.

Gynaecology

- Women having surgery attended pre-operative assessment clinics to ensure they were well enough for surgery and to identify risk factors for an anaesthetic.
- Nurses told us they would call a doctor if they were concerned about a deteriorating patient. The National Early Warning Score (NEWS) system was used. There was a clear escalation protocol. Nurses reported a prompt response to emergency calls by doctors. Doctors assessed patients and nurses took over once the patient was stabilised and a care plan was in place.
- Staff were all aware of the trust's escalation protocol for unwell patients, as well as about falls prevention and the post-fall pathway and a bed rails decision making tool. The agency nurses we spoke with were also aware of policies for escalation of deteriorating patients.
- Compliance with the trust policy on use of NEWS was audited monthly. Data for the period January to April 2016 indicated 92% compliance with recording and monitoring of vital signs and identification of deteriorating patients across all surgery wards.
- Consultant surgeons conducted ward rounds with doctors in training to review patients and identify any concerns or additional care needs.

Midwifery staffing

- On CQC's previous inspection in January 2015 low staffing levels were considered a risk to women's safety. In response, the funded midwife to woman ratio at the Royal London Hospital had been increased to 1:28 (the national average), from a ratio of 1:31. The Birth-rate plus midwifery workforce planning tool had been used in the past to provide guidance on midwife staffing levels.
- At this inspection, midwifery staffing was still on the risk register graded 16. The funded establishment was 1:28. However, due to vacancies, the number of midwives working clinically was well below this. During 2015/16 there had been an average of 182 midwives working clinically. lower than staffing levels at any time in 2015/6. This was most acute on the delivery suite. Other midwives were also affected because they were regularly called on to work in the delivery suite. Little attention was paid to skill mix, the focus being solely on staff numbers.
- The number of midwives working clinically was not shown on 2016/7 the maternity dashboard, although it had been displayed in the previous year. This meant the

shortfall was not clear to trust management. Staff told us that midwives were leaving for units with better support and better work/ life balance. Managers told us midwives' perception of turnover were mistaken and assured us retention strategies were in place, including a comprehensive preceptorship programme.

- We were subsequently told there were 32 clinical midwife vacancies.
- Managers had declared a safe minimum staffing of 12 midwives on the delivery unit at night, however midwives said this did not feel safe when there were fewer other clinical staff around. At midnight on 8 August there were 12 midwives on the delivery suite. Of the three midwives in the low risk are: one was on triage, one was giving 1:1 care and the third midwife was caring for the remaining seven women. Staff believed this was not safe.
- The safety huddle book showed minimum staffing from permanent staff had only been met on six of the last 28 days. The staff numbers displayed on the ward showed that they were at least one midwife short of planned numbers every day in June 2016. We saw several examples of insufficient daytime staffing. There had been only 13 midwives (instead of 15) during the day on 8 August. On Wednesday 10 August there were 13 midwives instead of 16. When we returned on 27 September, the delivery suite were one member of staff short, and on the previous day they had been two short. Managers told us, in September,that midwifery staffing was their highest risk.
- Best practice is to have an experienced supernumerary delivery suite coordinator to oversee safety on the labour wards, to support clinical staff and manage workload and activity. At RLH coordinators were not supernumerary. Managers said supernumerary coordinators would only become possible when the unit was at full establishment. Existing midwives expressed concern that the absence of a supernumerary coordinator would be a higher risk when newly qualified midwives started in the autumn, as they would not have adequate training and support.
- Although staff strove to achieve 1:1 care in labour, midwives said this was not always possible. The maternity dashboard showed 92% of women had one to one care in 2016. When midwives were busy with women giving birth, those awaiting triage, having inductions, or mothers still on the delivery suite after giving birth, could wait a long time for care or assessment.
- During our inspection, one midwife was allocated to the three women having elective caesareans. This delayed the theatre list because the next woman could not go to theatre until the midwife had finished her work with the first mother and her baby. All three planned caesareans should have taken place in a morning but the second of three caesareans did not take place until 1pm. Staff said there should be two midwives but staff shortage usually prevented this.
- There were two HCAs on the delivery suite, one of whom accompanied emergency cases to theatre. At such times the remaining HCA said women did not have their observations completed on time.
- Although the policy during the year before our inspection had been not to use agency staff, the manager had agreed to use some over the summer holiday to cover staff leave. However, not enough bank and agency staff were employed to bring the ratio of midwives to women to the funded establishment level, only to the minimum level.
- Midwives were worried there would not be enough midwives to cover the extra capacity when the new alongside midwifery unit (AMU) opened in September. We were told that the intention was to staff the new AMU with four band 6 and four band 7 midwives and five MCAs. We learned after the inspection that the AMU opening had slipped to November 2016.
- The HDU was staffed by a level 2 trained nurse or two midwives with HDU training. At night there was one midwife. On our inspection we saw the daytime midwife pulled from HDU to support the delivery suite, leaving only a nurse on HDU who was not trained to carry out observations on babies or help women with breastfeeding.
- The day assessment unit was staffed by two midwives. On the day of our inspection 24 women attended the unit which we considered a high workload for two midwives.
- The midwives were able to rotate through booking clinics, fetal medicine and the DAU so that there was variety in their role. Staff worked four days 8am – 6pm and could choose their day off. Midwives said they could access medical staff relatively easily and said consultants were approachable and happy to help

- The postnatal ward staffing was four midwives and three MCAs by day and three midwives and three MCA at night. Band 4 nursery nurses assisted midwives in the care of transitional care babies. Midwives on the post-natal ward said they were regularly pulled for the delivery suite so there were rarely the establishment number on the ward which led to delays in discharge.
- There were a number of specialist midwives, for example, for postnatal, antenatal and new-born screening. There was also a clinical practice facilitator; a practice development midwife and an audit midwife. A clinical educator midwife supported the preceptor midwives.
- Midwives did not feel managers were interested in staff well-being. For example, whereas it is normal practice to plan rosters six to eight weeks ahead, the midwives regularly received rosters late. Midwives told us they had only received the roster for the following week in the week before our inspection, less than two weeks ahead. Another concern was a change to the annual leave booking process to allow senior managers to scrutinise annual leave for the year ahead. Staff complained of long delays in leave approval, for example a midwife whose request for leave in September 2016 had been made in January 2016, did not receive approval until late July.
- Midwives did not like the rotation, and said managers did not listen to their concerns. Staff preferences had not been taken into account which had led some staff to leave. However, a few staff told us they had fixed shifts, which demonstrated inconsistency in the management approach.
- Community midwives continued to express concerns about the on call system, as they had on CQC's previous inspection. Whilst they accepted on call is a necessary element of their role, staff reported that when called out at night, they are still expected to work the next day or their women do not get seen. No flexibility or cover was built into the roster to ensure midwives got the compensatory rest required if they have been called out at night. This continued to have an impact on morale.The expected pattern of on-calls was three times a month but many midwives found themselves on call every week.
- Managers told us that sickness management and staff lateness had been problems but were being tackled. We observed poor midwife timekeeping on the mornings of our inspection.
- We saw no evidence of midwifery managers doing clinical work when the delivery suite was under pressure.

Obstetric staffing

- At the previous inspection CQC had concerns about the level of consultant cover on the delivery suite. The level of cover was still at the same level: 71.5 hours a week. The RCOG recommendation was for 98 hours for a unit delivering 5000 babies. Obstetric consultant presence was on the risk register graded 15. On weekdays consultant cover was from 8am to 8.30pm then on call. There was consultant cover from 8am to 12.30pm on Saturdays, and from 8am to 12pm on Sundays.
- We were told that there would be 81 hours cover by August 2016 when two more consultants took up post. Obstetricians said the would have to submit a business case to increase cover to 98 hours but there was no date for this.
- Most consultants' shifts worked four-hour shifts which did not give good continuity of medical care to women. We were told that by mid-August there would be 12 hour shifts on Mondays and Wednesdays. Existing consultants did not want to move to 12 hour shifts so these were only being introduced as new doctors were taken on.
- There was a lead obstetric consultant for the delivery suite and postnatal ward. Staff reported that the medical team of 10 WTE consultants and the rota included junior doctors and trust doctors who worked well as a cohesive team. There were two rotas, one for day cover and another for evening and weekends, where staff were paired according to skill mix. Day time cover was separate for obstetrics and gynaecology, but at night three doctors covered both specialities. A gynae-oncology doctor cross -covered gynaecology in A&E in the day time.
- Anaesthetic cover met Safer Childbirth (RCOG 2007) recommendations. A consultant obstetric anaesthetist covered the delivery suite between 8am and 6pm. At night cover was from a training grade anaesthetist specific to obstetrics, with support, as needed from hospital anaesthetists. A consultant was on call. There was a resident hospital anaesthetist between 9am and 6pm at weekends.

- There was a separate obstetrician, assistant and anaesthetic theatre team for the elective caesarean section list which was normally three days a week. Additional operating lists could be organised on Mondays and/or Fridays if there was a demand.
- An anaesthetist did a ward round of the HDU three times a day and an obstetrician visited as necessary. The anaesthetists said they had good working relationships with obstetricians.
- Two consultants covered fetal medicine. A new appointee in August would assume responsibility for small–for–gestational age babies, i.e. those outside the 10th centile. There were daily fetal medicine clinics. Most referrals were from within the trust but a few from elsewhere in southern England.
- Doctors in training reported having a full induction over three days which included simulation training. They had a weekly CTG session supported by an e-learning package. There was a full rota. Gaps due to sickness were filled by trainees on locum pay or by research fellows. One locum obstetrician had been taken on to cover a gap in the rota until a replacement took up post. Trainee doctors told us they felt supported by consultants and reported good access to supervision, teaching and advice. Consultants reported positive feedback from doctors in training and locum doctors.
- Handover on the delivery suite involved midwives, doctors and anaesthetists. There was significant consultant input, although it was not clear who was leading the handover. Staff did not apply a structured tool such as situation, background, assessment and recommendation (SBAR) technique to communicate key information effectively and efficiently, fwhich meant handovers were longer than necessary. Care management plans were not agreed in this forum. The handover was disrupted by late arrivals and early leavers. There was no obvious learning shared at the morning handover we attended.

Theatre staff

- Obstetric theatres were staffed by the main theatre department. A paediatric theatre adjacent to the obstetric theatres could be used as a third theatre in an emergency.
- Sonographers were managed by the radiology team and services were cross charged to the Women's Division. Two midwife sonographers had been trained to work with the fetal medicine team.

Gynaecology staffing

- Nurses were led by a senior nurse and head of Nursing Gynaecology and Reproductive medicine. The 20 bed inpatient ward was staffed by a supernumerary ward manager, five nurses and two healthcare assistants. Nursing levels on the gynaecology ward were on the risk register because of reliance on bank and agency staff.
- The Emergency Gynaecology Unit had three WTE nurse sonographers, a band 6 nurse, a counsellor and a band 5 nurse to support day case procedures. A healthcare assistant acted as a chaperone and took blood. Staff said more sonographers were needed to replace agency use which was costly. The hospital was not training its own sonographers.
- The ward provided an acute gynaecology outpatients service, and patients could be referred from A&E if they had gynaecology problems not associated with pregnancy.
- Gynaecology ward staff were part of Women's Health. Eight out of 10 obstetric consultants also worked in gynaecology. Gynaecology oncology clinicians were managed by the Surgical Division.
- There was always access to a middle grade doctor on the ward. Staff reported that they had good support from surgical division and from the palliative care team as needed.
- Out of hours cover included gynae-oncologists and one of the fertility consultants.

Major incident awareness and training

- An escalation policy was followed to suspend or close the maternity unit in the event of staff shortages, postnatal bed shortages or a full labour ward. This could also be used in extreme situations such as infection outbreak in the maternity unit, or fire. There were protocols for deferring elective activity to prioritise unscheduled emergency procedures.
- Staff told us there was a business continuity plan for the hospital to cover emergency preparedness for periods of disruption which would be centrally managed by the trust. However, senior clinicians confirmed there had been no recent major incident exercise for maternity at the hospital.
- There was little awareness among staff about major incident plans. Some staff did not know where to access emergency information and there was limited awareness of major incident protocols.None were on display.

Maternity and gynaecology

Are maternity and gynaecology services effective?

Good

We rated the service as good for effective because:

- Outcomes for women and their babies within the maternity services were better than the national average.
- Staff working in maternity and gynaecology had access to and used professional, evidence-based guidance to inform care and treatment.
- The maternity and gynaecology services were continually collecting and monitoring outcomes through the use of rolling dashboards and audits.
- Multidisciplinary working was good in both maternity and gynaecology.
- Staff were competent in their roles and undertook appraisals.

However

- Some inconsistencies of practice had arisen where protocols had changed but were not being adopted by all staff, such as 'fresh eyes' for checking CTG traces, enhanced recovery for women with planned caesarean sections, and changes in VTE assessment which led to different algorithms being usedby doctors and midwives.
- Only 92% of women received one to one care in labour.
- Few women had a named midwife or continuity of midwifery care.

Evidence-based care and treatment

Maternity

- The service was following most aspects of the London Quality Standards for maternity which are consistent with effective national practice. Doctors played an active role the North East London network for benchmarking and peer review. Policies were based on national guidance produced by NICE and the Royal College.
- Women were receiving care in line with the NICE guidelines and quality standards. The Clinical Academic Group(CAG) had set up a maternity guidelines group to oversee the updating of the maternity guidelines trust-wide, including reviewing compliance with NICE guidelines.
- The hospital offered screening in line with the National Screening Committee (NSC) recommendations. They had not met the NSC target for 90% of women to have their initial antenatal appointment by 12 weeks and 6 days, as women in this demographic did not present for antenatal care early enough in pregnancy. Staff said the new NSC performance target for women to be booked by 10 weeks gestation would be a challenge. Between April and June 2016, the service booked 10.3% of women against a target of 50%.
- A new guideline for intrapartum care had recently been introduced with publicity and training for staff. Staff had carried out a baseline audit of monitoring in labour as services had not been audited since 2014. However, we saw from patient notes that midwives were not routinely using the well-established 'fresh eyes' system whereby a senior midwife would review the CTG recording of a baby's heart rate, or doing this through a buddy system. This was not on the risk register.
- One to one care was recorded on the maternity dashboard. 92% of women had received one to one care between April and June 2016.
- The service took part in national audits, for example they contributed HDU admissions information to the Intensive Care National Audit and Research Centre (ICNARC). They also carried out benchmarking with other maternity units in the trust, and external hospitals. For example, they compared post-anaesthetic data with results from another London hospital because the other trust maternity units used a different data collection system. RLH were also contributing data to the RCOG project Each Baby Counts, bringing together investigations into stillbirths, neonatal deaths and brain injuries occurring due to incidents in labour. They contributed data to the National Neonatal Audit Programme (NNAP) and to the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries in the UK (MBRRACE-UK), as well as measuring Key Performance Indicators required by commissioners, such as screening and unborn safeguarding.
- There was a programme of 47 local clinical audits for 2015/16 and these were used to monitor improvement. For example, we reviewed a spot-check re-audit assessing the documentation of swab and needle count

practice on the delivery suite. The re-audit showed a notable improvement. In the earlier audit 30% of case-notes reviewed had documented swab count pre and post-delivery but this had risen to 93%. Results of audits were communicated through a newsletter and in safety briefings.

- The service had not adopted the nationally recommended CTG stickers (2014) to monitor the fetal heart rate in labour. They used the 2007 NICE guidance, which was still used by many London hospitals. Obstetric staff told us this was part of a strategy to await universal agreement on optimal recommendations. They were currently reviewing the NICE 2015 guidelines and those of the International Federation of Gynaecology and Obstetrics (FIGO) 2016.
- At the freestanding birth centre, there were clear criteria, in line with recommended practice, for transferring women to hospital. 17.6% of women were transferred during labour, the top three reasons being significant meconium, prolonged second stage and prolonged first stage. Transfer was always by ambulance, and ambulances arrived in 11-15 minutes. After birth, 11% of women at the birth centre were transferred to hospital, the main reasons being extensive perineal trauma, haemorrhage and respiratory concerns in babies.
- Many women who had been in the obstetric theatre were taken to the postnatal ward after half an hour. This was not in line with trust policy on recovery which recommended women should stay for four hours in recovery. However, we saw that staff followed the trust's post-operative protocol on frequency of observations for women when they transferred to the postnatal ward.
- The obstetric anaesthetists monitored their outcomes and had recently produced a dashboard for key indicators capturing outcomes for labour analgesia, anaesthesia for caesarean sections and complications such as multiple attempts at needle insertion, intraoperative pain and accidental dural tap (when the epidural needle accidentally broaches the dura and a leak of cerebrospinal fluid occurs which causes severe headache). This monitoring tool had enabled staff to monitor complications and identify training needs.
- Across the trust sites there were 17 research projects in maternity, involving 3500 women. Examples of these were randomised controlled trials on giving progesterone for bleeding before 12 weeks in pregnancy and pre-eclampsia. The unit was also involved in research led by others, for example an evaluation of non-invasive prenatal testing (NIPT) for Down's syndrome, and a Patient reported survey and assessment of mothers oral health, looking at possible association between gum disease and premature birth.

Gynaecology

- The gynaecology service offered a comprehensive diagnostic service including colposcopy (for abnormalities detected on smear tests), outpatient hysteroscopy, specialist gynaecological ultrasound and biopsy. Patients could receive some of these diagnostic tests, and often treatment, in one visit. Women needing hysteroscopy had to re-book and attend a further appointment. 80% of hysteroscopy was carried out as an outpatient procedure.
- Minimally invasive surgery was on a day case basis.
- There were regular local audits on the gynaecology ward covering for example, hand hygiene and VTE assessments. We saw there had been audits of ectopic pregnancy and colposcopy.
- Women attending the EGU were offered a choice of treatment for miscarriage: outpatient medical management or surgical management. A manual vacuum aspiration (MVA) clinic was held weekly, Staff told us this procedure could also be used as a termination option for pregnancies up to 9 weeks gestation. MVA had been audited since the pilot began in 2013 and was increasingly being used instead of evacuation of retained products of conception (ERPC) under general anaesthetic. In 2015 74% of miscarriages were managed with MVA and 26% ERPC, which was safer for women and had lower rates of complications. NICE did not yet recommend one process over the other, but RLH evidence led staff to prefer MVA and they were recommending its use trustwide.
- Women with an ectopic pregnancy were offered medical management by injection to induce miscarriage and ongoing surveillance.
- Women suffering with hyperemesis were cared for as inpatients on the gynaecology ward. Ambulatory care had been explored but had not appeared to work well. Women were admitted to the gynaecology ward and usually stayed overnight for rehydration.
- 60% of all colposcopy was nurse-led.
- The endometriosis service was accredited by the British Society of Gynaecology Endoscopy (BSGE).

Endometriosis is a disease in which tissue that normally grows inside the uterus grows outside it, causing pelvic pain and infertility. RLH contributed to the BSGE database.
- Gynaecology inpatients were seen to have personalised plans of care, including mobilisation.

Pain relief

Maternity

- Women we spoke with said their pain had been well managed. Entonox, a ready to use medical gas that provides short term pain relief, was available in all the birth rooms
- There were birthing pools for pain relief in the delivery suite. One delivery room had a fixed pool. Inflatable pools were available for use in other rooms. At the birth centre 41% of births were water births and another 31% of women used the pool at some time during labour. 57% of women used gas and air at the birth centre.
- Midwives told us an anaesthetist was always available on the delivery suite. However, we saw women on the low risk area of the delivery suite could have long waits after requesting an epidural because of the policy to move such women to the high risk area. Midwives were often too busy to do this. We saw from the epidural surveillance sheet that such women could wait six hours for an epidural. The recommended time from request is 30 minutes, or exceptionally an hour.

Gynaecology

- The hospital had implemented the Faculty of Pain Medicine's Core Standards for Pain Management (2015) and there was evidence staff followed this in practice.
- Staff asked patients about their comfort, including pain levels. This information was recorded. We witnessed nurses asking patients whether their pain was being effectively managed and if they were comfortable.
- There was a dedicated acute pain team at the hospital with consultant, nurse and AHP input.
- Women told us nurses were responsive to their pain relief needs. Pain scores were recorded in the patient records we looked at.

Equipment

- An online system for cross-matching blood meant that blood was available at remote fridges very quickly. Blood type O negative, which can donate red blood cells to almost all other blood types, was available outside the obstetric theatres.

Nutrition and hydration

Maternity

- We spoke with two women on the postnatal ward who said the food was adequate and that the service could cater for special diets. However, we saw many partners bringing in food indicating that not all women liked the food.
- Women told us they had help with breastfeeding on the ward. 72.7% women were exclusively breastfeeding on discharge and 13.7% were only artificially feeding. As the unit held full accreditation from the UNICEF baby friendly initiative and had achieved Level 3 of the UNICEF baby friendly initiative for the second time we had expected higher breastfeeding rates. We noted that the milk fridge on the postnatal ward contained more formula than expressed milk. Some midwives, including the interim lead midwife were found to know little about the baby friendly status of the unit and the importance of encouraging high rates of breastfeeding in line with the award.

Gynaecology

- The hospital used the Malnutrition Universal Screening Tool (MUST) to monitor patients who were at risk of malnutrition. They also screened patients at risk of obesity. Patients identified as at risk of dehydration also had fluid balance charts to monitor fluid intake and output.
- Patients gave us variable feedback about the quality of food. Some patients said food was often cold and unappetising.

Patient outcomes

Maternity

- The maternity service was proud of its outcomes for women. MBRRACE rated the maternity service as green using risk adjusted methodology in perinatal mortality reports in 2014 and 2015 reports. The still birth rate was 10% lower than the hospital's peers (other units with a Level 3 NICU and a neonatal surgical unit).

Maternity and gynaecology

- At the last inspection we had concerns about the availability of data to monitor all outcomes. Considerable improvements had been made. Staff collected information about the outcomes of patient's care and treatment and monitored this using a maternity dashboard, a clinical governance tool for monitoring a range of clinical indicators to enable quality and safety assurance monitoring, as recommended by RCOG Good Practice No 7. The information was shared externally with stakeholders and within clinical networks, and internally for the service and the Trust Board.
- The dashboard had originally been developed with 111 parameters, but this had been reduced to just over 50 key areas reported monthly. We reviewed the dashboard for the year to March 2016. There were relatively few indicators where the service was not meeting national goals. The main challenges were in achieving recommended staffing levels, both consultant and midwife, and booking women before 12 weeks 6 days.
- Information on the dashboard showed that:
  - There were fewer planned caesareans than the London average, 8.3% in 2015/16. The national average was 10.7%.
  - The percentage of emergency caesarean sections had fallen by comparison with the previous year, from 16.6% to 15.2% which was in line with the England average of 15%, and below the London average of 18%.
  - One to one care in established labour had averaged 92.2% compared to the NICE standard of 100%. This had been noted in the investigation of a recent SI where lack of 1:1 care had resulted from increased activity. Staff could only achieve 1:1 care by not taking breaks on the delivery suite.
  - The percentage of babies with low or very low birthweight was at 10%, about the England average.
  - 9% of babies were delivered with a gestation of less than 37 weeks. This contradicted staff claims that they had a high rate of prematurity.
  - Third or fourth degree tears were low: 2.4%.
  - The percentage of inductions of labour was 20.8%, lower than the England average of 26.5%.
  - The postpartum haemorrhage rate was low with 3% of women experiencing blood loss over 1500ml.
  - 27% of births were normal unassisted births which was lower than the London average of 40%.
  - The percentage of vaginal deliveries was 61% which was below the service target of 65%, although the RCOG recommendation was 70%
  - The birth centre managed 8% of deliveries.
  - The home birth rate was low – only 50 women had given birth at home between April 2015 and March 2016. The national average was 2.3%.
  - There had been 295 unexpected admissions to NICU in 2015/16, about 6%. The main indication for admission was respiratory distress, although many of the admissions had several reasons for admission, including sepsis.
- The unit carried out amniocentesis and chorionic villus biopsies (tests performed during pregnancy to determine if an unborn child was at risk of a congenital defect). All women were offered free fetal DNA when they took part in screening. This test for a range of chromosomal abnormalities was not offered in many units. 75% of women accepted screening with the combined NT and biochemistry. Analysis was done at nearby trusts and results were available within three working days. There was a high background rate of abnormalities because of high consanguinity rate in the local population. There was also a higher incidence of pre-term delivery and mid-trimester loss. We were told that women and their families rarely chose termination for abnormalities for cultural and religious reasons. There were only 28 terminations for abnormality in the year to April 2016.
- The unit undertook 124 diagnostic procedures last year and had a loss rate of less than 1:1000 which was consistent with results elsewhere in the UK.
- A tight protocol enabled community midwives to manage low risk women with diabetes in local antenatal clinics. This had been audited and was successful.
- 40% of women stayed in HDU 24 hours or less (audit from 2014). Haemorrhage and hypertensive disorders were the main indications for HDU admission (in line with MBRRACE reports).
- An enhanced recovery programme for women having a planned caesarean section had been started in 2014 to encourage early mobilisation and enabling women to go home the next day if they were ready.
- Numbers were low and the use of this appeared to vary between doctors and was not embedded.

- We noted from an audit that 41% of emergency caesareans were not carried out within standard time limits, and the reasons for this were given as 'other'. It was not clear why there were delays as delays increase risk to women and babies
- Women were encouraged to have a 'vaginal birth after caesarean' (VBAC). for a second child after a caesarean birth first time. The service aimed for 72-76% women who are on the VBAC pathway to achieve normal birth in line with the RCOG standard.
- There was an action plan for optimising normal birth which was showing good progress against the plan.
- The unit provided care to women across the trust with placenta accreta because of the 24 hour interventional radiology availability and expertise. While they wished to build on this service we noted that the numbers were low, with only six recorded in the last year.

Gynaecology

- There were gynaecology theatre lists every weekday with a double list on Thursdays.
- Examinations, scans and assessments were carried out at clinics throughout the week.
- There was no gynaecology score card comparable to the maternity dashboard.

Competent staff

Maternity

- Newly appointed midwives had a two week orientation. Newly qualified midwives followed a nine month competency based preceptorship programme to develop their skills.
- Appraisals rates for midwives and support workers for 2015-2016 66%. This was in part due to staff absence. Appraisals had been scheduled to meet the 100% by end of November 2016.
- The function of statutory supervision of midwives is to ensure that women receive safe and high quality maternity care. Supervisors of midwives were a source of advice on all midwifery matters. The ration required by the NMC Midwives Rules and Standards is one SoM for every 15 midwives. The ratio at RLH was better than this at 1:12. The SOM's held group supervision. There were cross-site SOM meetings and SOMs had an oversight role on wards, checking records, for example. Midwives knew how to contact the on-call SoM.
- The unit had won funding for a sign up to safety programme to reduce litigation and improve knowledge and escalation for concerns in labour related to CTG. A new training package on intrapartum fetal monitoring including intermittent auscultation (a systematic method of listening to fetal heart tones with an acoustical device to monitor heart rate) and CTG monitoring had begun to improve multidisciplinary competency in fetal monitoring in labour and reduce stillbirth and intrapartum asphyxia (brain injury caused by oxygen deprivation). This had started in April. A new decision making tool had been introduced.
- HDU training levels for midwives working in the maternity HDU were maintained by a Maternal Critical Care Simulation Course run by anaesthetists. There was also a monthly in-service study day on recovery skills, although this was not externally accredited training. We were told that 24 midwives were trained in HDU care.
- Midwives were encouraged to present interesting cases at case reviews to spread learning. Staff could also attend audit meetings but generally did not have time to attend these because of clinical activity.
- Junior doctors reported having daily training on wards and spoke highly of their training and support they received from the obstetrics and gynaecology team. They said consultants were approachable and always willing to give advice. The doctors reported they also took part regularly on skills and drills for obstetric emergencies.
- There was a programme for retesting clinical skills. 83% of the Midwives who attended Phase one of the clinical assessments were retested. There was a clear improvement on CTG assessment and clinical skills, together with decision making and appropriateness in plans of care.
- Multi-professional training for band 6 midwives had been arranged to learn from the report of the Morecambe Bay investigation into a sequence of failures of care and unnecessary deaths in a maternity unit.
- 16 anaesthetists were taking part in training from the Advancing Quality Alliance (AQuA)
- There was no development offered to labour ward coordinators on staff management and leadership.

Maternity and gynaecology

Gynaecology

- There was good completion of annual staff performance appraisals. Staff told us appraisals were used to review performance, set objectives and identify learning and development needs.
- On the ward, experienced gynaecology nurses trained the more junior members of the team on the ward. A practice development nurse also provided training and updated the gynaecology nurse team.
- Staff told us the hospital supported their professional development, including formal qualifications, practical training, secondments, team days, mentoring and shadowing opportunities. Nurses told us they were encouraged to apply for development opportunities
- A doctor was training more doctors in MVA to ensure the service was sustainable.
- Doctors in the hospital participated in the GMC revalidation initiative for all UK licensed doctors to demonstrate they were competent and fit to practice

Multidisciplinary working

- Obstetric anaesthetists reported effective working with theatre staff, midwives and obstetricians in theatre as a functional multidisciplinary team.
- There was good communication with and support from specialists elsewhere in the hospital where women had medical conditions that might impact on their pregnancy, for example a joint obstetric cardiac clinic had been set up. This was open to women in other hospitals in the trust and there was a desire to increase the number of referrals so that RLH became the expert centre.
- MDT clinics involving an anaesthetist, obstetrician and dietitian were run for women with a BMI (body mass index) between 35 and 40, and a high risk clinic for larger women. Anaesthetists took part in clinics for women planning a caesarean.
- There was multidisciplinary obstetric team training including on interpretation of CTG traces.
- There was external MDT working across sites through the perinatal network, a multi-professional group working across the trust to review quality and develop cross site learning. This seemed to work more effectively for obstetricians than midwives who were less aware of activity at other sites.
- Transitional care of babies enabled mothers to stay with their babies even when the baby required additional specialist care from special care nurses, for example to receive antibiotics. An NNU doctor gave the first dose to a baby. A designated paediatrician was rostered each day for transitional care between 8am and 5pm and at other times the medical team on the NNU was available if required for these babies, although staff told us there could be delays out of hours. Relevant babies were seen on the night ward round by the paediatrician. 17.5 babies were admitted to transitional care for every 100 births. This figure was very high. In 2015/16 that represented 926 babies.
- An MDT for fetal medicine met monthly to discuss all current cases. This was attended by neonatal doctors, fetal medicine, genetics, midwives, paediatric surgeons and cardiologists. A record kept of attendance as required by the national screening committee. All data needed for the annual report to national screening committee (NSC) was channelled through the screening midwife.

Seven-day services

- The hospital delivered a full service on six days, with on call availability on Sundays for some services.
- The full range of imaging service was fast and most services were available 24/7. There was no access to gynaecology scanning out of hours unless the doctor on duty had the skills to do this.
- Some antenatal booking clinics were run on Sundays.
- The Emergency Gynaecology Unit was not open on Sundays.

Access to information

- There were enough computer stations with intranet and internet access on wards for staff to use to access patient information.
- Agency nurses told us they had access to the same ward training documentation, updates and information as permanent members of staff.
- Guidelines were available on the trust intranet. 59 maternity guidelines had been updated and amalgamated for use across the trust. Gynaecology guidelines still varied between hospitals in the trust. We checked a sample of five commonly used maternity guidelines and had been reviewed against national guidelines and were up to date. Staff were aware of how to find guidelines and policies.
- During our visit it was clear that staff on the postnatal ward were not aware of the trust-wide patient identification guideline, which included the policy on

labelling babies. However, we noted that the policy did not specify a procedure to cover lost, detached or damaged identity bands on babies, which would normally be part of such guidelines.
- Blood and other test results were not available to community midwives remotely.
- There was more than one database for recording women's antenatal screening results. For example, anomaly scans were on a different database from blood results and nuchal scans. Staff therefore had to cross check results. Multiple checks along the pathway sought to provide a failsafe.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There were arrangements to seek consent for surgery and other procedures, including screening. Patients told us staff explained treatment and care and sought consent before proceeding. We saw that consent forms had been appropriately signed and dated in the notes we reviewed. Staff gave women who wanted epidurals the epidural information card by the Obstetric Anaesthetists Association in their own language so that they could give consent.
- However, some midwives told us that when women did not speak English consent for procedures other than epidural, was not always taken properly.
- A midwife told us some women decided they did not want any screening or scans and their choice was respected.
- Medical staff took consent from women for terminations and would discuss the disposal of pregnancy remains in line with national guidelines.
- All gynaecology patients we spoke with said they had been given information about the benefits and risks of their surgery before they signed the consent form.

Are maternity and gynaecology services caring?

Requires improvement

We rated the maternity service as requires improvement for caring because:

- Women's experience of care was mixed. Some women and families we spoke with reported poor experiences, including not being treated with dignity and respect, and having no continuity of care. Staff focused on the the task rather than treating people as individuals.
- Not all women and partners felt sufficiently involved in decisions about their care.
- Some family members did not feel they were proactively kept informed by hospital staff, and women did not feel midwives helped them understand their treatment.
- Our findings about women's views of maternity care on inspection were similar to the results of the 'Women's experiences of maternity services 2015'. Scores at the hospital had fallen since the previous survey.
- Women from some ethnic and cultural groups experienced poorer care than others.
- Staff did not challenge cultural bias in their colleagues' behaviour.
- The midwifery service was not caring enough of its own staff and the morale of staff working clinically was poor.
- Stakeholders had concerns about the way staff treated some women in the maternity services.

However

- Women we spoke with had good experiences of care in gynaecology.
- Mothers who had given birth at the birth centre were very happy with the way staff treated them, and appreciated the continuity of care they had from midwives.
- Some mothers we spoke with who had given birth on the delivery unit were positive about their antenatal care and delivery and had found staff helpful.
- Mothers appreciated the arrangements to debrief mothers whose birth experience had not gone to plan.

Compassionate care

Maternity

- Women's experience of care, as reported by women we spoke with, was mixed. Some women praised the kindness and friendliness of midwives and were happy to have given birth in the hospital. However, some other women told us their care had been rushed and lacked

compassion. Some women, for example those awaiting triage, had long waits and felt midwives did not treat them with empathy given women's natural anxiety in the perinatal period.

- The trust had scored poorly in the CQC 'Women's experiences of maternity services 2015' survey which surveyed women who gave birth in February 2015. The trust scored lower in than in the previous year. The average score to questions was worse than the national average, particularly on partner involvement and kind and understanding care. 47% of women said they were not treated with kindness and understanding. This was lower than the previous year. Results were also low for women being moved in labour, for being left alone, for the response time after birth and for partner's length of stay. The findings of a Tower Hamlets health scrutiny panel had also recently reported that many women were not having positive experiences of birth and postnatal care at the Royal London Hospital.
- The results of the Friends and Family test were also mixed and had a response rate of 8% which was below the national average. Even with a low response rate, a high proportion would not recommend the service - 27% in August 2016. The service had adopted the 'iWantGreatCare' project to provide continuous, live feedback. The intention was to enable quicker management of any concerns that were raised and focus on the outcomes women thought were most important. The app was in 20 languages, which should enable staff to obtain feedback from a wider range of women, but it was too early to show results.
- Some women we spoke with said midwives did not treat them with dignity and respect. Two men told us their partners were bullied or patronised by some midwives because they did not speak good English. One fluent English speaker from an ethnic minority group said she had encountered several midwives who talked down to her, making inappropriate assumptions about her education and language ability based on cultural stereotypes.
- Some midwives were aware of stereotyping by their colleagues and that women were not always treated equitably without regard for ethnicity or socio-economic status. They found it difficult to raise this issue with managers or challenge their colleagues.
- We observed midwives and doctors on the postnatal ward referring to women by their bed number rather than by name, which did not support person-centred care.
- Mothers who had given birth at the birth centre were happy with the way staff treated them there and appreciated the continuity of care that midwives gave them
- The arrangements to debrief mothers whose birth experience had not gone to plan was appreciated by mothers.

Gynaecology

- Women spoke highly of the nursing staff on the gynaecology ward and told us their care had been professional and that staff were kind and courteous.
- In the Friends and Family test 100% of women said they would recommend the gynaecology ward (July 2016), although the response rate was low. However the trust collected information from patients, families and carers in other was such as the annual NHS inpatient surveys and the iWantGreatCare. Staff encouraged patients to fill in feedback on discharge.

Understanding and involvement of patients and those close to them

Maternity

- From the maternity survey 44% of women did not believe they were involved enough in decisions about care, 39% considered their concerns were not taken seriously and 45% felt they were not able to get help from staff in a reasonable time. These scores were all worse than the previous year at RLH. Managers said that at the time of the survey (February 2015) there were significant increases in activity and funded establishments were not in line with recommendations. However, from our observation, staffing levels were still low but this measure was more about attitude than staff numbers. We spoke with women and their partners who did not feel that women were central to care planning and did not feel involved in decision making.
- Managers told us involving mothers in decisions about their care was a key action for 2016/17.
- Sharing in decision-making required communication that mothers could understand. In part this depended on access to interpreters, and potentially to written information to back up what women discussed with

midwives and doctors to ensure women and their partners understood the benefits, the risk and the consequences of decisions. Interpreters were only available for appointments over 30 minutes long, as a trust policy. It was therefore likely that some women did not gain enough information from their shorter appointments as the use of language line reduced discussion time further.

- Women also told us they had received inconsistent advice as they had seen different midwives and doctors during their pregnancy. This meant it was difficult for women to develop confidence in staff. Managers told us that 'women having confidence in the staff' was not scoring levels they aspired to, and it had not improved over the last year. This too was a training priority for the year ahead.
- Women planning to give birth in the birth centre who had benefited from continuity of care and active birth workshops had a more positive experience of birth. We spoke with two women who had hoped to use the birth centre and not been able to. Both mentioned receiving inconsistent messages from staff about infant feeding during their short stay on the postnatal ward.

Gynaecology

- Women we spoke with said they had clear explanations from medical staff about their condition and the risks and benefits of treatment.
- Two women who had surgical procedures said the anaesthetists had explained what would happen and checked that they understood.
- However, we were told family members were not always kept informed by hospital staff and family members telephoning the hospital found it hard to get information.
- The trust could offer overnight accommodation to patients' families who did not live in the local area so they did not have to travel long distances to see their relative.

Emotional support

Maternity

- One woman on the postnatal ward told us she had been treated as childish because she was upset that her baby was in special care. She overheard a ward manager telling another member of staff that she was 'crazy'. However, the same women told us that later on when she was still upset another staff member gave her a hug and took time to listen to her worries.
- There was good perinatal support for women with mental health concerns, who were seen by a perinatal psychiatrist, a psychologist, a perinatal mental health nurse and midwives from the Gateway Midwifery Team.
- When we asked some midwives about emotional support we gained the impression they considered this a mental health issue. There appeared to be a lack of empathy with women's experience of birth or responsiveness to women's personal preferences.
- A bereavement midwife saw all women suffering perinatal loss were seen by the midwife and the hospital wrote letters to the GP and the family. The charity SANDS (Still birth and neonatal death) was involved.

Gynaecology

- Patients told us nurses were very supportive and they felt able to speak to staff about concerns and staff had time to listen. They were also aware of spiritual support services and that the chaplain could link with community religious leaders, such as imams.

Are maternity and gynaecology services responsive?

Requires improvement

The maternity service required improvement because:

- Not all women currently received continuity of midwife care from a named midwife.
- There was an inconsistent approach to translating and interpreting, and inadequate provision of written information, in both maternity and gynaecology, in community languages.
- There was not always time to explain things properly to women who were not fluent in English because of the time it took to use language line.
- Many women, and their families, did not feel the maternity service was addressing their individual needs.
- The flow through the delivery suite was poor because of shortage of staff and of postnatal beds.

- Women experience waits for care throughout their maternity experience. Discharge processes from the postnatal ward were known to be slow but had not been audited.
- There had been delays in access to some gynaecology clinics and procedures, although reductions had been achieved over the previous three months by running extra clinics, and by using telephone follow up clinics where appropriate.

However:

- Perinatal bereavement care was sensitive and appropriate.
- Gynaecology services were responsive to women's urgent needs, particularly through one-stop and rapid access clinics and the emergency gynaecology unit.
- Antenatal clinics took place in 28 locations and the one stop booking clinic reduced the need for women to travel.
- The unit had set up the new clinic for women who had experienced sexual violence and who are contemplating pregnancy.
- There were appropriate arrangements in place to support patients with learning disabilities and those living with dementia.

Service planning and delivery to meet the needs of local people

Maternity

- There is a diverse range of ethnic groups in the area, including 55.0% black, Asian and minority ethnic residents. 35% of the local population do not speak English as first language (the national average is 10%) and 57% of mothers giving birth at the hospital were not born in England. Over a hundred different languages were spoken in the borough of Tower Hamlets. This placed demands on the service in terms of the need for interpreting services, different cultural norms, sometimes complex health needs and a range of different expectations of health service provision.
- The trust employed six WTE Bengali advocates between 9am and 6pm. All were women and were trained in discussing sensitive issues. They were based in the antenatal unit but could work in other areas of the maternity service too. Staff said there were not enough to support all Bengali women who would benefit. There was no comparable support for women from other communities.
- Staff said they could book interpreters for other languages but needed 48 hours' notice. For appointments under 30 minutes, language line was used which staff and women said was slow.
- Almost all written information was in English and although the large range of leaflets said on the back where to obtain translation, we saw no signs in other languages to tell women how to obtain information in their own language. Staff explained this was because many women were not literate in their own language. However we saw many women coming to clinics with partners or other family members who would be literate and able help families with information. The only information we saw in other language was information about epidurals, some information recruiting women for research studies, and the new iWantGreatCare app. We agreed with the report of the Tower Hamlets Scrutiny report in June 2016 that more work was needed in the maternity services to make information accessible.
- A service to visit new mothers at home to help with breast feeding had a helpline at weekends including in Bengali/Sylheti.
- The range of leaflets in English was wide and up to date, for example, we saw a new leaflet on care in early labour. However information was not always displayed where it was most useful. A number of the leaflets on the postnatal ward were designed for antenatal mothers, for example, high BMI in labour and external cephalic version, rather than being focused the needs of women who had already given birth.
- The one stop shop booking clinic staffed by core clinic and community midwives enabled 55 women a day to have their initial appointment (booking appointment). Their medical history, scans and blood tests were done at one appointment, so reducing the need for many women to come to the hospital more than once. The high numbers did lead to some congestion in the antenatal waiting area but the process was effectively managed. This clinic helped the hospital meet its target for booking women by 12 weeks and 6 days. There was no option for women to have their initial appointment nearer home.
- There were play areas for children in gynaecology and maternity clinics.

- Depending on clinical need women were streamed into low risk (midwife led) or high risk (consultant led) pathways. Low risk women were offered the options of birth at home, on the low risk labour ward (6E) or at the birth centre. The community midwife undertook all antenatal care.
- A variety of specialised clinics were run in the hospital for whose pregnancies were higher risk. Birth would be on the consultant led labour ward (6F).
- A lounge for women who were in the early stages of labour on the delivery suite was an option for women who preferred stay in hospital rather than go home. This contained two birthing couches. It provided limited privacy, and we were told that some women had given birth there.
- A number of the single rooms on the postnatal ward could be used as amenity rooms where women could paid for the use of a single room. At the birth centre women did not have to pay for rooms.
- Postnatal exercise classes with physiotherapists were provided and classes to help with infant feeding. An infant feeding specialist was supported by an MCA.
- 'You said' and 'we did' information was on display on the postnatal ward showing the ward's responsiveness to women's requests.

Gynaecology

- The Emergency Gynaecology Unit (EGU) was an outpatient service. It received referrals from GPs, the Sexual Health clinic and A&E. Women could not refer themselves. It was open from 8am to 6pm on weekdays and on Saturday mornings between 8am and 1pm. The EGU saw up to 30 women per day and cared for women with pregnancy related problems up to 16 weeks gestation. Staff could often manage ectopic pregnancies as an outpatient service.

Access and flow

Maternity

- The GP was the first point of contact for 97% of local women booking for maternity care. The area was served by over 50 GPs surgeries. Staff were trying to encourage GPs, through meetings and written communication, to refer women earlier to the hospital so they could have time-critical screening tests recommended in NICE guidelines. All referrals from GPs to the hospital booking clinic were made through the antenatal clinic reception and were vetted by clinic staff to ensure appropriate clinical review.
- Women told us that they had experienced delays in the hospital antenatal clinics, delays in triage, especially at night, delays in induction of labour when there were no beds on the delivery unit and women waiting a long time at home for induction, delays in elective C-section lists, and delays in medical review on the delivery suite. We observed this on inspection and saw that it was a topic of complaints. Staff were aware of these issues and had taken on more reception staff to help with clinic delays. It seemed to us that some improvements were on hold until the AMU opened, but this unit was only a part of the only solution to capacity and flow.
- Midwives in the Day Assessment Unit (DAU), open 8am to 8pm, saw women with concerns such as rupture of the membranes, bleeding, reduced fetal movements or high blood pressure, without an appointment and acted as a triage area during the day. We were surprised to note that the receptionist assigned the priority for seeing women when they reported to the desk. Normally a midwife would make this first assessment before formal triage.
- Triage was carried out on the delivery suite after the DAU closed. The target was for midwives to give an initial assessment within 15 minutes, and then prioritise women for full assessment according to a RAG rating. It was difficult to achieve the time target at night when there was only one midwife on duty.
- Some sessions for planned caesarean sections were over-booked which could cause delays for women.
- Inductions were often over booked which meant some women were not able to have their induction on the expected day which could be distressing for women. We also saw a case delayed because staff could not find an identification wristband to put on the women.
- Flow through the maternity unit caused problems because as there were not enough postnatal beds. Ten transitional care beds had originally been identified as the required number needed but changes in neonatal care, particularly the increased use of antibiotics meant that more mothers needed transitional care beds with their babies. We were told that sometimes up to 22 beds

might be used for transitional care. Some vulnerable women also needed to stay longer on a postnatal ward, increasing 'patient flow' issues for women who had delivered and needed a bed.

- We saw during our inspection that some postnatal women who did not need HDU level care were taking up HDU beds inappropriately. Other women were kept on the delivery unit for 12 or more hours after delivery due to lack of postnatal beds. This could impact on their care because of midwives in the delivery suite necessarily focused primarily on women in labour.
- Staff told us that diverting women to other hospitals in the trust was often considered. The unit diverted women when they ran out of rooms and staff to care for postnatal woman as well as when they could not care for all women in labour. There had been two closures in the week before our inspection. There had been seven closures between April 2016 and July 2016. However staff on the delivery suite considered that diverts should be put in place before the unit reached capacity to improve the experience for women already on the ward.
- The discharge process was cumbersome. Midwives said it took 30 minutes to generate the six page report for GPs and community midwives. This reduced the time they could spend talking with women and families to explain going home and follow up appointments. Other delays were caused by the wait for medicines to take away. There had been no audit done on postnatal ward discharge times.
- An improvement since our previous inspection was the introduction of a system to monitor mother and baby discharge. Mother and baby were 'signed out' by the ward clerk who counter-checked against the ward list and paperwork provided by the midwife.
- There was an area women could wait in before they went home, with comfortable seating and information leaflets for women to take away. This helped flow because beds were vacated earlier.
- Mothers and their babies were not discharged after 8pm at night.

Gynaecology

- In gynaecology referral to treatment times were not being met. There were insufficient colposcopy services to meet demand, and that service was heavily dependent on the work of one specialist colposcopy nurse.
- Staff told us that more theatre access was needed for emergency gynaecology cases. Staff said site based hospital management had increased their freedom to run theatres more efficiently and to organise clinics proactively to reduce waiting lists.
- Women awaiting an evacuation of retained products of conception (ERPC) procedure (a small operation to remove pregnancy related tissue inside the womb after miscarriage)were put on an emergency theatre list, but staff said there were often delays. The service did not collect data on the frequency of delays.
- The gynaecology ward was shared between general gynaecology and gynae-oncology. There were sometimes female patients on the ward who were not gynaecology patients which meant gynaecology patients might sometimes have to wait for beds. There were three such outliers on the day of our inspection. Staff reported that generally there were no delays in treatment of women who were not in hospital for gynaecology treatments and they were reviewed by the appropriate medical teams.
- Staff told us there was sometimes a backlog in printing off and despatching clinic letters because of shortage of administrative staff, although the dictation system turned letters round in 24-48 hours and clinicians could sign off the letters electronically.
- Patient discharge from the ward was doctor-led. There were sometimes delays because patients had to wait for pharmacy to prepare their medication. We were told there were no enhanced recovery pathways in gynaecology.
- There were hospital wide processes for management of non-attendance by patients. Staff would telephone women who missed appointments. Women who missed two appointments were discharged from the service.

Meeting people's individual needs

- Three woman we spoke with said they were not given a choice of birth location. They also said they had not been offered a tour of the maternity service at the hospital and understood these were only available for women taking antenatal classes. All women considering giving birth at the birth centre were offered tours.
- Continuity of care was not available to most women planning to give birth in the hospital. Women planning to use the birth centre or have a home birth reported having continuity of midwife care. Two other women we spoke with said that although they the name of a

midwife that they could telephone, they had seen different midwives and doctors at every appointment. They also said they had seen different midwives each day on the postnatal ward.

- Although two woman we spoke with on the postnatal ward were happy with their care, one of these was a member of staff. One woman told us a midwife told her 'she was crazy' because she was upset that her baby was in special care. She was offered no support. Another woman, who had spent twelve hours on the delivery suite awaiting a bed on the postnatal ward, had been told her children were not allowed to visit her on the postnatal ward even though she was in a single room. Her partner had experienced procrastination and rudeness when he had tried to sort this out and the siblings were not able to see her until 8 in the evening, after visiting hours. A third woman, second generation Bangladeshi, told us that midwives had been patronising and assumed that she did not understand, even offering her an interpreter.
- There were two bereavement rooms on the delivery suite. They were not significantly more homely than the normal delivery rooms, except that partners could stay.
- A Birth reflections clinic had been introduced a year ago. This was run once a month by a consultant midwife and a psychiatrist and was an opportunity for women to discuss what occurred during labour and birth.

Gynaecology

- RLH did not routinely offer termination of pregnancy except in cases of fetal abnormality. Women attended the gynaecology ward up to 18 weeks, and the delivery suite thereafter when they would be offered medical management. A few women (9 in the past year) were referred from elsewhere in the trust for social terminations, when cases were complex.
- Women who were having a termination, and who needed admission, were cared for in a single room on the gynaecology ward where possible.
- We were told that the bereavement midwife provided good support to such families. Memory boxes were given to all women who experienced pregnancy loss whether they had experienced the loss of a wanted or unwanted pregnancy. RLH ran a pregnancy loss clinic for those who lost a baby after 24 weeks gestation including still births.
- The surgical service responded to specific individual needs, including patients with complex needs and cultural and religious requirements.
- Patients with learning difficulties had a 'hospital passport' which included detailed information such as next of kin contact details and the patient's likes and dislikes. There was a lead clinical nurse specialist (CNS) for patients with learning difficulties.
- In theatres, staff reviewed the needs of patients with learning difficulties two weeks before their planned procedure to ensure suitable provisions were in place. A learning difficulty trained nurse attended the patient at each stage of their pathway through theatres. A relative or carer was allowed to accompany patients in the anaesthetic room and recovery area as required.
- The trust had arrangements to support patients living with dementia. The hospital used the abbreviated mental test score (AMTS) to assess elderly patients for dementia if concerns arose at pre-assessment stage before surgery. Relevant information about the patient's needs was recorded in patient notes to enable clinicians to prepare in advance. Ward managers told us they could book extra support workers to ensure patients were cared for properly.

Learning from complaints and concerns

- We saw the complaints policy and leaflets explaining how to raise a concern or give positive feedback on display in clinics and wards.
- There were many thank you cards on display on the wards but some were quite old (2013).
- There were 56 complaints about the maternity service in the year 2015/16 – four or five a month. The number of complaints was recorded in the maternity dashboard. Informal complaints on the postnatal ward were not recorded.
- Communication was the leading cause of formal complaints (32%), including women's understanding of the information provided, rushed appointments, poor communication and lack of compassion. Analysis of complaints had shown a reduction in complaints about poor attitude or behaviour since the previous year but our interviews with women indicated there was still room for improvement.
- Complaints about obstetric incidents had decreased since efforts had been made to ensure effective debriefing of women when things did not go as planned.

Maternity and gynaecology

- Women's Health use a number of methods to ensure that learning from complaints or concerns were shared with staff : themes from complaints, incidents and claims were shared with staff through newsletters; themes were also presented at the monthly Maternity Quality Safety and Assurance meeting; consultants held a weekly safety meeting which included local learning from complaints. Although there was some evidence of service improvement as a result, there was room to do more, particularly on communication and consistency of advice which several women mentioned to us had been confusing to them.
- For complaints where a detailed investigation was required and might also link to a serious incident investigation, a multi-professional 'Being Open' meeting was held.
- There had been one anaesthetic complaint since April 2016 where a woman had not understood that she needed a general anaesthetic for the birth.
- Gynaecology complaints accounted for 19 (42%) of all reportable complaints in the Women's service. Communication was a key theme.

Are maternity and gynaecology services well-led?

Inadequate

We rated well led as inadequate in the maternity services because:

- Insufficient progress had been made in response to concerns CQC raised in the inspection in January 2015 in respect of staffing, capacity and security.
- The vision and strategy for maternity services was not well understood by midwives working clinically, and there was a lack of engagement in governance from these midwives
- Leaders were defensive, and out of touch with the morale of community and ward midwives, which had deteriorated since CQC's last inspection.This barrier made if difficult for leaders to effect change.
- There was not an effective system to identify, manage and capture risks and issues. The system of dual risk registers for site and cross site risks was confusing and did not provide clarity and transparency on the risks specific to this site. Many of the risks had not reduced since the previous CQC inspection.
- The security of babies was not treated as a priority. There was no relevant infant abduction policy and no guidelines for staff on what action to take if a baby's ID labels were missing. Even after CQC had raised concerns about seven babies with no labels, this had not been investigated as a serious incident or been added to the risk register, and careful checking processes and information for mothers started in August, had lapsed by September.
- Team work was poor. Midwives reported they could not rely on others to help them if they asked for help,and we observed staff did not take responsibility for taking forward activities if others were off sick or on leave.
- Intra-cultural issues and some bullying behaviour, which management had assured us were historic in maternity care, were evident both between groups of midwives and between midwives and patients.
- It was too early to assess the impact of the significant organisational changes in women's health, made only a month or two before the inspection.

However

- We found some progress against CQC's previous concerns about governance and assurance of the maternity service. There was more reliable data to underpin some decision making.
- New site level leadership and governance structures had the potential to focus on site specific challenges,and site level budgets had enabled some long awaited changes to be made.
- Leadership in gynaecology was clear and we found no evidence that staff had particular concerns.

Leadership of service

- A site-based leadership model had been established at the hospital in September 2015. A hospital managing director led the hospital along with a medical director, a director of operations and chief nurse. In June 2016, four Divisions were formed, one of which was Women's and Children's Division. Paediatrics dominated the Women's and Children's division. It had 52 consultants compared to the 10 consultants in obstetrics and gynaecology and four consultants in fertility. The Women's services were led by a clinical director (a consultant clinician with two

days a week management time), a general manager and an associate director of midwifery responsible for maternity, gynaecology and midwifery. Some of the staff in leadership positions had worked at the trust for a long time, but were newly appointed to their respective posts.

- Senior managers and clinicians felt that the site based and divisional leadership model enabled appropriate focus on site specific challenges and areas for development. They felt it created a more responsive leadership structure. For example, we were told that historically obstetricians and gynaecologists had not had a voice in management but the new structure, with a budget, had enabled them to make some long awaited changes such as increasing consultant cover on the delivery suite.
- Senior managers in maternity and gynaecology said they had access to the hospital management team. The medical director was visible and supportive. A Clinical Academic Group(CAG) had a strategic role but no operational, financial or governance roles. These roles now lay with divisions

Maternity

- The maternity and gynaecology services related to the trust board through the chief nurse. No member of the maternity and gynaecology team at the hospital was on the trust board, and there was no named non-executive lead to champion their services. 'Better Births' recommended hospitals should designate a board member as the lead for maternity services.
- Members of the trust board and midwifery leaderswere not visible at ward level,
- There were still a number of vacancies in the maternity structure, for example the post of deputy head of midwifery and delivery suite lead. The work involved in setting up the management structure for midwifery at RLH, as well as planning for the opening of the new AMU had deflected management focus away from support for midwives working clinically.
- Centralised HR services were not supporting service managers as much as services would have wished. The slow HR processes were preventing the unit filling midwife vacancies and achieving safe staffing levels. An example given was a Midwife recruitment day, held in January 2016, which had resulted in 130 expressions of interest. As HR did not attend the recruitment day, applications could not be progressed immediately. Finally 40 potential staff were shortlisted, and 23 turned up for interview. Some midwives selected in January 2016 were only starting in July 2016. There were delays in advertising for medical staff too – a consultant appointed in April did not receive a contract until July. These slow processes were not on the maternity department's risk register.
- HR had placed administrative staff in post without involving the relevant team in the appointment. This was not good practice.
- Central financial support for the site was reported to be efficient.

Gynaecology

- The gynaecology service did not have a service manager or assistant service manager at the time of the inspection, although an appointment had been made to the service manager post from October 2016. Staff said they had support from the General Manager for women's health. There was a Senior Nurse and head of Nursing, Gynaecology and Reproductive medicine and a clinical lead for gynaecology.

Vision and strategy for the service

- There were was an annual business plan for both maternity and gynaecology. However managers told us that strategic planning had taken second place to reorganising services into site-based divisions with their own local governance and management structures. Key leadership staff were now in place so developing vision and strategy was a new priority.
- There were varying degrees of awareness of the future plan among the ward staff we spoke with, particularly more junior staff.

Maternity

- The high level vision was for women and babies to have safe, excellent care. However there had been limited progress on increasing the number of consultants and midwives which was fundamental to achieving this.
- Strategy was being developed by senior managers with limited involvement of midwives working clinically. There was a risk that financial pressures could undermine quality care.
- We were told that partnership working with other organisations was developing under the overarching umbrella of the Transforming Services Together (TST) programme. This programme was run jointly with the

three CCGs (Newham, Tower Hamlets and Waltham Forest) to improve care, offer choice and make sustainable change. Some senior staff told us they had little capacity to engage with this wider programme.
- The TST programme aligned with the priorities in Better Births Improving Outcomes of maternity services in England (2016). As a part of this, the service was seeking to promote maternity services better with local populations and GPs, to ensure more maternity services were available outside a hospital setting. The new midwife led delivery unit (AMU) was part of this plan and was expected to take 30% of births

Gynaecology

- Reorganisation in the past year had brought gynae-oncology into RLH. The enlarged gynaecology service was in new accommodation. Staff told us their long term vision for the services vision was still being developed.
- Long term objectives included expansion of the endometriosis service, establishment of a pelvic floor service, becoming a tertiary centre for urogynaecology and complex colorectal gynaecology, and treating more gynaecology and fertility patients in an outpatient setting. In the short term they sought to increase theatre capacity and improve flow on the inpatient ward, by reviewing existing pathways and developing new ones.

Governance, risk management and quality measurement

- The maternity and gynaecology services at RLH were part of the Women's and Children's Division. Within this Women's Health covered fetal medicine, maternal medicine, the maternity HDU, obstetrics, midwifery services, gynaecology and reproductive medicine. The division also covered neonatal intensive care which is reported in the Children and Young People's report. Theatres and gynae-oncology were managed by the Surgery Division.
- New site level clinical governance structures were being set up with monthly governance meetings. There were meetings and forums to monitor quality, review performance information and to hold service managers and leaders to account. The purpose of these was clear, but it was too early to assess the impact.

Maternity

- The service did not clearly know where their risks were at this site. Two maternity risk registers ran in parallel, one for the site and one for multi-site risks. Some of these risks were long standing, had been present on our previous inspection and were still not resolved. Top risks in maternity were midwife vacancies (graded 16) and insufficient consultants to meet recommended standards for delivery suite cover (graded 15). Capacity and flow through the postnatal ward were also continuing risks. Midwifery staffing seemed to us to present the highest risk for safe and timely care, and this was also the view of other staff in the delivery suite. However, maternity managers did not seem to recognise the level of staff concern. Staff shortages were blamed on sickness and leave arrangements, and a mantra was regularly repeated about the 1:28 ratio in the funded establishment. This 1:28 ratio was not a reality on the ground, and managers admitted that staff numbers did not yet allow for supernumerary delivery suite coordinators, which were nationally recommended as proven to support safe care.
- Baby security was on the multi-site risk register and graded 12. On the evidence of our inspection the risk was higher than this. Security of babies had also been raised at the previous inspection in January 2015, and the trust response had not been comprehensive. Midwives at RLH, including the head of midwifery were not aware of the trust policy on infant abduction of March 2015, written in response to the earlier inspection. That policy was, in fact of limited value, as the processes described assumed that electronic security tagging was in use, which it was not. This indicated that policies were not developed with the involvement of midwives working on the front line. Staff we spoke with did not know the processes to follow in the event of a baby abduction.
- We found in September 2016, two months after we escalated the concerns about babies without ID labels in transitional care, that no guidelines had been written for staff on how to act if a baby was found to have no ID labels. No systematic checking of baby labels was taking place. This aspect of security was not on the risk register in June, and it had not been added after CQC raised it as a risk during, and after, the July inspection. The risk was compounded because there were no checks on who was visiting the postnatal ward and because visiting hours were not being consistently enforced.

- There was a quality forum: the cross site Women's Quality Assurance and Safety Committee. This received input from the Women's CAG Education faculty, the Women's CAG guidelines group, the perinatal network board and the antenatal and new-born screening committee. The Committee reported to the Trust level Quality and Safety Assurance Committee. The minutes showed these followed a standing agenda and issues were identified and actions planned and reviewed. There was no obvious mechanism for clinical midwives to feed into this.
- Improvements in governance had been have been made since last CQC inspection. There was now a senior midwife with responsibility for maternity governance for the site. This appointment had led to more timely closure of incidents. In April 2016 RLH had about 200 overdue incidents. Although there were 19 overdue incidents at the time of our inspection but two weeks previously this had been zero. The Trust requirement was that all incidents were investigated and closed within 14 days.
- Accountability to the site lead was through a monthly performance review meeting that scrutinised incidents, investigations and complaints, finance, the cost improvement programme and the maternity dashboard.
- Weekly governance meetings were held with the clinical leads for anaesthetics and peri-operative medicine, the governance lead for obstetrics and the band 7 for obstetric theatres. These covered risks and issues. Minutes were shared by email with all paediatricians and anaesthetists.
- We noted that the service had recently agreed a tariff for transitional care beds. We were surprised this had not been negotiated earlier as the unit had been undertaking this specialised activity without receiving the appropriate payment for some years.
- At ward level, staff were aware of the trigger list for reporting adverse events.
- Managers were not effectively engaging midwives who worked clinically with strategic change. Some staff we spoke with felt there were too many initiatives imposed from above: new values, Listening in Action, Great Expectations; transforming services together, and other cross-site initiatives rather than focusing on improving basic care for women.

Gynaecology

- There were monthly gynaecology governance meetings to share learning. Senior managers provided feedback from governance meetings to their respective teams in team meetings and emails. Surgeons were encouraged to maintain their own databases of procedures and outcomes. There was as yet no formal internal mechanism for quality assurance.
- As in maternity, gynaecology staff welcomed the new site level clinical governance structures and felt they had the potential to be effective.
- There was a risk on the gynaecology risk register relating to high levels of agency staffing, and gynaecology governance was not as well developed as maternity governance, but we did not identify other gynaecology risks.

Culture within the service

- A top down management approach caused discontent. Midwives in the delivery suite and wards did not feel respected and appreciated by senior managers. They told us their concerns about persistent staff shortages were not heard, and that management had little interest in their well-being: late approval of annual leave requests and late rosters were cited as examples. At our previous inspection in January 2015, midwives had told CQC they loved coming to work and enjoyed caring for the diverse range of women. We did not hear this from staff on this inspection. Morale was lower than in January 2015.
- There was limited evidence of team working among midwives. Staff told us various things had not been done because someone was on leave, or off sick. Noone else picked up the responsibility. More than one midwife told us that, on occasion they did not receive support from colleagues when they asked for it. By contrast, medical staff worked as a close knit team with a culture of providing mutual support and a willingness to pick up the phone to ask for advice or help.
- Work was needed to develop and value staff, to improve staff retention. We were told about, and observed for ourselves, some intracultural issues that hampered team working and equality of care. Some staff who worked and socialised together, were, perhaps unwittingly, causing other staff to feel excluded.
- Intracultural understanding was seen as a barrier to improving women's' experience of maternity services. We saw evidence that some women and their families

were treated less favourably than others. Ethnicity should be irrelevant to the provision of care. Maternity managers seemed unaware of some of the unprofessional behaviours of midwives.
- Midwives on wards and in the community told us they felt unable to challenge on the behaviour and attitudes of some colleagues.

Public engagement

Maternity

- The maternity service had held a meeting with commissioners and local GPs in May to try to address some local misperceptions about care and quality at RLH. About 40 GPs attended and staff felt this had successfully raised awareness of issues involved in optimising normal birth. There was more work to do with GPs who had not taken part in this event.
- One of the recommendations of the Tower Hamlets scrutiny committee (June 2016) had been for a review of its midwife recruitment strategy to increase the diversity of staff to reflect the characteristics of the local population. Another recommendation was that staff should allow sufficient time for staff to provide information to patients, particularly for women who do not speak English as a first language. We found from women and families we spoke with that the experiences of some local women were not good.
- There were two patient experience initiatives in maternity. The Maternity Services Liaison Committee (MSLC) which aimed to involve local women in shaping the future of maternity services in the borough. It was supported by Social Action for Health and quality leads at CCG. It met bi monthly. However there were only 12 volunteers and we were not sure that this could be sufficiently representative. A newer project,Midwives understanding Mothers sought to improve intracultural understanding and provide more person-centred care.

Staff engagement

Maternity

- Morale among midwives both in the community and on the wards was low. There was rarely a full complement of staff in the delivery suite and midwives were pulled from other areas to achieve minimum numbers, thereby reducing staff numbers in other parts of the service. Staff said they were tired of hearing from managers about the improved establishment when this was not their experience on the ground. Staff we spoke with who had tried to escalate concerns, especially about staffing levels said that nothing had been done. One midwife told us it feels like “screaming in a room and no one hears”. Another midwife said she felt her registration was at risk from working in a place she feels can be unsafe; ‘it is just by the grace of God that nothing bad has yet happened’.
- Many staff said they did not feel involved by managers in developing the service. However, the community team reported an opposite experience. When they had concerns about the staffing plans for the AMU they proposed a way they would like to work and gained management agreement.
- Midwives said colleagues had left because of lack of support, and because management appear not to listen to concerns.
- Staff sickness and other absence was 23% in May and June 2016. Sickness can indicate poor morale. Three percent of midwives had handed in their notice in June. There were 32 vacancies in July and the time taken to fill vacancies was unacceptably slow.
- Midwives commented that senior midwifery managers were not visible and did not work clinically. They were cut off from the everyday experiences of midwives.
- Maternity managers felt there had been too much scrutiny of their service, from TDA, then from Health Education England (HEE) because student midwives had raised concerns, and more recently the Tower Hamlets scrutiny report to which a detailed action plan would be developed over the coming months. A further trust instigated investigation had recently been announced. Maternity managers we spoke with felt these investigations were disruptive and partly based on historic situations rather than the current service.
- The trust had run a training programme ‘Great Expectations’ in recent years which was part of mandatory training for band 6 midwives. This had sought to improve staff attitudes and improve women’s experience and satisfaction with care. However, whether from turnover of staff or resistance to change, we found problems with attitude, including staff feeling unable challenge poor behaviours in others. Some midwives we spoke with told us about bullying behaviour between different cliques of midwives and towards some ethnic groups. A new programme, called “Making every contact

count" based on the 6 C's pledges: compassion, care competence, communication courage and commitment, was another attempt to improve compassionate care.
- The increase in midwifery numbers had been more at Band 7 and Band 8 rather than among midwives working clinically. The policy had been not to use agency staff. Midwives in the delivery suite believed the agency staff had only been engaged because CQC was inspecting. However managers told us that there were insufficient midwives available over the summer holiday period, and bank staff were not available and this was the reason for booking agency midwives.
- A number of staff sought out CQC inspectors to say they felt practice on wards at RLH was sometimes unsafe, because staff were cliquey and did not always work as a team, and because of staff shortage.
- Midwives told us they had seen some midwives treat women badly, not asking for consent properly and were rude to women and their partners. Some staff worked together in a way that was intimidating to women and other staff. Managers appeared to believe intracultural issues were historical. However, some staff we spoke with revealed opinions based on culture and ethnicity.
- No midwife we spoke with mentioned the Listening into action programme to engage with staff in a new way by empowering staff at all levels in making improvements.

Gynaecology

- Gynaecology nurses reported good communications from their managers about changes within the service. Doctors said there were weekly communications from the trust executive team and said the medical director and chief nurse were visible and approachable.
- Some gynaecology staff mentioned the trust-wide Listening into Action programme to improve staff engagement and valued the opportunity to raise concerns.

Innovation, improvement and sustainability

- The transforming services together strategy had potential for achieving sustainable change.
- The EGU could access biomarkers for human chorionic 4 gonadotrophin (hCG) results (pregnancy test) within 20 minutes of taking blood. This provided a responsive service to women and improved the care planning process and meant women could have appropriate treatment promptly.
- Use of MVA enabling miscarriage to be managed under local anaesthetic without needing to go to theatre reduced waiting times and uncertainty for women. They had won an award for this service.
- RLH was providing obstetric oversight for a new cervical screening clinic 'My Body Back' for women who had been victims of sexual violence. This had progressed from offering STI testing and contraceptive fitting and advice, to providing pregnancy support for women in ante-natal classes, and care during labour and birth.

Services for children and young people

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

Information about the service

The hospital provides a range of paediatric services, including medicine, general and specialist surgery, paediatric intensive care for children and young people, neonatal intensive care for infants, and outpatient services. Children's services are based on the sixth, seventh, and eighth floors of the hospital, and sit within the Women and Children's Health Division.

The service provision included the 12 bedded Paediatric Assessment Short Stay Unit (PASSU), various medical wards, a six bedded Paediatric Critical Care Unit (PCCU), outpatient department, Children's Day Care Surgery ward, general paediatric surgery, and a discharge lounge. The provision also includes the 37 bedded level 3 Neonatal Intensive Care Unit (NICU).

During our inspection of services for children and young people at the Royal London Hospital, we spoke with parents / carers, children and members of the trust's staff. These staff included medical, nursing, management, administrative, and support staff. We visited the children's outpatients department, PCCU, PASSU, Children's Day Care Surgery, wards 7C, 7D, 7E and 7F, and the NICU. We observed care, reviewed patient records, and examined documentation from the trust and from other stakeholders.

Summary of findings

We rated this service as requires improvement. This was because:

- Inspectors observed a number of ligature risks throughout children's services, which would be a safety issue for young people at risk of self-harm.
- There were examples of safeguarding risks not being appropriately flagged or acted on in patient records. The safeguarding team also did not have the capacity to provide regular safeguarding supervision to all staff.
- Young people's wards were separated by clinical speciality rather than gender, which meant a lot of children were sharing rooms with the opposite gender. The trust was not reporting these as mixed sex breaches.
- Neonatal staff we spoke with stated it was often difficult to quickly transfer patients into their service due to elevator issues and a lack of accessible covered parking for the neonatal transfer service.
- Children's services did not meet trust targets for several significant mandatory training courses, including basic life support and the appropriate level of safeguarding training.
- The number of nursing staff across children's services was significantly lower than the nursing establishment provided by the trust. There was also high agency staff usage in some wards.

Services for children and young people

- There was a gap in oversight of serious incidents for young people between the ages of 16-18. Children's services also did not have an operational adolescent strategy or formal plans for improvement of care for adolescent patients.
- Children's services did not have a robust system of clinical audit in place to monitor adherence to evidence based practice.
- The neonatal unit had decreasing performance in most standards of the National Neonatal Audit compared to their previous report.
- The trust was not meeting targets for providing appraisals to staff, and there were no formal supervisions structures in place. Some staff reported they did not have supervision as part of their roles, or had not had an appraisal within the last 12 months.
- Staff we spoke with were unaware of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguarding (DoLS).
- Children's services did not have a specific learning disabilities pathway. Wards did not have access to input from specialist learning disabilities support, and staff that the needs of patients with learning disabilities were not always being met.
- There was a lack of information about children's services available in languages other than English for patients and their families.
- Children's services and the neonatal unit did not have formalised plans in place for the future strategy and vision for the division.
- Many of the staff that we spoke with stated they did not know who the executive team for the hospital site or the trust wide executive team were. Staff also told us the non-executive director with responsibility for children's services had also not visited the wards as part of their role.

However:

- Staff were encouraged to formally record concerns, and there was a good culture of learning from incidents and changing clinical practice to address identified risks. Risks assessments in patient records we viewed were thoroughly completed and updated, including early warning assessments for at risk patients.
- Children had access to a number of large, well-resourced playrooms, and age appropriate toys. Each ward had a play specialist available to work with children and provide exercises and playgroup sessions during their stay in hospital.
- Inspectors checked equipment throughout children's services and found that items had been regularly checked and tested.
- We found effective multidisciplinary working across children's services at the hospital.
- Children's Services staff had access to a number of Practice Development Nurses (PDNs) to support staff training and development.
- Patients and family members we spoke with were very positive about the staff that were caring for them. Across all children's and neonatal services we saw patients and family members were treated with respect and dignity.
- Children's services had transition pathways and guidelines in place for patients discharged into community care or transferring to adult services.
- We identified good examples of local leadership, both on the wards and within the new organisational structure for the division. Most of the staff we spoke with stated that the culture of the children's services had improved since the last inspection.

Services for children and young people

Are services for children and young people safe?

Requires improvement

We rated safe as requires improvement because:

- Inspectors observed a number of ligature risks throughout children's services, which would be a safety issue for young people at risk of self-harm.
- The safeguarding team did not have the capacity to provide regular safeguarding supervision to staff
- There were examples of safeguarding risks not being identified in patient records
- Children's services did not meet trust targets for several significant mandatory training courses, including basic life support and the appropriate level of safeguarding training
- The number of nursing staff across Children's services was significantly lower than the nursing establishment provided by the trust.
- There was a gap in oversight of serious incidents for young people between the ages of 16-18

However:

- Staff were encouraged to formally record concerns, and there was a good culture of learning from incidents and changing clinical practice to address identified risks.
- Children had access to a number of large, well-resourced playrooms, and age appropriate toys.
- Risks assessments in patient records we viewed were thoroughly completed and updated, including early warning assessments for at risk patients.
- Inspectors observed handovers and safety huddles taking place and found them to be well organised.
- Inspectors checked equipment throughout children's services and found that items had been regularly checked and tested.

Incidents

- Children's services reported 11 serious incidents (SIs) in the period between May 2015 and June 2016. This included four cases of treatment delay meeting SI criteria, and three cases of sub-optimal care of a deteriorating patient meeting SI criteria. The trust reported no never events in this same period. A never event is a wholly preventable incident, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level.
- Managers stated told us that children's services managers had oversight for all incidents for patients from birth up to 16 years old. This left a gap for incidents involving patients aged 17 to 18. Managers were not sure who had responsibility to investigate incidents for this group, and were not sure if these incidents had any governance oversight.
- Some staff in children's services were unsure about their responsibilities in relation to duty of candour (DoC). Inspectors observed information posters relating to DoC displayed on some wards, and noted an example of DoC recorded in patient notes, however some staff were unaware of what DoC was or when it would be important.
- Some staff told us that they did not think they were well informed about incidents outside of children's services. Managers told us that there had been some recent structural changes in the governance team and that they hoped to improve the structures for learning from incidents from other core services and other Bart's Health hospital sites.
- Safety Thermometer data was provided for the period between April 2015 and April 2016. The trust reported three pressure ulcers, three falls resulting in harm to the patient, and two catheter acquired urinary tract infections.
- Staff were aware of how to report incidents and told us that managers encouraged them to report concerns. Incidents were reported using an electronic records system, and staff received training in how to report incidents at induction. All incidents were viewed by the managers of the relevant wards, and the assistant director of nursing had oversight of all incidents within children's services.
- Staff told us they receive feedback and learning from investigations into incidents through many different sources. Staff stated there are regular emails on learning

from incidents sent by both managers and governance leads for children services, and this is followed up with discussion in team meetings, handovers, and safety huddles. Staff also told us there is a monthly newsletter from the governance team on learning from incidents, and information is also available on the trust intranet. Inspectors observed a safety huddle for staff in which learning from an incident was discussed.

- Children's services medical staff held monthly morbidity and mortality meetings to review any patient deaths and identify areas for improvement. The trust had previously only recorded attendance at these meetings, however had recently started taking minutes for these meetings to track actions more easily. The neonatal staff had a separate monthly morbidity and mortality meeting with obstetric and maternity colleagues to review any infant deaths, and this meeting reported into the perinatal board.

Cleanliness, infection control and hygiene

- The trust provided analysis of MRSA and Clostridium difficile (C.diff) infection rates across the trust between April 2015 and March 2016. The data states children's services recorded one case of MRSA in February 2016 and one case of C. diff in April. However the data provided by the trust on reported incidents for the same period identified a patient transferred between paediatric wards without staff being made aware of the patient's MRSA status . Although the incident report for this patient identified the actions taken to address the infection risk, this suggests some MRSA cases have been missed in transfers between paediatric units.
- Inspectors noted examples, both in the neonatal unit and in children's wards, of sharp boxes not being appropriately secured or not using temporary lids to keep the boxes closed when not in use. This issue was also identified in cleanliness audits for several wards.
- The trust provided data on MRSA screening within children's services between October 2015 and April 2016. The trust record a low of 54% completion of MRSA screening in this period in January 2016, however performance had improved month on month to 89% in April 2016.
- Hand hygiene audits were provided by the trust for the period between April 2015 and April 2016. Although we observed good practice on the inspection, the audits state that some wards, particularly the respiratory ward (7E) and Paediatric Critical Care Unit (PCCU), fell below the trust target of 90% for several months during this period. Hand hygiene performance had decreased from 96% in April 2015 to 61% in April 2016. The data provided also contained several gaps in recording of hand hygiene performance, which means the quality of monitoring hand hygiene is also impacted. Trust audits state that where concerns are identified, the IPC team carry out independent audits and will hand hygiene workshops where necessary.
- Each ward within children's services completed annual cleanliness audits examining the ward environment, information provided, waste management, and isolation compliance. Where issues are identified in the cleanliness performance of wards, action plans are developed with timescales for completion.
- Inspectors observed personal protective equipment (PPE) and hand hygiene containers outside all rooms in children's services. Staff were seen to display good practice to hand hygiene and infection control, with staff washing hands in between patient contacts and wearing PPE when required.
- Staff were able to identify the trust policies for hand hygiene and infection control on the trust intranet, and stated they could contact the infection control lead nurse when needed.

Environment and equipment

- Inspectors observed a number of ligature risks in assessment areas of children's services, which would present a risk to young people with acute mental health problems. This was a particular concern in the Paediatric Assessment Unit (PASSU), where they would accept mental health patients to the ward for assessment regularly. A risk assessment of ligature risks across the trust had been completed in April 2015, identifying children's wards as priorities for assessment, however there was no evidence a risk assessment of children's services had not been completed since then.
- Access to children's services was limited by elevator access and a lack of appropriate signposting for the wards. Parents stated there were not enough public elevators in the hospital, and that they had experienced delays queuing for elevators which had resulted in late arrival for appointments. Parents we spoke with also

stated that the lack of signposting could make it difficult to find the appropriate ward or department. Inspectors noted there was not enough signage to direct visitors to the relevant wards, and no signs or directions were available in languages other than English.

- Neonatal staff we spoke with stated it was often difficult to quickly transfer patients into their service due to elevator issues and a lack of accessible covered parking for the neonatal transfer service. Staff stated that as different elevators went to different floors, the current elevator in use for the neonatal unit was not easily accessible for maternity services, and this created delays in transferring patients between floors. Neonatal staff also stated they did not have an emergency override of the elevators to ensure quick transfers of patients when needed. Staff stated that it could be difficult to find appropriate space for transferring neonatal patients from accident and emergency vehicle bays. Staff told us there had been a recent incident in which ventilation equipment had malfunctioned due to rain during a patient transfer, and this lack of cover during transfers could put patients at risk.
- Inspectors noted that some of the environments we visited were sparsely decorated and not child friendly, particularly on the neonatal ward. While some areas had developed child friendly posters and murals, some of the environments were clinical and did not have much decoration. Senior staff we spoke with stated they were limited in what decorating could be carried out due to the ownership of the building, and they were also not able to change the names of the wards to something more child-friendly. This was due to the trust not owning the hospital building, and this restricted the improvement works that could be carried out.
- The Royal London Hospital had their most recent Patient Led Assessment of the Care Environment (PLACE) visit in July 2015. Assessors visited a number wards around the hospital, and included assessments of the neonatal unit, the paediatric gastroenterology unit, and paediatric surgery. The PLACE report states that assessors were either confident or very confident that each of the three children's services visited had the necessary environment to support good care.
- Children's services were able to provide accommodation for parents both on some wards and through Stevenson House, a 16 bedded, free of charge, accommodation site provided by The Sick Children's Trust charity. The Paediatric Critical care unit had two rooms available on the ward for parents to stay in, and there was documentation on wards we visited advertising these services to parents.
- The services we visited were clean and clutter-free. Cleaning staff were visible completing the cleaning rotas and any areas we checked were well maintained. Staff stated that the cleaning staff maintained a high level of cleanliness throughout the wards, and parents we spoke with stated the environments were tidy and regularly cleaned. Children's services at the Royal London also scored around the same as the England average for questions in the 2014 Children's Survey relating to cleanliness.
- Inspectors checked equipment throughout children's services and found that items had been regularly checked and tested. Electrical equipment had received regular testing from the facilities department, and there was evidence that clinical equipment was monitored and had been identified as working. Equipment was given a sticker to show when the next testing was due. Staff stated that if they noticed something broken or not working, they could access facilities easily and the issue would be dealt with quickly. Data provided by the trust shows most requests for repairs were addressed and completed on the same day.
- Children had access to a number of playrooms and age appropriate toys across children's services. There was a large children's play room available for all children's wards to access, which play specialists used to run fun activities and therapeutic groups. Older children also had access to an adolescent activities room, which contain more age appropriate activities. Individual wards also had access to communal areas which staff could use for therapy or activity groups.
- Inspectors checked resuscitation trollies throughout children's services and found them to be well stocked and regularly checked. Staff recorded checking the trollies regularly to ensure it contained the necessary resuscitation and defibrillation equipment, and trollies were easy to access in case of emergency.

Medicines

- Children's services had access to the pharmacy team 9am-5pm Monday to Friday, with out of hours cover on

evenings and weekends. The pharmacy team topped up medication stores on a weekly basis, or as required when contacted by the wards. Staff we spoke to said they had access to the on-call pharmacist when required out of hours and did not experience delays in receiving discharge medicines.

- Staff stated that they were encouraged to report any medication errors as incidents by their managers. Staff were able to provide examples where incidents with medication had resulted in changes in practice on the ward.
- Children's services had a monthly medication governance group attended by paediatric lead nurses to address medication incidents and identify themes. Managers investigated medication errors on their wards and fed back on the incident and actions in the governance meeting. Managers then fed back the outcomes of investigations and governance through team meetings.
- Children's services had recently introduced having pharmacists attend ward rounds with the clinical teams on each ward. This allowed the pharmacy team to assess the medication needs of each service and identify issues with medication administration. Staff told us that since introducing the pharmacist to ward rounds, medication errors had been reduced.
- Medication storage within the children's services we visited was well managed and monitored. Inspectors checked refrigerators for storing medication and found them to be secured, with temperatures check daily by staff. Staff prescribing controlled drugs were required to sign their name and record the dosage, and there was also separate storage for controlled drugs belonging to patients.
- We found that Patient Group Directions (PGDs), written instructions which allow non-medical staff to supply or administer certain medications, were in place at the hospital and were appropriately authorised. There was a policy in place to support the use of PGDs and we saw evidence that they were signed by authorised personnel, in date, and appropriately audited.

Records

- An audit of patient records showed significant gaps in recording vital patient information and evidence of patient contact, including known allergies and safety alerts. Children's services provided the results of an audit from 2015 of completeness of patient records. The audit used 28 randomly selected patient records to examine quality of patient records. Allergies and adverse reactions were recorded in none of the neonatal patient records examined, and in 69% of children's patient records. Safety alerts were also only record in 7% of neonatal notes and 38% of children's patient records.
- The audit of patient records showed safeguarding information for patients was not being recorded in notes. None of the patient records included in the audit had recorded names of parents and patient siblings. Notes also did not show if a social worker was notified of child protection concerns, or if the child being treated had been attending school.
- There was a lot of variation across children's services in the systems for managing patient records. Some services, such as the outpatients department were using an electronic clinical records system and printing out records for clinician, while other services continued to use paper notes such as the Paediatric Assessment Unit (PASSU) and Paediatric Critical Care Unit (PCCU). There were also examples on paediatric wards where doctors and nurses completed different sets of patient records. This meant it could take longer to access patient information, and there was risk of information being overlooked. Some administrative staff we spoke with also stated it was time consuming to have to print off folders of patient records for patient visits, when the information was available on the clinical records system.
- A quality assurance visit from Commissioners in May 2016 found staff in outpatients were unaware of safeguarding flags on patient records. This meant that important safeguarding and child protection information relating to patients may not have been known to clinicians providing care. Commissioners identified this as an area for improvement in their report.
- Inspectors examined copies of the paediatric inpatient admission booklet in use on some wards. Of the nine examples we viewed, five were missing information relating the patient admission, with sections left blank, including some missing the patient admission checklist and if patient had received an ID band. The ID band uses

different colours to help identify patients with clear clinical risks, for example allergies. Senior staff we spoke with stated the trust was developing a new admission pack.

- Inspectors observed patient records on the PASSU were not signed or dated by the attending medical staff. Of six patient records viewed in this area, none of the documents contained the name or signature of the attending clinician.
- We viewed 25 sets of patient records across different children's services and found the majority of notes contained comprehensive recording of risk assessments, ward rounds, medication charts, and information on diagnosis.
- Records we viewed across children's services were clear, accurate, and legible. Interactions with patients were recorded thoroughly by staff and provided good information to other clinicians viewing patient notes.

Safeguarding

- The safeguarding team does not have capacity to provide regular safeguarding supervision to children's services staff. The child safeguarding lead stated that one of the main challenges for the safeguarding team was providing adequate support and supervision, and that this was an ongoing challenge for children's services. Staff we spoke with stated that they were not receiving safeguarding supervision regularly.
- Mandatory training data provided by the trust shows that many wards did not meet the trust target of 90% for safeguarding level three. Safeguarding level three is required by all staff working with children and their families, however only 82% of staff have completed the training. Trust figures show that 40% of medical staff in the high dependency unit had completed the appropriate level of training, while in paediatric surgery only 43% of medical and 54% of nursing staff are compliant. Many of the staff we spoke with also had not completed Prevent training, for awareness of patients or families at risk of radicalisation.
- Staff informed us that the human resources department had waived the need for staff to have completed a Disclosure and Barring Service Check prior to beginning employment with the trust. We were told this was put in place to help staff start their employment as soon as possible, however this presented a significant safeguarding risk to patients. Senior staff told us that children's services were exempt from this approach, and staff on children's wards would still need to have completed a DBS check before beginning employment. However staff were not sure how this would be managed for young people over the age of 16 who were on adult wards.
- The staff we spoke with were well informed on their responsibilities in relation to safeguarding. Staff described the process for identifying safeguarding concerns and how they would contact the safeguarding team. Information on how to contact the safeguarding team was available on the wards and staff could easily find safeguarding information and policies on the intranet.
- The trust had robust arrangements in place to identify children and young people who may be safeguarding risks, both within children's services and in other departments. Emergency services completed a safeguarding proforma for each admission under the age of 17 which identified any social care, mental health, or safeguarding risks before they were transferred to children's services. The neonatal unit also worked closely with maternity and the tower hamlets gateway team to identify any children that may present a safeguarding risk, and there was a safeguarding lead midwife for the Royal London site.
- The safeguarding team liaised closely with the Multi Agency Safeguarding Hub (MASH), a local working group of healthcare services, police, education and social care services. MASH had worked together in the past to deliver joint training and local initiatives.
- The safeguarding team was consulted during the recruitment process for new staff. The safeguarding team had developed questions for interview panels, checked Disclosure & Barring Service (DBS) forms when concerns had been identified, and the safeguarding lead nurse had been involved in the appointment of the post for senior divisional staff.
- The child safeguarding team had oversight of incidents and concerns raised within children services. The safeguarding team was copied into any incidents for the division, and contacted the member of staff if they felt there were safeguarding concerns or if more information

was required. The safeguarding lead also receives notification of any complaints relating to children's services. Inspectors also viewed patient records and noted safeguarding risks were flagged when there were existing or previous concerns, particularly for children on Children Protection plans or Looked After Children.

- Staff we spoke with showed good knowledge of Female Genital Mutilation (FGM) concerns and how to best manage risk for patients and families. Some staff provided examples where they have reported concerns to police with support from the safeguarding team. The safeguarding team stated they had delivered sessions for staff locally on FGM awareness.
- Nursing and reception staff we spoke with were aware of the chaperone policy for the trust and what their responsibilities were. Staff were able to identify the policy easily on the trust intranet.

Mandatory training

- Children's services are not meeting the trust mandatory training target of 90% for several required courses, including basic life support, and moving and handling patients. Data provided by the trust shows a lot of variability in completion of mandatory training across different services and disciplines, with overall compliance at 89%. However many significant training courses have low rates of completion, including basic life support (72%), moving & handling (74%), and fire safety (78%). This presents a significant risk to patient safety if staff do not have the required training.
- Nursing and medical staff on the neonatal unit was not meeting mandatory training targets in several key areas. Overall neonatal nursing staff was complaint with mandatory training targets of 90%, however there were low rates of training completion in emergency planning (73%) and basic life support (81%). Neonatal medical staff had an overall training completion rate of 77%, with lower compliance rates in infection control, and information governance (both 33%).
- Staff we spoke with stated there was good access to mandatory training, and the list of competencies to be completed was comprehensive, however some staff stated it was difficult to make time for training. Staff stated that they monitored their current compliance using a training management software tool, and would be alerted by a message when training was about to expire. Senior staff also stated they are alerted when staff required training, and will follow this up with staff individually and in team meetings as required.

Assessing and responding to patient risk

- Children's surgery uses the World Health Organisation (WHO) Safer Surgery Checklist, a six step process to improve communication between staff in surgical procedures and reduce the risk to the patient. Children's services completed a monthly audit of performance and found paediatric surgery to be compliant in most areas. However the audits provided from March to April 2016 show some staff did not complete debriefs following surgery. This was as lowest in March 2016, when 32% of audited checklists did not record a debrief following surgery.
- Children's services used the Paediatric Early Warning Score (PEWS) to identify children and young people who required immediate care. The Neonatal service used a different early warning system designed specifically for neonatal risks (NEWS). Inspectors viewed patient records and found PEWS and NEWS documents comprehensively completed and regularly reviewed. Children's services also regularly audited the completion of the PEWS scores on wards to review performance.
- Staff we spoke with were aware of the appropriate action to take if they identified a patient as unwell or deteriorating, or if patients scored highly on early warning assessments.
- Children's had processes in place to manage the safe transfer of patients to the appropriate intensive care facilities when required. Paediatric critical care staff were available to provide support to colleagues on general paediatric wards if needed, and could respond to emergency paediatric resuscitation calls if needed.
- Inspectors observed patient safety information displayed on boards across all wards in children's services. The safety information contained data on pressure ulcers, falls, staffing levels, and the Neonatal and other speciality wards had specific safety data relating to their unique clinical risks displayed.
- Children's services had implemented the Situation Awareness for Everyone (SAFE) developed by the Royal

College of Paediatric and Child Health. SAFE huddles are nurse led multidisciplinary ward rounds lasting ten minutes to discuss unwell and deteriorating patients on the ward, with escalation plans made to facilitate appropriate patient care. Inspectors observed huddles taking place across children's services at designated times throughout the day, with both nursing and medical staff attending

Nursing staffing

- The number of nursing staff across Children's services was significantly lower than the nursing establishment provided by the trust. Data provided by the trust stated children's services needed 213 whole time equivalent nurses (ranging from ward managers to support worker), and were currently meeting approximately 70% of that target. The gap was most significant in Band 5 nurses (70%) and Bands 2 or Band 3 support workers (60%). Senior staff were aware of the gap in staffing and had been addressing the issue through recruitment drives. Staff we spoke with stated that while staffing had improved, there were some units that had high usage of non-permanent staff.
- Children's services did not have a formal acuity tool for measuring the number of staff needed on shift. Senior staff stated that an acuity tool was being developed in consultation with staff, but that acuity was currently monitored through our handovers, ward rounds and safety huddles.
- Staff we spoke with stated there had been ongoing delays with HR in terms of recruiting and confirming new nurses into post. Staff stated that it could be difficult to contact the HR department, and this had caused significant delays in confirming offers of employment, organising salaries, and Disclosure and Barring Service (DBS) checks. Senior staff stated there had been instances where people had accepted roles, however due to delays with HR, the applicants took employment elsewhere.
- Children's services provided data on the use of bank and agency nursing staff within the past six months (November 15 to April 16) across all services. In total, the trust required bank staff to fill 7% of their shifts, with agency staff filling 9% of shifts. The trust used regular bank staff to fill nursing shifts much more frequently than agency staff, however some wards still required a large percentage of bank and agency staff to fill nursing shifts. Agency staff use was particularly high in Children's Day Care Surgery and Ward 7F, often above 20% of total nursing shifts in the six months of available data.
- Staff we spoke with stated that there is generally enough staff on each shift to meet the needs of the unit, with an appropriate skill mix spread across the team. Staff stated that managers can organise additional or replacement staff quickly if needed, and there was support available out of normally working hours to bring in additional staff if needed.
- Inspectors observed handovers taking place and found them to be well organised. Handover was organised twice a day at the changeover in shifts, and staff appeared to be well informed. Information was recorded using a handover template and information was communicated well to staff coming on shift.
- Children's services had a ward escalation process in the event of some services being understaffed. Staff stated there was a buddy system where staff could support another associated ward if there was a need for additional staff or if acuity on a ward increased.

Medical staffing

- Staff we spoke with stated there had been use of locum medical staff to cover senior medical vacancies, particularly on the neonatal unit and on the paediatric critical care unit (PCCU). Medical staff and managers stated that the locum use would remain in place until recruitment had identified suitable candidates for the substantive roles, which was underway. Managers for the neonatal unit stated that the service did not currently have the substantive consultant cover required to meet the needs of the unit.
- Children's services had sufficient Monday to Friday cover for non-consultant medical staff. Junior Doctors and Registrars were available across children's wards, with reduced cover on night shifts and weekends. In addition to staff on the wards, there was also a paediatric doctor in the emergency department to facilitate patient transfers to children's services, and a critical care unit registrar who attended paediatric resuscitation calls.
- The trust provided a breakdown of the skill mix of medical staff across children's services. The trust has a significantly higher percentage of registrars (61%)

compared to the England average, and was lower than the England average for consultant and middle career medical grades. This meant there was less access to experience support when compared to other children's services nationally.

- There was appropriate consultant cover for patients across children's services. Children's services used a 'consultant of the week' model (COW), where a consultant will cover paediatric general wards every day from 8.30 am to 5.30 pm, with a separate paediatric consultant on-call from 5.30 pm to 8.30 am the next day. There was also a general paediatrician rostered to cover the wards from 4.30 pm to 8 pm during the week and paediatric consultant cover weekends from Friday evening until Monday morning.
- Staff stated there were able to contact consultants out of hours for support if needed. Consultants were available both over the weekend and throughout the night to provide advice and clinical support to other medical staff when required.
- Medical staff attended handovers with nursing staff at the beginning and end of shifts. Inspectors observed the handovers and we found that information was communicated well to staff coming on shift.

Major incident awareness and training

- Mandatory training records provided by the trust state that 87% of children's services staff had completed the emergency planning training, against a trust target of 90%. Staff told us that emergency planning training was part of the mandatory training programme, but were not aware of any recent training exercises to test the service readiness.
- Staff we spoke with were aware of major incident and business continuity policies and were able to access the documents on the trust intranet. Inspectors viewed major incident and business continuity policies and found them to be up to date.

Are services for children and young people effective?

Requires improvement

We rated effective as requires improvement because

- Children's services did not have a robust system of clinical audit in place to monitor adherence to evidence based practice.
- Young people using children's services were not having their nutritional needs appropriately assessed or recorded.
- The neonatal unit had decreasing performance in most standards of the National Neonatal Audit compared to their previous report.
- The trust was not meeting targets for providing appraisals to staff, and there were no formal supervisions structures in place.
- Staff we spoke with were unaware of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguarding (DoLS).

However:

- We found effective multidisciplinary working across children's services at the hospital
- The care we observed within children's services was in line with the practice outlined in local policies and guidance.
- Pain management appeared to be well managed by staff within children's services.
- Children's Services staff had access to a number of Practice Development Nurses (PDNs) to support staff training and development.

Evidence-based care and treatment

- Children's services did not have a robust system of clinical audit in place to monitor adherence to evidence based practice. The therapies team within children's services had developed their own programme of local audit and children's services had examples of some local audit, however there was currently no overall strategy or monitoring of audits. Senior staff stated this was an area for development within the service.
- Trust staff we spoke with stated that the availability of reliable information to the Clinical Academic Groups (CAGs) remained a problem for children's services. This had been identified in the previous CQC report as an issue. Senior staff stated they were developing the

systems to provide better information to support service, and the new governance structure had improved the availability of information, however it would take time to embed the structures into practice

- The trust had in place Clinical Academic Groups (CAGs) for each core area of services provided at the three main hospital sites. The aim of the CAGs was to support clinical development within their associated core service, direct research, and support the improvement of clinical standards. The CAG Director for women and children's health was experienced in children's services, and had input into other associated CAGs relevant to children's health such as surgery CAGs
- Procedures and policies in place across the hospital's children and neonatal service were up to date and reflected most recent evidence for best practice and NICE guidelines. Policies we viewed were up to date and regularly reviewed. Staff we spoke with stated they felt the trust work to the best available guidance in clinical practice.
- The care we observed within children's services was in line with the practice outlined in local policies and guidance. Staff stated that policies were regularly reviewed and improved to reflect changes in national guidance, and managers would frequently prompt staff to view policies which had been reviewed or developed.
- The review of clinical guidelines and the development of new policies took place at a trust-wide board level. A children's services manager from Whipps Cross Hospital had oversight of any trust-wide policy to ensure they also reflected the needs of children and their families. Children's policies and updates to guidelines were supported by the work of the CAGs
- Children's services had significant involvement in the inflammatory bowel disease Quality Improvement Project, organised by the Royal College of Physicians. The report identified access to diagnostic services and the quality of information available as areas for improvement; however the overall report on the service provided was positive. A peer review visit to the paediatric gastroenterology team stated that the Royal London Hospital provides an excellent service for children and young adults with inflammatory bowel disease.

Pain relief

- Pain management appeared to be well managed by staff within children's services. Staff were aware of pain management policies for children's services, completed pain assessments for patients and offered medication as required. Family members of patients told us their child had been offered pain relief when admitted and that this was regularly monitored by staff throughout their admission.
- Inspectors spoke with a clinical nurse specialist (CNS) with responsibility for paediatric pain management, who provided support to paediatric staff mainly at the Royal London Hospital, but was available to support children's services at other Bart's Health sites. The CNS provided support to anaesthetic and surgical teams as well as to staff on the ward, and also provided time released pain management and epidural services. The CNS had also been involved in writing and updating prescription and pain management guidelines for the trust.
- Play specialists across the wards and in the children's outpatient department provided relaxation techniques to help children manage pain. This was particularly noted for children requiring frequent cannulation, such as in sickle cell anaemia treatment. Play specialists also stated that they monitored children in wards and those waiting for outpatient appointments for any signs of pain, and if any needs were identified they would be reported to the manager for the service.
- Patient records throughout children's service showed clear evidence that pain management was being measured and medication provided as appropriate. Records showed completed pain assessments for patients across wards and prescription information completed and signed.

Nutrition and hydration

- The trust provided evidence of a Screening Tool for Assessing Malnutrition in Paediatrics (STAMP) audit completed at the Royal London Hospital in April 2016. STAMP is a validated tool for nutritional screening for children aged 2-16 admitted to hospitals in the UK. The STAMP tool had been introduced in 2010 at the Royal London Hospital with the aim of identifying malnutrition, reducing length of stay, and making more effective use of trust dietetic resources. The audit stated that 63% of patient records audited had a completed

STAMP document. This meant that many young people using children's services were not having their nutritional needs appropriately assessed or recorded. The audit included several recommendations to improve use of the stamp tool, including training for all staff and improving awareness of the tool.

- The neonatal service provided access to a dietician, as is required for level 3 neonatal units by the British Association of Perinatal Medicine (BAPM). However, staff told us that the support available was not dedicated time to the neonatal unit, but that dietetic support was available when needed. Staff stated that there was not enough availability of dietetics for the neonatal unit to meet the needs of the patients.
- A choice of meals was available each day for the young people. Parents could also access meals if necessary and there were kitchens available on wards for patients or visitors to make drinks. Staff informed us that due to patient feedback, children's services had reintroduced a hot trolley service for meal choices, as patients were unhappy with the previous choice of food. Patients and family members we spoke with were positive about meal choices and dietary requirements.

Patient outcomes

- The neonatal unit participated in the National Neonatal Audit Programme undertaken by the Royal College of Paediatrics and Child Health (RCPCH). The latest report was published in November 2015 for the period from January 1 to 31 December 2014.
- The hospital's performance against the four national standards with a target of 100% compliance was that:
- 91% of babies of less than 29 weeks gestation had their temperature taken within the first hour of birth. The percentage difference between 91% and 100% was four babies out of 45 that didn't have their temperature taken with one hour of birth. The neonatal unit had achieved an 87% score in the previous audit from October 2014.
- 87% of mothers who delivered their babies between 24+0 and 34+6 weeks gestation were given a dose of antenatal steroids. The percentage difference was 18 births in 136 where the mother was not given antenatal steroids. The neonatal unit had achieved a 99% score in the previous audit.
- 99% of small / delivered early babies underwent the first retinopathy of prematurity screening. One eligible baby out of 93 was not being screened. The neonatal unit had achieved a 99% score in the previous audit.
- The hospital had documented a consultation with parents / carers with a senior member of the neonatal team within 24 hours of admission in 81% of cases, which was 353 out of 438 cases. The neonatal unit had achieved a 92% score in the previous audit.
- Almost all children's services had an emergency readmission rate in line with, or significantly lower than, the national average. The paediatric medical oncology ward had an emergency readmission rates within two days of discharge of 4%, double the national rate of 2%. However the rest of services we visited were lower, with paediatrics services having an emergency readmission rate of 0.5% compared to a national average of 3%.
- Children's services participated in the Paediatric Diabetes Audit for 2014/2015. The data indicates that the Royal London Hospital performed better than the England average and hospitals in London for management of patients glucose levels. Children's services also performed better than the England average in providing the all seven key care process for diabetes, including assessment of blood glucose, body mass index, blood pressure, and cholesterol.
- Children's services performed approximately the same as other NHS trusts in England for questions relating to the effectiveness of services in the 2014 Children's Survey.

Competent staff

- Neonatal managers stated that there were difficulties in finding nursing staff with the appropriate skill mix for neonatal roles, particularly those with a qualification in speciality (QIS). Senior staff at the neonatal service stated it takes up to 18 months to develop staff to band 5 competencies, with further training required for band 6 competencies, and the neonatal unit supports staff in completing this training at university. However the neonatal service currently had 50% of staff who were QIS, when the British Association of Perinatal Medicine (BAPM) staffing toolkit suggests 70% of staff to be QIS. Managers we spoke with were aware of the issue and it was on the service risk register.

- However the neonatal service had 50% of staff who were QIS, when the British Association of Perinatal Medicine (BAPM) staffing toolkit suggests 70% of staff to be QIS. Managers we spoke with were aware of the issue and it was on the service risk register.
- Managers we spoke with stated that it can be difficult to access a registered mental health nurse through the staff bank, particularly ones that have experience working with children. Staff stated they had been working with a young person that was a risk of self-harm and this had been difficult to manage without specialist mental health nursing input.
- Within children's services, just fewer than 80% of staff were up to date with their appraisal, against a trust compliance target of 90%. Children's services had set a deadline for completion of appraisal to trust standards by the end of July 2016; however this target was not met.
- Children's services did not provide data for the availability of clinical supervision to staff, and it did not appear to have a structure in place to offer staff regular individual supervision.Staff we spoke with stated they did not have supervision, particularly in neonatal and outpatient services, but felt they could access managers for informal support if they needed.
- The trust had structures in place to identify nurses requiring revalidation by the Nursing and Midwifery Council (NMC) and support nurses to make applications. Staff we spoke with staff children's services had been supportive when staff had to apply for revalidation. Medical staff we spoke with also stated the trust were helpful when staff needed revalidation.
- Children's Services staff had access to a number of Practice Development Nurses (PDNs) to support staff training and development. Staff we spoke with stated they felt very supported by the PDNs and had been able to access training to improve their competencies and develop in their roles. New staff stated that PDNs had been very helpful by supporting them in their roles and facilitating access to necessary training.

Multidisciplinary working

- We found effective multidisciplinary team (MDT) working across children's services at the hospital. A range of weekly, multidisciplinary meetings took place allowing staff from across the various services to discuss, plan and reflect on patient care. Medical, nursing, and Allied Health Professional (AHPs) and we spoke with stated there was a good relationship between disciplines and this facilitated more effective working.
- Examples of MDT working and input were evident in patient records we viewed and people we spoke to. MDT working was recorded in patient notes, and parents shared with us examples of specialist input their children on various different wards. This included access to physiotherapy, occupational therapy, specialist medical input, dietetics and psychology.
- Children's services used an electronic discharge system, which all staff could log in to and which supported the timely transfer of information to local authorities and community services such as health visitors and GPs.
- A neighbouring mental health trust had a service level agreement with children's services to provide the psychology and mental health support across all departments. This included supporting and advising children's services staff, providing assessment for patients and facilitating their referral to mental health services, and helping to develop care plans with colleagues from other disciplines. Staff we spoke with stated that the psychology provision for the department was well managed.
- Staff from the neonatal unit worked closely with colleagues in maternity to identify patients before birth who may need support. The neonatal service also held a weekly psychosocial meeting weekly with social care, safeguarding, mental health and neonatal staff to ensure care plans covered as many risks as possible.
- Children's service liaised with community colleagues to provide additional support to patients, particularly if this meant it prevented an admission to a hospital bed. Staff we spoke with often support community services with arranging outpatient appointments, and a lot of MDT staff in children's services (for example, occupational therapy) had good links with their community counterparts to provide easier access to services.
- The trust works closely with other children's hospitals to provide transfer to their specialist services if needed. The trust works closely with other children's services

with specialities in oncology, psychology, neurology and trauma, and can support patients to access these other services if needed. This was also the case for the neonatal unit and their involvement in the London Neonatal Network.

- Children's services staff had regular outlier meetings to identify young people under the age of 18 who were being care for on adult wards, and providing specialist support.

Seven-day services

- The neonatal service has access to their own imaging equipment, such as ultrasound, to support quicker diagnosis and assessments for patients. Other departments in children's services could offer seven day access to some diagnostic equipment, however this was limited on weekends in some medical specialities due to availability of experience staff.
- Nursing and medical cover was available 24 hours a day, seven days a week, with on-call support and advice available if required. The Paediatric Assessment Unit (PAU) and Critical Care Unit (PCCU) had additional staff available out of hours to support transfers from accident and emergency services and manage patient risk.
- All of children's services had access to an on-call pharmacist out of hours who could be contacted for advice and assistance with medicines supply issues.
- Physiotherapy services were available seven days a week during the day, with an on-call physiotherapist available out of hours if required.

Access to information

- Children's services had different methods of recording information across disciplines and wards, which meant access to information could be limited. Both nursing and medical staff across wards had different records systems for documenting case notes, and staff stated this can create delays in accessing information. The outpatient department administrative staff printed out the most recent patient notes for staff from computers, but did not print out patient's full case histories for clinicians. This meant clinicians were not receiving full access to information when seeing patients.
- Staff stated that discharge information is provided verbally currently to patients, with information sent to GPs. Staff in children's services told us they are currently working on a discharge checklist to improve the quality of information provided to patients and other healthcare professionals.
- Senior staff we spoke with stated that children's services were not ensuring use of a Personal Child Health Record (PCHR). Staff told us there that some patients found it difficult to use if they did not have English as a first language, and the service was looking to develop a patient passport which would be easier to use, however there were no plans on when this would be available.
- The transfer of information between different departments working with children's services was well managed, particularly from the accident and emergency department. Inspectors viewed examples of patient records transferred from emergency services to children's department and found they contained relevant risk assessments, case notes, and test results. Staff stated that the flow of information from other departments was well organised and easy to access.

Consent

- Children's services provided the results of an audit of patient records in 2015, including recording of consent to treatment for neonatal surgery. Of four patients records viewed, all had records had recorded consent to treatment, and consent forms were deemed to be legible.
- Staff we spoke with were unaware of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguarding (DoLS), which would apply to young people over the age of 16. Staff we spoke with stated they had not had training on MCA and DoLS and data provided by the trust shows this was not part of the mandatory training programme. Staff also stated that they did not have restraint training as part of their mandatory programme, and were not sure what the process would be to manage patients that did not consent to treatment. Staff we spoke with did have an understanding of Gillick competency and Fraser guidelines for consent.
- Inspectors observed across children's services in patient records that parents and children had signed consent forms for treatment. Staff had recorded discussions on consent in patient notes, and parents we spoke with

stated they had discussed consent with clinicians and signed documentation when appropriate. Inspectors also observed staff obtaining verbal consent with patients and parents prior to beginning treatment.

- Consent forms in children's services contained information on the risks of receiving treatment and information on patient rights, and parents were provided with a copy of the documentation for their information.

Are services for children and young people caring?

Good

We rated caring as good because:

- Across all children's and neonatal services we saw patients and family members were treated with respect and dignity
- Each ward had a play specialist available to work with children and provide exercises and playgroup sessions during their stay in hospital.
- The trust offered support to counselling services through the CAMHS psychological support services to patients and families.
- Patients and family members we spoke with were very positive about the staff that have been caring for them.

However:

- Some wards restricted the visiting hours of siblings and grandparents.

Compassionate care

- Children's services had 55 responses to the Friends and Family Test (FFT) in the past month from patients. From this number, 87% of patients would recommend the service to family and friends if needed. The trust also worked closely with an organisation that collected satisfaction data from the public regarding their experience of care, and The Royal London Hospital had a five-star rating from over 30,000 reviews, with children's wards consistently reviewed positively.
- Across all children's and neonatal services we saw patients and family members were treated with respect and dignity. Staff were observed to be understanding and empathetic in their interactions with patients, and were very welcoming and supportive towards visitors to the unit.
- Staff introduced themselves when meeting with patients and family members, and were respectful of patient's privacy on the wards. Staff discussed patient's care with family members in private, and were sensitive and caring when discussing diagnosis and treatment.
- Patients and family members we spoke with were very positive about the staff that have been caring for them. Feedback from patients and family members stated that staff were friendly and caring, and that staff made an effort to talk to children as well as parents. Feedback about neonatal staff stated the team were kind and compassionate, and that parents felt they could access the right staff when they needed to.
- We observed reception and clerical staff were patient and friendly when interacting with patients and family. Reception staff were respectful of patient confidentiality and polite when offering support or booking in appointments.
- The results from the most recent Children's Survey (2014) show that the trust scored around the same as other trusts nationally in questions relating to compassionate care.The responses were consistent across young children (up to seven years old) and adolescents (seven to 14 years old).

Understanding and involvement of patients and those close to them

- The trust had developed an adolescent forum for patients, which ran monthly at Whipps Cross, but was open to children's services patients from all hospital sites. The aim of the group was to provide patients with an outlet to discuss the service they received, and also for staff to gather feedback from patients on how care could be improved.
- The results from the most recent Children's Survey (2014) show that the trust scored around the same as other trusts nationally in questions relating to understanding and involving patients and family.The responses were consistent across young children and adolescents.

Services for children and young people

- Each ward had a play specialist available to work with children and provide exercises and playgroup sessions during their stay in hospital. The play specialists worked closely with local charities to offer age appropriate play and therapeutic activities, including a full timetable of activities for children outside of the school term.
- The neonatal service offered 24 hour visiting for parents except during ward rounds and during nurses handovers, however patient information leaflets stated visiting hours for grandparents was for four hours a day and siblings was only for three hours on one day of the week. While the staff stated that alternative visiting arrangements could be organised with the Senior Nurse, this could discourage family members from attending. Staff stated that this policy had been put in place due to previous infection control incidents.

Emotional support

- A range of clinical nurse specialists were available on the wards to support children and offered support to colleagues across children's services. Some clinical nurse specialists we spoke with covered children's services across several hospital sites.
- Children's services worked closely with psychological services, which was provided to the department by a neighbouring mental health trust. Child and adolescent mental health (CAMHS) psychologists attended weekly psychosocial meetings on the wards, along with colleagues from hospital social services, to decide patients and families mental health or social care needs. Staff stated that CAMHS psychologists provided advice and support in referring to local mental health services, as well as assessments and support to patients.
- The trust offered support to counselling services through the CAMHS psychological support services to patients and families. Staff stated that these services were discussed as needed or following bereavement, and staff also provided bereavement boxes, which contained items belonging to the patient and advice and support for families. Staff also stated that counselling support services were also available to staff if required following difficult cases or traumatic events.

Are services for children and young people responsive?

Requires improvement

We rated responsiveness as requires improvement because:

- Children's services did not have a specific learning disabilities pathway.
- There were high rates of missed appointments in some services.
- Children's services did not have an operational adolescent strategy in place or formal plans for improvement of care for adolescent patients.
- There was a lack of information about children's services available in other languages than English for patients and their families.

However:

- There were good processes in place for managing and identifying the availability of beds in children's services.
- Interpreters and advocacy services were available to provide support to families who did not speak English.
- Children's services had transition pathways and guidelines in place for patients discharged into community care or transferring to adult services.

Service planning and delivery to meet the needs of local people

- When we last inspected the trust in October 2013 and May 2015, the provision of adolescent care was identified as an area the trust must improve, however children's services did not have an operational adolescent strategy in place or plans for improvement. The trust had plans in place to develop an adolescent ward and currently worked with colleagues in adult wards to provide joint support to adolescents, but there was no overall approach to caring for adolescents identified.
- The Paediatric Critical Care Unit (PCCU) operated close to capacity and there was recognition from staff that this service needed to be expanded. Occupancy rates show that the PCCU operated at 94% capacity in the 12 months prior to our inspection, which the service expanded into additional beds in November and

December to meet the demands of winter pressures. This means that the service may find it difficult to meet the needs of a further increase in emergency unplanned admissions. Staff on the PCCU recognised that the service was stretched, and we were informed there was a case to develop the service and open an additional four beds all year round to meet demand.

- The pain management team at the trust for children's services was being expanded to meet increase demand. A clinical nurse specialist we spoke with stated the service would take on an additional number of nurses to provide pain management support to children's staff. This team would be based across the trust hospital sites.
- The capacity of the neonatal service was to be increased due to a recent review of capacity for all neonatal units in the London Neonatal Network. The network report recognised the need to increase available bed spaces to meet demand, and the unit at the Royal London Hospital was the only unit in the network with immediate scope to expand.

Access and flow

- Patients coming through the emergency department were referred to the Paediatric Short Stay Assessment Unit (PASSU) for assessment and transfer into the appropriate area of children's services. PASSU had a maximum stay of 48 hours before moving to another ward, however staff stated that this would be breached sometimes based on bed availability.
- Staff we spoke with stated that the paediatric assessment unit was often very busy, and it could be difficult to move patients into the appropriate area due to a lack of available beds. Staff stated that social circumstances (lack of a home or sufficient child protection plan) could often impede wards from discharging patients.
- Children's services provided did not attend (DNA) rates for patients missing appointments in July 2016. Children's services had an overall DNA rate of 18%, with the highest numbers of missed appointments in Cardiology (25%), epilepsy (25%), and rheumatology (27%). These DNA rates could create significant delays for other patients accessing these services.
- The trust provided data on the amount of time it takes from referral to treatment (RTT). The NHS Constitution gives patients the right to access services within a maximum RTT of 18 weeks. In the six months prior to inspection the trust was meeting the 18 week target for approximately 94% of children's services patients, against a target of 90%. This was most significantly delayed in paediatric epilepsy (86%) and paediatric urology (88%)
- Patients not presenting at emergency services could be referred to specialist wards by GPs or other community services. Surgery wards were available for preparation of patients and recovery period after procedures.
- Children's services had access to a discharge lounge, which could be used to step patients down from requiring a bed to preparing to leave hospital care. This arrangement allowed patients to await assessment results or receive more basic treatment (such as dressing wounds), while also making beds available for patients requiring more acute care. The discharge lounge was not operated overnight, but did have two available cubicles for sleep studies.
- There were good processes in place for managing and identifying the availability of beds in children's services. Bed management was coordinated between a dedicated bed manager and a supporting ward manager, who remained in regular contact with wards to identify beds becoming available. Bed managers attended daily bed management meetings with ward staff to remain informed of discharges, and staff stated the flow through the department was well managed.
- The average length of stay for patients in children's services was in line with the national average for other children's services in the UK.

Meeting people's individual needs

- The service did not have a specific area for the care of adolescent patients and did not have a standard operating procedure for the management of adolescents. Patients over the age of 16 were generally cared for on adult wards, and staff told us they would have outlier meetings to identify young patients in wards outside of the children's department. Senior staff told us that plans to develop an adolescent space was in development, however currently young people over the age of 16 were often being cared for on adult wards.

Services for children and young people

- Children's wards were separated by the treatment they were receiving, rather than by gender or age. This meant that young people may share a room with a child much younger than them, or wards would have mixed sex breaches. Children's services had reported mixed sex breaches, however we saw examples of ward with young people of different genders sharing rooms. Senior staff stated that this was managed on an ad-hoc basis depending on the mix of young people on wards, and if there were issues patients would be split into different rooms.
- Children's services did not have a specific learning disabilities pathway. The wards did not have access to a specialist paediatric learning disabilities nurse or pathway to provide quick access to families. Staff stated that the therapies team provide ad-hoc support to patients with learning disabilities, and play specialists will work with wards to provide activities, however staff told us that the needs of patients with learning disabilities were not always being met. The therapies team also stated that the lack of specialist support made it more difficult to co-ordinate care for patients discharged to community services, and also for patients transitioning to adult services.
- Children's services had transition pathways and guidelines in place for patients discharged into community care or transferring to adult services. This included comprehensive transition strategies for diabetes, haematology, and respiratory support.
- The Paediatric Liaison Team (PLT) provided in-house CAMHS support to patients and families within children's services. The PLT offered direct clinical work with children, young people and their families referred because of identified concerns, or those who are considered at risk of developing difficulties. The team was also available to provide support to paediatric staff by providing advice and helping to develop treatment plans.
- Interpreters and advocacy services were available to provide support to families who did not speak English. Staff also stated that they have a diverse workforce who can speak many languages, and can provide interpreting support if needed. Telephone interpreters were available to cover evenings and weekends, and if patients requested information in different languages this could be organised by PALS.
- Children's services used a multi-disciplinary approach to supporting children with complex needs. Wards had weekly psychosocial meetings with psychology, therapy and social services colleagues to identify children who may require additional support. Children's services had nurse practitioners with specialist knowledge and interests in some areas of complex care (for example, neurology) who were available to provide advice and support in planning care.
- Patients and their families had access to a variety of entertainment within children services. All children's wards had access to a large, well-resourced play rooms which were used for group sessions with play specialists or could be accessed individually. The wards also provided portable television devices for young people to watch movies. Young people stated they had access to Wi-Fi through the trust network, however the reception could be lacking and connection speeds slow.
- Each ward had a play specialist within their teams who provided fun activities for children, support clinical work, and worked together to deliver groups. Play specialists were available to provide activities and groups to children outside of treatment, but also used distraction techniques with children during treatment to alleviate anxiety and could carry out therapeutic play activities. Play specialist stated they have age appropriate toys and resources for children of all ages, and there was a play budget for buying equipment. Play specialists also stated they work closely with other charities to provide activities for children.

Learning from complaints and concerns

- Some parents we spoke with that stated that they had difficulty contacting the PALS office when they wished to make a complaint. Parents stated they had tried phoning and visiting the PALS office, but no one answered on the occasions they went.
- Parents stated that they felt supported by staff to submit a formal complaint if they were unhappy with the service the service they received. Information leaflets and posters for the PALS service were visible around the wards of children's services. Staff stated that while they encourage patients and families to make complaints if they are not satisfied, the team will try to address the issue informally if possible and also identify learning from these cases.

- Staff used handovers and team meetings as an opportunity to discuss complaints and learning from complaints. Inspectors observed staff discussing recent complaints as part of a handover within the neonatal unit and as part of a safety huddle within paediatric services. Managers stated that once a complaint was received, senior staff would nominate a member of staff to investigate the issue and identify learning.
- Mandatory training figures for the trust show that 87% of children's services staff had completed complaints training, against a trust target of 90%.
- The trust provided data for all complaints at the Royal London Hospital from May 2015 to April 2016. Of 718 complaints, 22 applied to children's services. Of these 22, 18 related to either complaints regarding care patient received or the attitudes of staff. 9 of the complaints made were either upheld or partially upheld by the trust.

Are services for children and young people well-led?

Requires improvement

We rated well-led as requires improvement because:

- Children's services and the neonatal unit did not have formalised plans in place for the future strategy and vision for the division.
- Many of the staff that we spoke with stated they did not know who the executive team for the hospital site or the trust wide executive team were. The non-executive director with responsibility for children's services had also not visited the site.
- Staff told us that although the culture was improving, there had been instances of bullying and harassment on some wards, particularly towards clerical and domestic staff.
- The reorganisation of governance structures had yet to be fully embedded in the service.

However:

- Children's services had meetings to regularly discuss clinical governance and actions for serious incidents.
- Most of the staff we spoke with stated that the culture of the children's services had improved since the last inspection.
- We identified good examples of local leadership, both on the wards and within the new organisational structure for the division.

Leadership of service

- Many of the staff that we spoke with stated they did not know who the executive team for the hospital site and the trust wide team were. Staff stated they were unfamiliar with the leadership outside of their division, and did not know who had responsibility for representing children's services at a board level. Some staff also stated they did not know who the chief executive for the trust, or the board member with responsibility for children's services, was.
- Staff stated that members of the board and executive team had not visited the wards. Senior staff stated that the non-executive director responsible for representing children's services had arranged to visit wards in the near future, but staff could not say when board level representatives had been to the ward last.
- Within children's services we identified good examples of local leadership, both on the wards and within the new organisational structure for the division. Managers were seen to be approachable and well informed regarding the overall needs of children's services, and ward managers were confident they had the support structures within the divisional team to raise issues.
- Many of the staff we spoke with stated that leadership within the service had improved in the last year, and that managers for children's services at the Royal London Hospital were much more accessible now. The trust had developed an organisational structure which offered more site level management, which provided children's services at the Royal London with more managerial support and autonomy. Staff stated they knew the heads of the divisional team for children's services, and stated they were approachable and visible throughout the ward.

Vision and strategy for this service

- Children's services and the neonatal unit did not have formalised plans in place for the future strategy and vision for the division. The senior team had identified

business priorities for the coming year follow the annual performance review, but strategic plans were at a draft stage following large changes to the organisation structure.

- Children's services were in the process of developing a strategic plan for the department, and the document was at draft stage at the time of inspection. The organisational structure for the department had undergone changes, and senior staff stated the new strategy would encompass corporate and clinical vision for the future of children's services. Senior staff stated that they aimed to develop the directorate into a children's hospital which is based within the Royal London Hospital site, however this had yet to be formalised into a strategic plan.
- The divisional team for Women and Children's Health had completed a performance review of services in May 2016. The review recognised that divisional structure was still to be clarified, both within the Royal London Hospital and in the relationships with other trust sites, and that divisional priorities had yet to be decided.
- Frontline staff we spoke with were not sure about the long term vision of the service or were not aware of any future strategic goals. Some staff stated that their wards had put business plans together for additional resources or developments to the service, however they were not sure if their plans were successful and had not had any feedback. Senior staff we spoke with and divisional documentation stated there is work underway to address outstanding business plans and decide on which cases will be implemented.

Governance, risk management and quality measurement

- Senior staff we spoke with stated they had made some changes to the governance structure following managerial changes within the department, which they felt were still in the process of embedding into children's services. The clinical director for children's health was taking a more involved role in managing clinical governance and the risk across the Royal London site, and the governance team stated that this had a positive effect linking risk management with clinical practice. However, the team stated that these changes were still being embedded and would take time to improve the quality of information from governance.
- Children's services risk registers did not reflect some of the risks identified by the inspection team. The trust risk registers for the Royal London Hospital and across all hospital sites did not include any ongoing risks for children's services, as of July 2016. The children's services local risk register contained 18 current risks, but none with a high risk rating. However this did not reflect some of the risks identified by the inspection team, such as ligature risks, risk of mixed sex breaches, and gaps in service for patients with learning disabilities.
- The trust governance arrangements had been independently review by the Good Governance Institute, an organisation which evaluates governance structures and makes recommendations for change. Following this report, the trust has recognised the need to redevelop the architecture for collecting governance date, which was viewed to be quite old. The trust aims to develop a better model for collecting governance data as part of the new data quality strategy, however this is currently still in development.
- Inspectors attended and viewed minutes from Children's Health monthly governance meetings, and serious incidents meetings. Inspectors found the meetings to have open discussions on how to best manage risk, action plans for newly presented serious incidents, and feedback from presenters on how changes had been implemented.
- Children's services provided examples of departmental governance presentations to the hospital board. The divisional team for children's services provided regular updates to executive team, including presentations from children's services staff on initiatives to improve measuring quality and managing patient risk.

Culture within the service

- Although staff and senior managers stated there had been positive changes in the culture of the service within the past 12-18 months, inspectors were informed of instances of bullying throughout the wards, particularly towards clerical and domestic staff. Other staff stated that while the culture of children's services had changed for the better, there were still some people who would behave aggressively towards other staff. A small number of staff stated that they had been discouraged from speaking to inspectors while they were present.
- Most of the staff we spoke with felt there had been a significant and noticeable change for the better in the culture of children's services since the previous CQC inspection, and that there was a much better working

atmosphere on wards now. Staff stated that they were working better together as teams, and that managers on the unit were more approachable and supportive. Senior staff stated that it had been a long process to improve the quality of the culture of children's services, and while there was still more work to be done, they felt the working environment had significantly improved for staff.

- Bank Nurses and other temporary staff we spoke with stated the trust is a support and comfortable place to work. Temporary staff stated that they were made to feel like part of the team and that many of them worked regularly with children's services. Some regular bank and agency staff had been able to access training to develop their competencies for the role.
- Neonatal staff we spoke with stated there was a good culture within the service, and that staff from different disciplines had good working relationships. Staff also stated that in the last 12-18 months they felt that managers listened to them more often and they were more approachable.
- Most clinical staff described the culture as open and supportive in discussions with inspectors. Staff stated they were encouraged to discuss where services could be improved, report incidents when they arose, and that they could approach managers with problems when they needed to.

Public and staff engagement

- Patients and families we spoke with were unaware of any public engagement initiatives relating to children's services. Parents stated that they had been asked to complete feedback on the care they received and their opinion of services, but they did not know of any consultations or opportunities to become involved in developing children's services.
- As part of the recent recruitment drive, the trust had recognised the opportunity to find new nursing staff locally, and had been promoting the trust as a place to work for local people. Posters for recruitment could be seen outside trust sites and in waiting areas throughout the trust, including in children's services, advertising vacancies to locals.
- A monthly youth empowerment forum was run from Whipps Cross Hospital for all Bart's Health patients and families. The forum offered young people the opportunity to feed back to the trust on the care they received and provided the trust with public consultation on the development of services. The forum was run with support from a previous patient of children's services, and minutes were taken to provide a record for the trust.
- The trust worked with Listening into Action (LiA), an organisation which develops structures within services to obtain staff opinions and engagement in the running of services. Senior staff we spoke with stated that LiA had provided opportunities to consult more frequently with staff on how services should be developed or improved, and some of these changes had been implemented.

Innovation, improvement and sustainability

- The Paediatric Critical Care unit (PCCU) has been trialling and researching the use of continuous positive airway pressure (CPAP) hoods with children, a treatment that uses mild air pressure to keep the airways open without the need for intubation. The CPAP hood relieved pressure on facial areas and also provided an effective seal for children with facial abnormalities, which were both problems with masks. Staff from the PCCU have published articles on the use of the CPAP hood with children and presented the findings at international conferences.

End of life care

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

Information about the service

The Royal London Hospital offers a range of local and specialist services. It is one of London's larger trauma and emergency care centres and hyper-acute stroke centres.

There were 984 deaths at Royal London hospital between January and December 2015, the rate of deaths was 0.97%.

The Royal London hospital palliative care team (HPCT) is a specialist palliative care service for people who have progressive and life-limiting illnesses. The team consists of nurse specialists (CNS), doctors, social workers and clinical psychologists, with training and experience in palliative care. The team has access to a range of multi-disciplinary services including occupational therapy, physiotherapy, dietetics, and chaplaincy. The HPCT are an advisory services which works alongside referring teams but do not take over the patient's care completely. The teams see patients from any ward or service where pain or other symptoms are difficult to control, patients or family require support, or patients require future care planning.

We visited a number of wards where care was being given to patients at the end of their lives. These included general medical wards, care of the elderly wards, orthopaedic wards, acute assessment wards, cardiac/respiratory wards and gastroenterology wards. The hospital did not have specific oncology wards.

We spoke with nine patients and relatives to gather their views on care provided. We reviewed medical records. We spoke with over twenty staff including: porters, chaplains, mortuary and bereavement office staff, ward clerks, healthcare assistants, consultants, doctors, nurses and service managers.

End of life care

Summary of findings

We rated the service requires improvement because:

- Systems and processes were not always reliable to keep people safe. For example staff access to syringe drivers out of hours could be problematic as syringe driver stocks were running low due to patients taking them home and the syringe drivers not being returned or collected.
- We found records where there were gaps in patients' nutrition and fluid records and pain scores. Some staff on the hospital wards told us they had not received training on how to use the new nursing bundle documents.
- Staff told us 'to take away' (TTA) medicines were not always provided by the hospital's pharmacy in a timely way and this had led to delays with discharging patients.
- A face to face end of life care (EoLC) service was provided by the HPCT 9am to 5pm Monday to Friday. However, this was not in accordance with the National Institute for Health and Care Excellence (NICE) guidance (QS13) which recommends that palliative care services should ensure provision from 9am and 5pm, 7 days a week.
- There was a lack of consistency in decision making with some staff using Mental Capacity Act 2005 (MCA) decision assessments generically, and some staff were confused about decision specific assessments in assessing patients' decision making capacity. This meant not all decision making was in line with guidance or legislation.

However, we also found:

- Staff were aware of how to report incidents and could demonstrate how and when incidents had been reported. Lessons were learnt from incidents locally and staff felt confident in raising incidents through the reporting system.
- There were appropriate protocols in place for safeguarding vulnerable adults and children, and staff were aware of the requirements of their roles and responsibilities in relation to safeguarding.
- Medicines were found to be in date and stored securely. There was a policy on the consistent use of opioids,
- Patients received care and treatment that was evidenced based. The HPCT had introduced the compassionate care plan (CCP) in response to the withdrawal of the Liverpool Care Pathway.
- Staff worked together in a multi-disciplinary environment to meet patients' EoLC needs.
- HCPT staff were competent to perform their roles. Staff were supported in their roles by ongoing EoLC specialist training and development opportunities. EoLC link nurses had been introduced across the wards.
- Most of the nine patients and relatives we spoke with were positive about the way staff treated people. Most patients told us the care they received met their expectations. We observed staff being caring and supportive in interactions with patients and their families.
- Staff demonstrated awareness of people's needs and the limitations associated with their conditions. Patients' psychological and emotional needs were appropriately supported.
- The hospital had completed a 'deep dive' in EoLC in February 2016. As a result the hospital had introduced a number of improvement projects, including: a site improvement dashboard.
- EoLC had been developed collaboratively with local CCG's.
- There had been no formal complaints about mortuary services, the Bereavement Office, or HPCT in the previous 12 months.
- Staff knew and understood the vision of the trust.
- Senior managers and the chief nursing officer (CMO) understood the risks and challenges to the service. There was a system of governance and risk management meetings at both departmental and divisional levels.

There was an open and honest culture within the service, morale had improved.

End of life care

Are end of life care services safe?

Requires improvement

We rated the service requires improvement for safe because:

- Systems and processes were not always reliable to keep people safe. Staff access to syringe drivers out of hours could be problematic as syringe driver stocks were running low due to patients taking them home and the syringe drivers not being returned or collected.
- We found records where there were gaps in patients' nutrition and fluid records during the night shift. Some staff on the hospital wards told us they had not received training on how to use the new nursing bundle documents.
- The 1.6 WTE consultant staffing levels in the hospital palliative care team (HPCT) did not correspond with the 'Commissioning Guidance for Specialist Palliative Care 2012.' There were periods on Fridays where there was a lack of consultant cover in the HPCT.

However, we also found:

- Staff were aware of how to report incidents and could demonstrate how and when incidents had been reported. Lessons were learnt from incidents locally and staff felt confident in raising incidents through the reporting system.
- There were appropriate protocols in place for safeguarding vulnerable adults and children, and staff were aware of the requirements of their roles and responsibilities in relation to safeguarding.
- Medicines were found to be in date and stored securely. There was a policy on the consistent use of opioids
- Staff were able to describe the procedure if a patient became unwell in their department and knew how to locate the major incident policy on the intranet. The hospital had introduced the compassionate care plan (CCP) in response to the withdrawal of the Liverpool Care Pathway.

Incidents

- There had been 143 incidents reported in EoLC between 25 June 2016 and 30 April 2016. The hospital palliative care team (HPCT) reported that there had been no serious incidents or never events requiring investigation between June 2016 and May 2016.
- Staff understood their responsibility to raise concerns, and record incidents on the trust's electronic incident reporting system.
- Staff confirmed they received feedback on incidents that took place in other areas of the hospital as well as their own. Staff and managers we spoke with told us they were satisfied there was a culture of reporting incidents promptly.
- Staff at the HPCT explained in the event of an incident requiring investigation a root cause analysis (RCA) would be completed. RCA's would identify learning from incidents; and lessons learned from incidents would be shared across teams. An action plan would be developed as a result of RCA's. We did not view any HCPT team RCA's as none had been required in the 12 months prior to our inspection.
- HPCT team staff told us incidents were discussed at weekly MDT meetings. Learning from hospitals across the trust was shared at the meetings. Incidents were also reviewed and discussed monthly at the EoLC steering group to identify and monitor trends. Staff on the HPCT team told us incidents would be discussed and disseminated to staff at MDT meetings and learning would be shared across the trust where applicable.
- Staff confirmed they received feedback on incidents that took place in other areas of the hospital as well as their own. For example, learning from incidents within the cancer directorate was disseminated at HPCT team meetings. Staff and managers we spoke with told us they were satisfied there was a culture of reporting incidents promptly.
- There had been no 'never events' or serious incidents (SI) reported from the Royal London hospital in regards to EoLC in the previous 12 months. A never event is a wholly preventable incident, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level.

- Staff on the wards told us safety alerts were sent to clinical leads by email and displayed on the hospital's intranet. The alerts were reviewed by clinical leads for their relevance and disseminated to staff by email or discussed at team meetings.
- Staff across the wards and departments were aware of the duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) ofcertain 'notifiable safety incidents'andprovide reasonable support to that person. Staff at the HPCT told us they were always open and honest with patients and their families.

Cleanliness and infection control

- We saw that personal protective equipment (PPE) was available for use by staff in all clinical areas and wards.
- All the ward areas we visited were clean and free from clutter. We saw housekeeping staff cleaning on the wards and departments throughout our visit.
- We saw staff on the wards regularly washing their hands between treating patients. Hand washing facilities and hand sanitising gels were readily available. Staff wore clean uniforms with arms 'bare below the elbow'.
- The importance of all visitors cleaning their hands was publicised on the wards we visited and hand gels were available from dispensers on the wards.
- We viewed cleaning records at the mortuary and these were up to date. The mortuary had an infection control policy in place for deceased patients with infectious diseases.

Environment and equipment

- Staff at the HPCT team told us they did not have access to a FAX machine in the HPCT office and this had led to staff having to visit the wards to use their FAX machines to send patient discharge summaries.
- There were monthly environment audits across the hospital. We viewed the results of the audits from April 2015 to April 2016 and found most wards and departments regularly scored 100%.
- Staff we spoke with in the HPCT team and on the hospital wards we visited told us there were usually sufficient amounts of equipment. However, some staff told us accessing syringe drivers out of hours could be problematic and that syringe driver stocks were running low due to patients taking them home and the syringe drivers not being returned or collected.
- Maintenance and procurement of replacement equipment was planned by the hospital's equipment services team. The equipment services team was responsible for the maintenance and servicing of equipment; and updating medical device registers.
- Medical device registers were monitored by the equipment services team. The device register indicated the date equipment was due for service; as well as the date of electrical testing for electronic devices. We saw that devices had been serviced in accordance with the registered date for servicing.
- The equipment service team were responsible for all trolleys. Staff had access to a hydraulic trolley for bariatric (obese) patients. Wheelchairs and trolleys were available to transport bariatric patients around the hospital. Wheelchairs and trolleys we viewed were in an appropriate state of repair.
- Equipment was provided out of hours by the medical equipment library for the hospital.

Medicines

- Staff we spoke to said it was difficult to get access to syringe drivers, used to administer regular continuous analgesia. These were available through the medical equipment library. The syringe drivers used had been standardised in response to a national patient safety alert.
- The hospital had a policy on the consistent use of opioids, in accordance with NICE CG140 opioids in palliative care guidelines (opioids are medicines that relieve pain). This meant that the scope for medicines related errors and misprescribing had reduced since the last inspection. We found there was a consistency in the use of opioids. Staff had access to guidelines for the prescribing of opioids on the trust intranet
- Clinical nurse specialists (CNS) on the HPCT team demonstrated how staff would access the hospital's prescribing guidelines on the hospital's intranet.

- Staff on the wards told us doctors were good at prescribing anticipatory medicines.

Records

- Referrals to the HPCT were received via the HPCT referrals line. The calls were taken by the HPCT administrator. However, staff at the HPCT told us CNS's completed referral documentation and telephoned professionals to clarify the details of referrals.
- The hospital had introduced new nursing assessment and care planning documentation, the 'nursing documentation bundle', in June 2016. However, some staff told us they had not received training on how to use the nursing bundle documents. Staff also told us they were spending time explaining the document to new agency staff.
- We reviewed nine patient records during our inspection and found patients had individualised initial assessments, risk assessments, care plans, reviews and consent documentation. Nutrition and fluid plans were followed with fluid balances totalled and acted upon appropriately. However, on ward 14F we found the recording of two palliative care patient's fluid balance charts were inconsistent during the night shift. For example, one patient's fluid balance chart was not completed on 23 July and 27 July 2016. There was also no record of the patient having eaten in the evening on five occasions from 13 July to 27 July 2016. Staff assured us that the patient had received food in the evening. Staff told us some agency staff could be inconsistent with recording.
- Patients' records recorded referrals to the HPCT team, and indicated they were receiving end of life care. Patients' care records had the facility to record when relatives had been informed of a patient entering the dying phase.
- A communication form accompanied patients when they were transferred to a hospice or back to the community. The form contained details of the patient's diagnosis, preferred place of care, family and next of kin (NOK) details, and information about health and social care professionals who were involved in the patient's care.
- Overall, we found patients' information was protected. However, we saw two computers that were logged on and left unattended on ward 12F. The computers had notes from a sisters meeting on display that could have been read by an unauthorised person.

Safeguarding

- Staff on the HPCT team told us they worked closely with the local authority palliative care social worker who provided the team with advice and support in regards to safeguarding. The social worker informed HPCT team staff of any patients who were considered vulnerable, the social worker also followed up patients the hospital considered to be at risk.
- Staff we spoke with on the HPCT team were able to describe the categories of abuse and how they would report potential safeguarding issues. Staff told us safeguarding issues were reported to the hospital's safeguarding lead for further investigation.
- Learning from safeguarding investigations was shared at team and MDT meetings and across services where appropriate.
- The trust had an up to date safeguarding policy. Staff were able to explain their understanding of the policy and how they used this as part of their practice.
- Patients we spoke with told us they felt safe and expressed confidence in the staff that worked with them.
- Porters, mortuary staff and staff at the bereavement office received level 1 safeguarding training. Training records demonstrated these were up to date. The HPCT completed level 2 safeguarding training, all of the CNS were up to date with safeguarding training.
- The trust's website included a contact form for the safeguarding unit. Safeguarding information leaflets for patients and visitors were available in various sites across the hospital.

Mandatory Training

- The service used an electronic record widely used in the NHS to monitor compliance with mandatory training. Staff also had a mandatory training booklet, this contained course materials and a quiz for staff to test their knowledge. Staff told us they signed the booklet when completed.

End of life care

- The HPCT team provided an education programme for palliative care to healthcare staff. This included an education programme for medical staff; as well as the EoLC components of staff training courses. The training included: nursing induction; clinical updates for nursing staff; and ward based training for ward staff.
- Training took place on a day-to-day basis informally on the wards. The HPCT team also offered informal training when liaising with junior medical and nursing staff involved in the care of patients who had been referred to the SPC team.
- EoLC training provided by the HPCT team included general palliative care and some specific nurse training to enable staff to correctly assess patients and use equipment such as syringe drivers.
- Mandatory training for the HPCT team included: Pressure ulcer prevention; early warning systems; blood transfusions, amongst others. 97% of HPCT staff had completed the required mandatory training.

Assessing and responding to patient risk

- The hospital had withdrawn the Liverpool Care Pathway (LCP) from clinical practice in recommendations made in the publication: 'Independent Review of the Liverpool Care Pathway'. In its place the trust introduced the 'compassionate care plan' (CCP). Nursing and medical staff we spoke with on the wards told us that following the introduction of the CCP staff had been actively encouraged to refer all patients who may be approaching the end of their life to the HPCT team.
- The HPCT team had adopted the '5 priorities of care for the dying person' and had developed the CCP for the nursing and medical teams to use on the electronic patient record. The CCP focused on encouraging staff, patients and families to continue with treatment in the hope of recovery, while talking openly about people's wishes and putting plans in place should the worst happen.
- We saw that patients CCP assessment and planning records were based upon the '5 priorities of care for the dying person'. Patients had individualised multidisciplinary initial needs assessments. This included space to record recognition that the patient was dying; and recorded conversations with patients and families about this.
- The CCP covered the control of symptoms including nutrition and hydration, prescribed EoLC medicines, patients preferred place of care, whether there were any concerns from professionals or relatives in regards to patients care and the support patients required in regards to their social, psychological or spiritual needs. We viewed four patients CCP and saw these had been reviewed on a daily basis by the HPCT and were up to date. CCP care plans had been signed and authorised by a doctor who had received specialist training in palliative care
- Staff at the HPCT team told us that where a patient appeared to be deteriorating the team would work with ward staff to establish the cause of deterioration and its relevance to their EoLC diagnosis. Staff said they would speak with families and discuss any planning needs patients had, including their preferred place of care. However, the hospital were unable to collate data on the numbers of patients achieving their preferred place of care.
- 100% of HPCT staff had received training in basic life support and resuscitation.
- HPCT team staff told us there had been improvements in ward staff recognising when patients required EoLC. Staff told us the medical staff at the hospital were identifying patients approaching the end of their life earlier and referring to the HPCT team.
- We attended a safety huddle meeting on ward 14F. These were daily meetings where safe care was discussed and monitored on the wards. The hospital had introduced a policy that all EoLC patients would be discussed at the safety huddles. The CCP was a standard agenda item at safety huddles. Patients with 'do not attempt cardiopulmonary resuscitation' decisions (DNACPR) were discussed at the safety huddle, as well as whether or not patients were on the EoLC pathway. Staff also discussed the needs of a recently referred palliative care patient. Staff at the huddle provided feedback on whether they considered the care on the wards to be safe. Staff attending the safety huddle did not identify any issues with patient safety on the day, for example, staffing.

Nursing staffing

- HPCT staff told us nurses worked between sites within the trust. Staff told us they would usually be allocated the same hospital sites, but might be asked to move

sites to cover maternity leave or sickness. Staff in the HPCT team told us staffing in the team had improved in the past 12 months, but, could be "thinly spread" if staff were asked to cover other hospital sites.

- Staff on the wards told us staffing levels on the hospital wards had improved over the past 12 months. For example, staff on a ward told us, "We are allowed to use the same agency staff and fill shifts. That didn't happen before. Staffing has improved." However, HPCT staff said there were a few wards which still had high agency staff usage.
- The HPCT team worked on a ratio of eight patients per CNS. The HCPT team for both Royal London Hospital and St Bartholomew's Hospital consisted of: One whole time equivalent (WTE) band 8b lead nurse; 0.6 WTE band 8a lead nurse who worked Tuesday, Wednesday, and Thursday: 4.4 WTE band 7 clinical nurse specialist (CNS): One band 5 WTE acting as band 6.
- A few HPCT staff told us staffing on the HPCT was improving. Staff said a CNS that had been seconded to Whipps Cross Hospital until May 2016 had returned to the team. The hospital were also advertising for a further band 7 WTE nurse to join the HPCT at Royal London Hospital.

Medical staffing

- The trust had a lower proportion of consultants and junior doctors compared to the England average. The medical skill mix was 35% consultants, compared to the England average of 42%; 4% middle career, compared to the England average of 9%; 49% registrars, compared to the England average of 36%; 12% junior doctors compared to the England average of 14%.
- The HPCT staffing figures we viewed were for Royal London Hospital and St Bartholomew's Hospital, as the team covered both hospitals. There were two consultants working 1.6 WTE. The team also had two WTE registrars. At Royal London hospital consultant cover was provided 9.00am to 5.00pm Monday to Thursday.
- HPCT staff told us Friday's could be difficult due to the Royal London Hospital specialist palliative care consultants being off site for part of the day on Fridays. Staff told us they would ask the registrars to look at patients or telephone the palliative care consultant at Newham Hospital for advice or consultations on a Friday. However a CNS told us, "It can be difficult to get a consultant to have eyes on a patient on a Friday."
- The Office for National Statistics mid-2015 population estimates estimated the population of Tower Hamlets as 292,500 in June 2015. This meant the 1.6 WTE consultant staffing levels were not in line with the 'Commissioning Guidance for Specialist Palliative Care 2012'. This recommends that there should be two WTE consultants in EoLC per 250,000 population.

Major incident awareness and training

- The HPCT team had a plan for seasonal fluctuations in demand. During the summer months the HPCT team would complete patients discharge planning. During busy winter months the team would act in a more advisory role, supporting staff on the wards with patients care, treatment, and discharge planning.
- Staff on the wards told us there had been improvements in discharge arrangements, for example, the HPCT rapid discharge process, which could be used to establish additional bed capacity, staff told us they worked closely with stakeholders to minimise discharge delays.
- The trust had a major incident plan, which set out key responsibilities and actions to be taken by staff. Training on major incidents and business continuity had been provided to most of the staff we spoke with.
- The mortuary service had a major incident plan. This included guidance for staff on the retention of forensic evidence and liaison with the coroner.
- 100% of CNS on the HPCT had up to date training in emergency planning.

Are end of life care services effective?

Requires improvement

We rated the service requires improvement for effective because:

- Staff on ward did not always use pain charts to record patients' pain scores.
- The hospital was unable to provide us with data on the effectiveness of the rapid discharge process as there was no system in place to monitor this.

- A face to face EoLC service was provided by the HPCT 9am to 5pm Monday to Friday. However, this was not in accordance with the National Institute for Health and Care Excellence (NICE) guidance (QS13) which recommends that palliative care services should ensure provision to: visit and assess people approaching the end of life face to face in any setting between 9am and 5pm, 7 days a week.
- There was a lack of consistency in decision making with some staff using Mental Capacity Act 2005 (MCA) decision assessments generically, and were confused about decision specific assessments in assessing patient's decision making capacity. This meant not all decision making was in line with guidance or legislation.

We also found:

- Patients received care and treatment that was evidence based. The compassionate care plan (CCP) was informed by the 'One Chance to Get it Right' document which outlined the duties and responsibilities of health and care staff in the care of dying people.
- There were no formalised patient outcome measures in place. However, work was in progress for the hospital to introduce the integrated palliative care outcome scale (IPOS).
- Staff worked together in a multi-disciplinary environment to meet patients' needs.
- HCPT staff were competent to perform their roles. Staff were supported in their roles by ongoing EoLC specialist training and development opportunities. EoLC link nurses had been introduced across the wards.
- Information relating to patients health and treatment was available from relevant sources. Information was shared with patients GPs following hospital admissions to ensure continuity of care.

Evidence based care and treatment

- The national guidelines from the National End of Life Care Strategy (2008) published by the Department of Health, sets out the key stages of end of life care. The National Institute for Health and Care Excellence (NICE) end of life care quality standard for adults (QS13) sets out what end of life care should look like for adults diagnosed with life limiting conditions. The hospital had implemented NICE quality standards for improving palliative care for adults, with the introduction of a HPCT.
- The HPCT had introduced the 'compassionate care plan'(CCP) to enhance the quality of life for people with life limiting conditions, and ensure they had a positive experience of healthcare. The CCP was informed by the 'One Chance to Get it Right' document which outlined the duties and responsibilities of health and care staff in the care of dying people.
- The hospital had conducted an audit of the CCP in November 2015. The audit identified areas for improvement in regards to: expected deaths being started on the CCP; and completion of CCP documentation by staff. The audit highlighted areas for improvement as: improved education and training for staff on the CCP; meetings with staff at the intermediate care unit (ITU) to discuss how medically expected deaths could be better managed; and a re-audit in 2016 to assess whether actions the HPCT had taken had led to improvements in the use of the CCP and patients EoLC. We saw that staff were in the process of implementing the recommendations of the audit, for example, increased training and support for staff in the use of the CCP.

Pain relief

- Patients commenced on the hospital's end of life care pathway required regular pain assessments to ensure that symptoms were managed effectively. We noted from our review of records that most nursing staff had completed pain assessments. However, Staff on ward 14F told us they always assessed and asked patients about pain they were experiencing; but said staff did not always use pain charts.
- Some staff on the wards had received training on the use of syringe drivers, for when patients' symptoms required pain to be managed in a controlled way. A senior nurse on ward 10E told us the SPC team responded quickly to requests for support and advice from ward staff and were available to advise on any issues ward staff were experiencing in regards to caring for EoLC patients.

- Staff we spoke with told us there was no specific care plan for managing the pain of patients with dementia. Patients we spoke with told us they were regularly asked if they were experiencing any pain and provided with pain relief when required.

Patient Outcomes

- Staff told us there were no formalised patient outcome measures in place. However, work was in progress for the hospital to introduce the integrated palliative care outcome scale (IPOS). IPOS is a validated range of tools to measure patients' physical symptoms, psychological, emotional and spiritual, information and support needs. IPOS outcomes can be used in clinical care, audit, research and training.
- The hospital had a Commissioning for Quality and Innovation (CQUIN) target tied into the hospital being able to collate data on EoLC. The hospital's plan to meet the target included the introduction of IPOS.
- The hospital were unable to provide us with data on the percentage of patients who achieved their preferred place of care or the effectiveness of the rapid discharge process.
- The hospital had taken part in the National Care of the Dying Audit (NCDAH), published in March 2016. The audit found that the trust was below the England average for three out of the five indicators. These were KP3 documented evidence that the patient was given the opportunity to have concerns listened to, the trust score was 79% the England average was 84%; KP4 documented evidence that the needs of the person(s) important to the patient were asked about, the trust score was 44% the England average was 56%; KP5 documented evidence in the last 24 hours of life of a holistic assessment of the patient's needs regarding and individual plan of care, the trust score was 36% the England average was 66%. However, managers told us there had been changes implemented since the NCDAH audit had been undertaken in 2015 and the trust were addressing this via a new strategy for EoLC which was being drafted and a draft business plan to address staffing in EoLC

Nutrition and hydration

- A dietitian was available on referral for palliative care patients.
- Patients' nutrition and hydration was assessed as an aspect of their CCP. Patients also had multi-universal screening tool (MUST) assessments in place. MUST is a screening tool to identify adults, who are at risk of being under nourished, or obese. Staff on ward 10E told us they would always discuss the nutritional needs of patients in receipt of EoLC with the HPCT team; and would refer EoLC patients to the speech and language therapy (SALT) team and dietitian's to ensure their needs were met.
- Staff told us that patients were offered five hot drinks a day and in addition, there were regular water rounds. Patients were offered three main meals and two snacks each day.
- Staff across the wards told us they discussed spiritual/ religious diets with patients or their families. We did not speak with any patients who had spiritual/religious dietary needs. However, we noted that the patients' records we viewed had specialist dietary needs recorded where required. Staff on the wards told us families could provide assistance with patients' personal care and feeding upon request.
- Patients we spoke with were generally positive about the quantity and quality of the
- food they received.

Competent staff

- The HPCT provided formal and informal teaching to ward staff as requested. Staff on the wards told us the HPCT could be contacted and would respond quickly if ward staff needed support or advice on managing an EoLC patient's care or treatment.
- The HPCT used regular clinical supervision to discuss both clinical and staff support issues. All of the HPCT team had had an annual appraisal in the previous 12 months.
- The HPCT had an annual 'away day' this was a day reserved for staff training and development.
- Staff at the HPCT told us there had been improvements in the team's education commitments. The HPCT had a rolling programme of education in EoLC and the CCP. The HPCT CNS's were also involved in rolling out an EoLC module on the trust's induction and nursing preceptorship. Most staff we spoke with confirmed they had received EoLC training during their induction.

- However, two recently recruited staff, a band 5 bank nurse on ward 11F and a doctor on ward 13F, told us they had not received any training on EoLC from the Royal London hospital; but had received the training in their previous employment.
- Overall, the trust was rated about the same as expected in the 2015 General Medical Council (GMC) Training Survey; but, was rated as 'worse than expected' for Induction and feedback .
- The trust had introduced an EoLC programme manager who organised members of the MDT team to deliver training. The trust's lead palliative care nurse had developed an education tracker to monitor training sessions and ensure that staff that were rostered to provide sessions did not have other commitments at the same time. However, some HPCT staff said the sessions had placed pressure on the team as staff were being asked to provide cover at other trust hospital sites due to staff sickness.
- Staff at the HCPT team told us work was in progress to introduce the 'quality end of life care for all' (QELCA) programme of training for ward staff, this is a nationally recognised course to empower staff in delivering high quality EoLC.
- HCPT staff told us they offered two annual teaching days but there had been poor attendance from staff on some wards. For example, staff on ward 14F told us they were offered courses by the HPCT team; but, not all staff had been able to attend due to the ward being unable to cover staff released for training. However, staff on ward 11E told us they had attended EoLC training with the HCPT, and spoke favourably about the training a typical comment was that the training was, "Excellent."
- The ward manager on ward 14F told us four out of nine nursing staff had been trained in administering syringe drivers. The manager said there were five new staff on the ward who would undertake this training, but this had not been scheduled.
- Staff on ward 14E and 14F told us work was in progress to recruit two practice development nurses to support staff with their professional development.
- Staff on wards 14E, 14F, and the acute admissions unit (AAU) told us the palliative care consultant had rolled out training to staff on the CCP. Staff were able to demonstrate where they would access CCP guidance on the hospital's intranet.
- Work was in progress to appoint link nurses for EoLC. For example, ward 11E staff told us the link nurse had been pro-active and had attended an EoLC study day. On other wards staff were undergoing training for the role at the time of our visit. Staff at the HPCT said the link nurses on the wards had improved EoLC by "putting it on the agenda".
- HPCT staff told us the hospital were supportive of requests to do further training as long as it was relevant to their role. For example, a CNS said the hospital were supporting them in completing a Master's degree.
- Staff at the Bereavement Office had completed a level 3 diploma in 'grief and bereavement counselling.' The staff member had funded their own training as they did not get the hospital's loss and bereavement training as mandatory training. Bereavement Office staff told us they received the administrators' mandatory training; but said, "Our job isn't just administrative in this office; a lot of what we do is supporting families."

Multidisciplinary working

- Throughout our inspection, we saw evidence of MDT working in the ward areas. Clinical staff told us nurses and doctors worked well together within their medical speciality. There were daily safety huddles which included, doctors, nurses, and occupational therapist (OT) or physiotherapist.
- Physiotherapists and pharmacists we spoke with all told us that multi agency working was generally effective. Allied healthcare professionals we spoke with told us that they felt part of the hospital team.
- The HPCT team had a weekly MDT team meeting on Wednesday mornings. The meetings were attended by CNSs, medical and social work staff. Other healthcare professionals were also invited to attend on an ad hoc basis to discuss EoLC patients they were working with. However, there were no HPCT staff at the hospital on Wednesday 27 July 2016 in the morning. Staff told us this was due to staff attending a MDT meeting at St Bartholomew's Hospital. Staff told us this had been

raised at the HCPT 'away day', where the use of teleconference facilities had been discussed to enable staff to attend MDT meetings whilst they were on-site at the hospital they were working in. Staff said they were not aware of when teleconferencing would be implemented, as it was a recent meeting. However, staff told us the technology was in place, as they held daily allocation meetings via teleconferencing.

- The daily allocations meeting were attended by the HPCT and palliative care social workers.
- The HPCT team worked closely with a local authority palliative care social worker. The team also worked closely with a hospital psychologist that covered both Royal London Hospital and St Bartholomew's Hospital.
- The HPCT team had developed close links with the team at St Joseph's hospice. Staff told us they had formal meetings with the St Joseph's admissions team on a six monthly basis. We did not ask to view minutes of these meetings.
- The HPCT team provided specialist knowledge to wards and departments across the trust with up-to-date holistic symptom control advice for patients in their last year of life. Staff at the HPCT told us they had increased visibility on the wards as EoLC had a higher profile in the hospital in the past 12 months.
- Staff on ward 14F told us nurses felt empowered to raise whether patients were approaching the end of their life during MDT meetings. However, some staff told us patients approaching the end of their life could be put on the CCP earlier.
- Staff at the Bereavement Office told us they had a, "very good", working relationship with staff on the wards and the mortuary.

Seven day services

- The HPCT CNSs provided a face to face 9am to 5pm service Monday to Friday. NICE guidance (QS13) recommends that palliative care services should ensure provision to: visit and assess people approaching the end of life face to face in any setting between 9am and 5pm, 7 days a week. However, staff at the HCPT team told us they did not currently have the resources to provide seven day face to face services. We spoke with the chief medical officer (CMO) who was the executive lead for EoLC. They told us that seven day a week working was under review at the time of our visit, and a business plans was being formulated to enable the HPCT to provide services seven days a week.
- St Joseph's Hospice provided out of hours over at weekends and bank holidays and overnight daily from 17.00 to 09.00. Out of hours cover was provided by the consultants on call at St Joseph's Hospice. Ward staff told us they knew the consultants at the hospice and they were always available to provide advice and guidance out of hours. For example, staff on ward 11E showed us guidance for staff on contacting St Joseph's Hospice. This meant staff on the wards had round the clock access to specialist advice via the telephone.
- The chaplaincy team could be contacted via the ward staff 24 hours of the day, seven days a week.
- Staff at the mortuary and on the wards told us bereaved relatives who wished to visit the mortuary outside of regular hours could request this. Close relatives would receive an accompanied visit with a nurse who was familiar to the family.

Access to information

- Senior staff we spoke with were aware of the trust's Caldicott Guardian (this is an appointment whereby the holder has responsibility to ensure the protection of patient confidentiality). This meant the trust had systems in place so that patients could be sure that their confidential information would only be shared appropriately.
- Information for patients on access to patient records was available in corridors around the hospital. The leaflets explained people's rights to access medical records under the Freedom of Information Act 2000.
- A number of staff told us Wifi access could be a challenge at the hospital, and this had an impact on researching information on the internet.
- HCPT staff told us they carried folders with printed guidance, for example, a CNS showed us their folder which included copies of the World Health Organisation (WHO) checklist, the bereavement checklist, and the trust's renal guidelines. Staff told us they carried guidance as accessing computers at the hospital could

be difficult as they were usually in use on the wards. Staff told us they reviewed their folders when new guidance was issued to ensure the information they carried was up to date.

- GPs were routinely informed during the inpatient stay that a patient was receiving EoLC by the patient's discharge letter informing EoLC as their management priority. These letters would mention priorities and patient's preferences for EoLC and whether the patient had been referred to the community palliative care team. The GP was always informed if the patient died during the admission procedure.
- If a patient who was imminently dying was discharged home, the managing medical team would discuss this with the patient's GP before discharge by phone so that an urgent GP visit could be arranged. This ensured that considerate and timely death certification could take place in the community avoiding unnecessary distress for relatives and avoiding the unnecessary involvement of the coroner's service.
- When a patient died the Bereavement Office would inform the patient's GP, as part of the service's day after death procedures.

Consent, Mental Capacity Act, Deprivation of Liberty Safeguards

- The hospital had introduced monthly 'Schwartz Rounds.' These were groups where staff reflected on the emotional and social aspects of their roles. HPCT staff told us they had attended 'Schwartz Round' sessions that reviewed the mental capacity act 2005 (MCA) and deprivation of liberty safeguards (DoLS), as well as sessions on safeguarding.
- The nursing documentation bundle had a flowchart to support staff in assessing patients' capacity to consent to care and treatment, this offered staff step by step guidance. The document also carried guidance for staff on escalating concerns about a patients' capacity and signposted staff to the relevant hospital department, for example the psychiatric liaison team or external agencies, such as the police.
- The nursing documentation bundle recorded next of kin (NOK) and family contact details. However, the document did not prompt staff to record whether the patient had a power of attorney (POA) in place. Staff told us this could be recorded in the section of the document that recorded patients 'relevant past medical history.' Staff told us patients were asked about POA on admission.
- We saw some wards had a flowchart poster which provided staff with guidance on assessing a patient's decision making capacity.
- Overall, we found 'do not attempt cardiopulmonary resuscitation' (DNACPR) decisions to be in accordance with recommendations from the Resuscitation Council UK. However, we noted that some patients, who lacked the mental capacity to make a decision, did not have a best interest decision recorded in regards to DNACPR decisions. Staff told us they were using previous assessments of the patient's mental capacity to inform DNACPR decision making. However, this meant decisions that were supposed to be specific were being used generally to assess patients' decision making capacity.
- The trust had redesigned the DNACPR decision form and we found the new form was in use across the wards and combined with an anticipatory emergency care plan that identified what treatments would be suitable for a patient in the event of a patient deteriorating.
- The hospital had completed an audit of staff use of the DNACPR form in May 2016 and found 67% of the 97 forms audited were compliant. However, as part of the HPCT education plan DNACPR training had been rolled out to medical staff including consultants, registrars, and other senior clinical staff between April and June 2016.
- Staff at the Bereavement Office told us all deceased patients with 'deprivation of liberty safeguards' (DoLS) in place were referred to the coroner, as this was the practice locally.
- 100% of CNS on the HPCT had received training in consent.

Are end of life care services caring?

Good

We rated the service good for caring because:

End of life care

- Most of the nine patients and relatives we spoke with were positive about the way staff treated people. Most patients told us the care they received met their expectations. We observed staff being caring and supportive in interactions with patients and their families.
- Patients and relatives told us they were involved in decision making about their care and treatment. People's individual preferences and needs were reflected in how care was delivered.
- Staff demonstrated awareness of people's needs and the limitations associated with their conditions. Patients' psychological and emotional needs were appropriately supported.
- The chaplaincy service provided support for people's spiritual and emotional needs. A psychologist was attached to the HPCT and provided psychological and emotional support to patients.

Compassionate Care

- Throughout our inspection, we mostly observed caring, compassionate care being delivered by staff to patients receiving EoLC. Staff were seen to be very considerate and empathetic towards patients. Staff we spoke with demonstrated understanding of patients' emotional wellbeing.
- We saw staff pulling curtains around people when they were receiving examinations or care and treatment. This meant consideration was given to patient's privacy and dignity.
- Staff on the wards told us the care the HPCT team provided was sensitive and caring**.** We observed an HPCT CNS reviewing EoLC patients. We saw that patients were reviewed by the HPCT in a professional, caring and compassionate manner.
- Most of the patients and families we spoke with were generally pleased with the care provided. They told us doctors, nurses and other staff were caring, compassionate, and responded quickly to their needs. However, two patients on ward 14F told us staff did not respond to their requests in a timely way.
- Staff on the wards told us they always tried to put EoLC patients in a side room with open visiting. However, during our inspection a patient passed away in the accident and emergency (A&E) unit's resuscitation room due to staff being unable to locate a bed on the wards. Staff told us it was a rare event that a bed could not be located for a patient at the end of their life. Staff said they would usually offer EoLC patients and families a private room on the A&E in the event that a bed could not be located. However, the private room on the A&E was in use when the patient was admitted. The staff built a relationship with the family involved, and demonstrated care and compassion for both the patient and family.
- The trust scored lower than the England average in the 'patient led assessment of the care environment' (PLACE), 'privacy, dignity and wellbeing' category in 2015. The trust score was 82%, the England average was 86%.
- The Bereavement Office sent families a card following the death of a relative. Staff told us it was to recognise the shared experience of the hospital's staff and the family.

Understanding and involvement of patients and those close to them

- The hospital scored 80% in the NCDAH key performance indicator two (KP2) for documented evidence that health professionals had discussed the patient would probably die in the coming hours or days with families. This was slightly better than the England average of 79%. The hospital also met KPI seven (KP7), above 80%, for seeking the views of bereaved relatives or friends between 1 April 2013 and 31 March 2015.
- The trust was rated in the bottom 20% of trusts in 24 of the 35 question in the Cancer Patient Experience Survey (CPES) 2015. The trust was rated the same as the middle 60% of trusts in 11 of the 35 questions. This included: "patient given choice of different types of treatment," and "possible side effects of treatment given in an understandable way."
- Staff we spoke with told us ward doctors would review patients daily and talk to families where necessary to ensure that patients and families were involved in decision-making.
- A patient told us the staff had involved them, "in every step," of their assessment and decision making process.

End of life care

- Patients' records had a section for staff to record patient discussions and involvement. Patients' preferences and wishes were also recorded.
- On ward 11E, the ward sister told us they encouraged relatives to get involved in the mouth care of EoLC care patients.
- Ward 14F had introduced a weekly afternoon tea for the families and carers of patients.
- The recently refurbished relatives' room attached to the Bereavement Office carried a variety of information for bereaved families, including the contact details of the hospital's patient liaison service (PALS). The Bereavement Office co-ordinator supported bereaved families and offered them advice and information on actions they needed to take following the death of a relative.

Emotional Support

- HPCT assessments documented patients psychological and spiritual support needs as part of their holistic needs assessment.
- Staff on the HPCT team told us ward staff generally provided good EoLC in terms of tasks. However, some staff at the HPCT team thought that staffing on the wards and in the HPCT meant ward staff occasionally did not have the time to provide appropriate emotional support to EoLC patients and relatives. All the staff on the HPCT team told us staffing on the wards and in the HPCT had improved in the past 12 months and that emotional support for EoLC for patients was improving.
- The hospital had eight chaplains covering most of the major UK religions. Chaplaincy staff told us ward staff tended to involve the chaplaincy at the end of people's lives, instead of asking patients of faith if they would like chaplaincy support on admission to facilitate relationship building with patients and their families.
- Information leaflets explaining how to contact a local befriending service for older people were available on the older people's wards.
- The bereavement office's information pack for bereaved families carried information on bereavement counselling services.
- A psychologist was attached to the HPCT. The HPCT could refer patients in need of psychological support to the hospital's psychologists and therapists.

Are end of life care services responsive?

Requires improvement

We rated the service requires improvement because:

- There was no means of measuring the percentage of patients achieving their preferred place of death due to the hospital being unable to capture this data.
- Staff on told us 'to take away' (TTA) medicines were not always provided by the hospital's pharmacy in a timely way and this had led to delays with discharging patients.

However, we also found:

- The hospital had completed a review of EoLC services in February 2016. As a result the hospital had introduced a number of improvement projects, including: a site improvement dashboard.
- EoLC Commissioning for Quality and Innovation (CQUINs) payments framework had been developed collaboratively with three local CCG's.
- Interpreting services were available to patients and relatives upon request and were easily accessible.
- There had been no formal complaints about mortuary services, the Bereavement Office, or HPCT in the previous 12 months.

Service planning and delivery to meet the needs of local people

- The trust's bed occupancy had been above 90%, this was equal with the England average since October 2014.
- There had been 984 deaths at Royal London hospital between January and December 2015, the rate of deaths was 0.97%.
- The trust had a draft strategy for EoLC. However, managers told us this could only be implemented if the HPCT had increased staffing levels. The HPCT had produced a detailed business case for increased staffing in the HPCT. The trust had conducted a gap analysis as an aspect of the business case to identify the current and future needs of the service. The business case identified the KPI's that would be used to measure the

proposed strategic objectives for EoLC. The business case also considered the constraints to delivering the strategy. The business case proposed four possible options in regards to EoLC service delivery. Option one: "do nothing," the plan recorded that EoLC services in this scenario would be, "unable to deliver further improvements"; option two: "minimal level of staffing investment", the scenario would be, "severely limited ability to achieve the objectives of the business case"; option three: "intermediate level of staffing investment", the scenario would be, "limited ability to achieve the objectives"; option four: was the "gold standard of staffing and service", the scenario was, "a robust workforce giving the ability to achieve the objectives of the business case." Staff told us the preferred option was option four. The draft business plan was in the process of being submitted to the trust board for consideration.

- The hospital had completed a 'deep dive', this was a comprehensive review of EoLC services, in February 2016. As a result the hospital had introduced a number of improvement projects, including: a site improvement dashboard which was red, amber, green (RAG) rated. The dashboard identified areas for improvement. For example, an area for improvement was to ensure a comprehensive EoLC service was provided by the hospital, working in partnership with the local clinical commissioning group (CCG), local authority, charities and local third sector partners. The dashboard recorded that the director of nursing from Royal London Hospital was sitting on the local authority's 'Last Years of Life Steering Group' from May 2016 to design, "seamless 24hr access to care."
- The trust's EoLC Commissioning for Quality and Innovation (CQUINs) payments framework had been developed collaboratively with three local CCG's: Tower Hamlets, Newham and Waltham Forest. The trust were working towards the CQUIN targets for quarter two. The quarter one target was: all older people and general medical wards to have two EoLC link nurses on the hospital wards. Information on whether the trust had met the target was not available as this would not be compiled until the end of July 2016. The targets for the following quarters were: the trust to report on the number of link nurses who had undertaken the foundation in palliative care training course; and the trust to conduct and report on an evaluation of the model of co-training. There was a clear timeframe and action plan in place for achieving these targets.

Meeting people's individual needs

- 100% of CNS on the HPCT had up to date mandatory training in equality and diversity and dementia awareness.
- All of the trust's information leaflets informed patients that the leaflets were available in other languages.
- Staff told us interpreting services were available to patients and relatives upon request and were easily accessible. Staff told us staff who spoke languages would be approached first if an interpreter was required. Staff also had access to a telephone interpreting service. Staff said families sometimes provided interpreting services, but this was not an expectation, and would only happen where both the patient and family were happy to provide this.
- Staff on ward 14F told us there was a care programme for patients with dementia, whereby patients received one to one care. Staff also used a visual analogue scale (VAS) to assess dementia patients' health.
- Work was in progress for two day rooms at the hospital. The rooms would be used by families or by staff to break bad news.
- Staff at the Bereavement Office told us the wards were responsive to informing the office of deceased patients with religious needs that needed to be acted on quickly.
- There was a recently refurbished relatives' room next door to the Bereavement Office. Staff told us the room was used by both the Bereavement Office and Chaplaincy to speak with bereaved families or could be used as a private area for bereaved families.
- Families were facilitated to stay overnight in either one of the two relatives accommodation rooms the hospital provided, or on a recliner chair in the patients room, if a patient was in a side room. However, there were no provisions of beds for families if they wished to stay in a room with a relative at the end of their life.
- The chaplaincy at Royal London Hospital had a Christian sanctuary and Muslim prayer rooms available for patients and families to use. There was also a Jewish

community room in the hospital. Chaplains told us the team could minister to all faiths. The chaplaincy had a resource book that staff could use to contact representatives of all the major religions in the UK. Chaplaincy staff told us some of the wards were, "superb", in addressing patients' spiritual needs. However, chaplaincy staff told us patients' spiritual needs were not always recorded when patients were admitted and ward staff tended to refer patients to them at the end of life instead of earlier when they could form relationships with patients and their families.

- Staff on the wards we visited were able to explain the procedures following the death of a patient. We were shown the necessary documentation and wrist bands. Body bags and shrouds were also available on the wards.
- The mortuary service had a viewing suite where families could visit their relatives. The suite was clean and provided seating and tissues for relatives. We were told by the mortuary staff that families were supported during the viewing and that they would ensure that relatives knew what to expect. During out of hours families would be supported during a viewing by a nurse they were familiar with.

Access and flow

- There had been 698 new referrals to the Royal London Hospital and St Bartholomew's HPCTs between April 2015 and March 2016. The hospital informed us that they were unable to separate the data for each site. The total number of deaths between January 2015 and December 2015 at Royal London Hospital were 984.
- HPCT staff told us patients would be formally referred to the service by the team's telephone referral line; this was administered by the team's reception staff. Referral guidelines for the HPCT team were available on all the hospital wards and the hospital's intranet. The HPCT team told us they also received verbal referrals from both medical and nursing staff on the wards or from community palliative care teams, whose patients had been admitted to hospital.
- There had been 191 referrals for symptom control to the HPCT between April 2016 and June 2016; 102 of these patients were seen within 24 hours; four were seen but this was over one day; 21 had reviews planned; 51 patients time to be seen were recorded as unknown; two patients died before being seen within 24 hours; two patients died without being seen over one day; nine patients were discharged within 24 hours of referral and were not seen as a result.
- Each morning at the daily allocations meeting members of the HPCT team triaged new patients and reviewed current patients; the team also prioritised and allocated new referrals. Patients who had complex problems were seen on the consultant's ward round.
- On a weekly basis all new patients and all on-going patients, including those who had died or had been discharged were discussed at the MDT meeting. In the case of urgent referrals, if the HPCT team couldn't assess the patient immediately, the HPCT team would offer symptom control advice to staff on the ward, until the patient was assessed.
- Patients were discharged from EoLC under the following situations: discharge home, hospice or nursing home: patients who no longer required specialist palliative care involvement; palliative care problems were not the main reason for admission; at the request of the patient or family.
- HPCT staff told us on discussion with the patient and on assessment of need, if the patient was going home or to a nursing home, referrals were made to the relevant community palliative care team. A standard discharge letter, to complement the medical discharge summary, was sent to the doctor into whose care the patient was being discharged. A copy of this was sent to the appropriate community palliative care team, the treating consultant and the patient, or relative if they had given their consent.
- Discharged patients who had made a DNACPR decision, always carried a copy of a paper based DNACPR form for transfers. Staff told us ambulance services, GP services, and community services were familiar with the red DNACPR form.
- The trust had a rapid discharge process for completing the NHS continuing health care funding paperwork for eligible patients who were considered to be in the last four to six weeks of their life. This ensured people received their care funding in a timely way and could be transferred to their preferred place of care quickly.

End of life care

- Staff on the wards and the HPCT team told us patients could be moved to their preferred place of care rapidly. Staff on the HPCT team told us patients could usually be discharged to their preferred place of care in 24 hours. Staff said discharges were not usually less than 24 hours due to the logistics of getting support for people and getting equipment in place. Staff said the speed of transfer was dependent upon how quickly the patient's local authority could respond to requests.
- Staff on ward 14F told us they referred patients to the HPCT as soon as a patient had been identified as approaching the end of their life. This enabled the patient and their family to receive assistance with assessing their wishes in regards to their preferred place of death. Staff told us the HPCT team usually responded to their referral within 24 hours.
- Staff told us patients preferred place of death was discussed with patients and their families. However, staff did not know the percentage of patients achieving their preferred place of death due to the hospital being unable to capture this data. The trust were introducing the integrated palliative care outcome scale (IPOS) and staff said they would have access to this data once the IPOS system was up and running.
- Staff on ward 14F told us 'to take away' (TTA) medicines were not always provided by the hospital's pharmacy in a timely way and this had led to delays with discharging patients, as they had to wait for their medicines. Staff on ward 11E told us pharmacy were often slow in responding to medicines requests, especially at night.
- Staff told us the lack of a FAX machine in the HPCT team office had led to delays in sending discharge summaries to patients GP's. However, staff at the Bereavement Office had introduced discharge summary follow up to monitor discharge summaries being sent to GP's in a timely way.
- Portering services told us they had a 90 minute standard response time for transfer of deceased patients to the mortuary. Staff on the wards confirmed that portering services responded quickly to requests for a porter.

Learning from complaints and concerns

- The EoLC steering group had complaints as a standard agenda item. However, there had been no formal complaints about mortuary services, the Bereavement Office, or the HPCT in the previous 12 months.
- The trust had complaints handling policies and procedures in place. All complaints to the trust were recorded. Information on the trust's complaints policy and procedures was available on the trust's internet website.
- Information available to patients and visitors to the hospital included leaflets about how to make comments and compliments; or how to raise concerns or complaints. The patient advice and liaison service (PALS) was based in the hospital. Most patients we spoke with were unaware of the complaints procedure. However, the relatives we spoke with were aware of their rights to make complaints and told us there was information available in the hospital if they wished to make a complaint.
- Staff at the Bereavement Office told us the system of monitoring of discharge summaries to GP's had been implemented as a result of GP's raising concerns.

Are end of life care services well-led?

Good

We rated the service good because:

- Senior managers and the chief nursing officer (CMO) understood the risks and challenges to the service.
- Clinical leads were visible and approachable.
- There was a system of governance and risk management meetings at both departmental and divisional levels.
- There was an open and honest culture within the service, morale had improved.
- There was evidence of continuous improvement and development of staff and services.
- Staff knew and understood the vision of the trust.

However, we also found:

- The HPCT lead nurse worked part time and had been managing staff in another of the trust's hospitals. HPCT staff we spoke with felt the HPCT team needed a full-time lead nurse due to the volume of referrals on Mondays and Fridays.

Leadership of the service

- Staff at the HPCT told us there had been improvements in EoLC at the hospital. A typical comment was, "It has definitely improved."
- The trust's chief medical officer (CMO) was the board member with specific responsibility for care of the dying. Staff at the HPCT told us that the appointment of a board member for EoLC had been a positive development for the service. Staff said the appointment of the CMO had increased the profile of EoLC at board level.
- There was a clear governance structure and lines of accountability for EoLC. We viewed a EoLC management and governance flowchart which clearly detailed how the Royal London Hospital task and finish group fed into the trust's EoLC steering group, which reported to the trust board.
- Staff at the HPCT expressed confidence in the team's leadership provided by the team consultant. HPCT members told us they felt well supported within the team. However, the HPCT team lead nurse worked Tuesday to Thursday. The lead nurse told us they had until recently also been supervising staff at Newham Hospital as well as Royal London Hospital. Staff told us the lack of a lead nurse had been mitigated by the trust's lead nurse for palliative care offering staff support and visiting the hospital frequently.
- Staff told us Monday's and Friday's were the HPCT team's busiest days due to the numbers of referrals on these days. HPCT staff we spoke with expressed concern about team leadership being stretched on these days.
- Some staff at the HPCT team told us they had received, "excellent leadership," from trust's lead nurse for palliative care. However, staff said the trust's lead nurse was on a temporary contract and said they were worried that the lead nurse for palliative care would not be offered a permanent contract.
- Staff on the wards told us senior management and executives were, "more visible." However, a few staff told us there had been a lot of management changes and it was not always clear who managers were.

Vision and strategy for this service

- The trust's chief medical officer (CMO) was the executive lead at board level for EoLC. The trust had a draft strategy, 'End of Life Care Strategy 2016-2019,' which was based on the '5 priorities of care for the dying'.
- HPCT staff told us they were aware that a vision for EoLC services and a strategy of improvement and change to service delivery for EoLC was being developed. However, staff said they were unaware of what this would entail. However, managers we spoke with told us there would be a period of staff consultation commencing in August 2016.
- The trust had a draft business case, 'increased staffing to improve end of life care and specialist palliative care across Barts Health NHS Trust'. A programme manager had been employed to manage the planning and eventual delivery of the business case and strategy. The business case was linked to the trust's priorities, objectives and plans.
- The trust's values and behaviour statements were displayed on notice boards around the hospital, as well as on the trust's intranet and internet. Most staff we spoke with told us the trust's vision and strategy was publicised on the trust's intranet and on emails. Staff said they incorporated the trust's values and behaviours into their practice.

Governance, risk management and quality measurement

- EoLC services had been involved in the National Care of the Dying Audit (NCDAH). This enabled the service to measure their performance against the Royal College of Physician guidelines for the care of dying patients. We saw that the trust had an action plan in place following the NCDAH and this was regularly reviewed and updated. The December 2015 review recorded that the trust had achieved some of the recommendations. However, in regards to access to specialist support for care in the last hours or days of life, staff told us the hospital lacked the resources to offer a seven day service. In response the HPCT team were in the process

of submitting a business case for increased medical and nursing staff to enable the hospital to offer specialist palliative care from 9.00am to 5.00pm Monday to Sunday.

- The hospital had introduced monthly EoLC work stream meetings. These were attended by HCPT managers. The May 2016 meeting had reviewed EoLC improvement plan, the EoLC education strategy, and the CCP. This meant managers were aware of development in the HCPT and able to monitor the service.
- The trust's EoLC steering group met monthly. We reviewed minute of the steering group meetings for February, March, and April 2016. The group monitored EoLC key performance indicators. Including how the trust was performing in regards to: National end of life care strategy (2008); NICE quality standard for end of life care for adults QS13 (2011); the national council for palliative care guidance and reports; CQC standards; National cancer peer review palliative care measures.
- Managers and staff told us regular MDT meetings and daily allocations meetings took place. Our review of documents showed that these meetings were recorded and included case discussions. Actions taken were documented and reviewed in subsequent meetings.
- The HPCT had two risks identified on the trust risk register, both related to adequate numbers of staff and the potential impact staffing could have for patients. Most of the staff we spoke with were aware of the staffing risks.
- The specialist palliative care risk register was RAG rated and contained five identified risks. The risks were assessed and scored when added to the register, and assessed and scored when reviewed; the register also gave the hospital's target score for risks. There were five identified risks on the register: two of the risks had reduced and met the hospital's target: three of the risks had reduced but had not met the hospital's risk target.

Culture within the service

- All the staff we spoke with from the HPCT told us the team were supportive. Staff we spoke with told us they felt they could raise concerns with team leaders. Staff at the HCPT told us the team culture was open and honest.
- Staff at the HCPT told us they felt respected and valued by the ward staff. The quality of patient experience was seen as a priority by the SPC team.
- HCPT staff were aware of whistleblowing information and a confidential telephone service was available for staff who wished to raise concerns.
- Staff at the HPCT told us morale in the team and across the hospital had improved in the past 12 months. Staff said the hospital had launched 'listening into action' events. These were groups staff could attend to speak with senior manager or board members about services at the hospital.
- Nursing staff we spoke with on ward 14F told us there had been a culture shift on the wards and "current" doctors valued nurses opinions, "more than previously."
- The staff we spoke with told us the HCPT team worked collaboratively with staff on the wards in providing EoLC. The HPCT told us ward staff worked constructively with the team. Across the wards we visited, we saw that the HPCT worked well together with both the ward nursing and medical staff.

Public and staff engagement

- The public were involved in patient led assessments of the care environment (PLACE) in July 2015. In response the trust had produced a, "you said, we did", report addressing all the issues the PLACE assessment had raised. For example, marks on doors on the wards were escalated to the domestic services supervisor.
- The hospital were in the process of developing a Macmillan information 'pod' on the hospital site. This would provide advice and information for patients receiving palliative care as well as their families.
- Staff on the wards told us they could access counselling support following the death of a patient. Staff told us their teams were supportive if a patient passed away and teams tended to support each other.
- The chaplaincy service told us they offered a confidential staff counselling service upon request.
- Staff we spoke with told us they had not been engaged with the EoLC strategy. However, managers told us the ratification of the new strategy had been delayed whilst staff feedback was obtained. The staff consultation was due to commence in August 2016.

- HPCT staff told us they were encouraged by managers to attend 'Schwartz Round' sessions.

Innovation, improvement and sustainability

- Staff on the wards we visited told us there had been improvements in the provision of EoLC in the past 12 months. This was echoed by the HPCT who also told us EoLC on the wards had improved. For example, a staff member told us, "We have embarked on the journey."
- The CMO had a particular interest in EoLC for patients with kidney disease. The CMO arranged an annual bereavement conference at the trust. The 2016 conference had a number of invited speakers that were specialists in palliative and EoLC.
- The hospital had withdrawn the Liverpool Care Pathway (LCP) from clinical practice and had introduced the 'compassionate care plan' (CCP) in 2015.

Outpatients and diagnostic imaging

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

Information about the service

The Royal London Hospital provided a range of clinics covering the majority of clinical specialties including general outpatients, phlebotomy and dressings, ophthalmology, audiology, ENT, pre admission, lung function, fracture clinic, cardiac test, dermatology, neurophysiology, urology and renal services. The department had around 150 consulting rooms in total across all clinic areas plus treatment rooms and audiology facilities. The clinics were located into various areas of the hospital. The dental clinic was separate from the main outpatients' areas.

The diagnostic and imaging department carried out routine x-rays as well as more complex tests such as magnetic-resonance imaging (MRI) and computerised tomography (CT) scans.

The imaging department provided outpatient services between 8am and 8pm Monday to Friday and supported outpatient clinics as well as inpatients, emergency services and GP referrals. The department undertook x-rays, CT scans, interventional imaging, fluoroscopy, ultrasound, nuclear medicine and MRI.

Some services were available at weekends and in the evenings, there was an on-site radiologist which provided a 24-hour, seven-day service, as well as specialist on-call cover for general X-ray, CT scans, MRI, nuclear medicine and ultrasound.

There were pathology laboratories on site, which provided a 24-hour, seven-day service. The phlebotomy service held clinics five days a week and provided a service to the outpatients and GP referral services.

We visited all areas associated with the outpatient and diagnostic imaging services and spoke with 38 patients and 26 members of staff including senior managers and service leaders. We observed care and treatment and looked at care records. Before our inspection, we reviewed performance data about the trust and data specific to the hospital.

Outpatients and diagnostic imaging

Summary of findings

We rated this service as requires improvement because:

- There were five never events reported in dental outpatients between January – June 2016 where patients had suffered harm due to wrong site surgery as a day case. There was a lack of evidence to demonstrate feedback and shared learning with other outpatients services within the hospital.
- The trust was not meeting referral to treatment times (RTT) and was working collaboratively with stakeholders to actively resolve the issue of RTT.
- The trust suspended monthly mandatory 18-weeks Referral to Treatment (RTT) reporting from August 2014. This followed the identification of significant data quality concerns relating to the accuracy, completeness and consistency of the RTT Patient Tracking List.
- There were significant issues with availability of appointment slot; there were over 2 weeks of backlog of appointment waiting to be booked.
- Room and fridge temperatures were recorded daily and were generally found to be within the recommended range. However, in clinic 2, we found that maximum and minimum temperatures were not recorded. This meant that there was a risk that medicines were stored outside of the recommended range.
- We saw pre-prepared trays containing oily phenol injections as well as syringes and needles in clinic 3, which were stored outside of their normal packaging. However, they were stored in a locked cupboard when not in use.
- In the ophthalmology clinic we saw medicines which should be locked in a secure medicines cupboard left unsecured in the laser treatment room. We also saw an expired dermatology cream in the dermatology clinic which expired in August 2015.

However:

- The trust had implemented a full RTT recovery programme. This had led to the extraction of 4.2 million pathways from the patient administration system followed by the application of national and local (NHS IST approved) rules as well as a continuing validation programme.
- Clinical staff and managers had a vision for the future of their departments and followed systems and processes to monitor risks and gather information about patient experiences.
- Clinical staff felt supported by management and encouraged to discuss and learn from incidents and complaints and to improve their practice.
- There were no significant concerns identified within the diagnostic services we inspected where we found patients were protected from avoidable harm and received effective care.
- Nursing staff had a good understanding of safeguarding principles and how to make safeguarding referrals and mandatory training had improved compliance across the outpatient and diagnostic imaging department. Clinical staff had good knowledge of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- Patient outcomes were now being measured by the trust. Local audits plans were comprehensive and had lead clinicians identified. Patient care and pathways followed national guidance and best practice

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Requires improvement

We rated safe as requires improvement because;

- There was a lack of evidence to demonstrate feedback and shared learning with other outpatients services within the hospital about never events which occurred in dental clinics.
- Maximum and minimum fridge temperatures were not recorded and this meant that there was a risk that medicines were stored outside of the recommended temperature range.
- Medicines such as oily phenol injections as well as syringes and needles in clinic 3, which were stored outside of their normal packaging.
- In ophthalmology clinic, we saw medicines were not locked in the locked medicine cupboard, we saw medicines in the laser treatment room and the laser machine, which were meant to be locked away in a medicines cupboard.
- We also saw an expired dermatology cream at the dermatology drug medicines cupboard which had expired in August 2015.

However;

- Staffing levels and the skill mix of staff was appropriate for both the outpatient department and diagnostic imaging.
- Nursing staff undertook appropriate mandatory training for their role and they were supported to keep this up-to-date.
- The departments were clean and hygiene standards were good. Staff had enough personal protective equipment in all the areas we inspected and staff knew how to dispose of items safely and within guidelines.
- Staff ensured equipment was clean and well maintained, so patients received the treatment they needed safely. Equipment was seen to be safety tested.

Incidents

- The departments had robust systems to report, learn from incidents and reduce the risk of harm to patients. Staff told us that the culture was one of honest reporting and a positive move towards change.
- The trust used an electronic programme to record incidents and near misses. Staff we spoke with knew how to use the programme and report incidents. Staff could give examples of incidents that had occurred and investigations that had resulted in positive changes in practice.
- Managers told us that the incident reporting procedures allowed staff at all levels and across multidisciplinary teams to reflect on practice. The matron gave feedback in monthly safety briefing meetings to all staff.
- There were three incidents reported in the outpatient's data pack and no never events. Never events are are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- Nursing staff at the dental outpatients department were knowledgeable about the incident reporting process. They confirmed that there had been five never events at the service in the first six months of this year.
- Nursing staff participated in daily huddles (morning briefing meetings). They told us these meetings were used to discuss incidents and learning from them and that they felt it improved communication across departments.
- We were told by the nursing managers that all incidents were investigated including the never events using root cause analysis and we saw evidence including action plans and learning from incidents to support this. However, there was no evidence to suggest that these never events were discussed with staff from different outpatient's service areas.
- In the diagnostic imaging department, all staff were aware of hospital policies and procedures and knew how to report incidents. Staff told us they knew with how to report incidents on the hospital's 'Datix' incident reporting system.
- Diagnostic imaging staff we spoke with confirmed learning from incidents was discussed within the teams and at team meetings. However staff in ultrasound told us they were not aware of any recent incidents.

- Themes from incidents included overbooking and under booking of clinics, delays in patients being seen by staff, problems with patient notes being available, cancelled clinics and patients turning up for clinics when their appointments had been cancelled

Duty of Candour

- The Duty of Candour regulation, is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Nursing staff were aware of this new regulation and understood its implementation.
- Senior nurses were able to describe how Duty of Candour formed part of their working practices. The process they followed was a verbal apology and explanation followed by a written apology and explanation of the incident and what was done by the trust. The patients were also invited to a face-to-face meeting with the trust. The dental clinic gave us an example of where duty of candour process was implemented.

Cleanliness, infection control and hygiene

- The staff we observed in the outpatients department complied with the trust policies and guidance on the use of personal protective equipment (PPE) and were seen adhering to 'bare below the elbow' guidance.
- We observed staff in all outpatients areas washing their hands in accordance with the guidance published in the Five Moments for Hand Hygiene published by the World Health Organisation (WHO 2014).
- There was hand-sanitising gel available throughout the outpatient and diagnostic imaging areas, and we observed staff using it in accordance with good practice.
- There were hand hygiene, 'Bare below the Elbow' audits undertaken which demonstrated staff were compliant with best practice guidance. These were done for each outpatient's area. The hand hygiene audit results for the outpatients and diagnostic imaging department ranged between 98% and 100% compliance with hand washing techniques.
- Staff working in the outpatients department had a good understanding of their responsibilities in relation to cleaning and infection prevention and control.
- Domestic services staff carried out daily and weekly cleaning regimes. Clinical areas were monitored for cleanliness by domestic team and results were displayed on patient information boards in each area of the outpatients department. Domestic staff could be called to carry out additional cleaning, where staff felt it was necessary.
- Nursing staff were responsible for cleaning clinical equipment. We saw that there were checklists in place in each clinic room and observed that these had been completed to provide assurance that the rooms had been cleaned.
- All patient waiting areas, consultation rooms, treatment rooms and private changing rooms were visibly clean and tidy. The trust provided single sex and disabled toilets and these areas were clean. Patients told us in their view they found the hospital to be clean and well maintained.

Environment and equipment

- The equipment that we saw was in good repair and had been safety tested with safety test stickers on them. We saw equipment clean and ready to use with stickers showing when it was cleaned. Staff adhered to a standard operating procedure for setting up and cleaning equipment in the clinic.
- We saw that staff ensured treatment rooms and equipment in all departments were cleaned regularly. Staff cleaned and checked diagnostic imaging equipment regularly. Imaging staff cleaned and decontaminated rooms and equipment used for diagnostic imaging after it was used.
- The diagnostic imaging department supported the safe delivery of diagnosis, treatment and care. Safety signage and visual warning lights were displayed externally on rooms where X-ray or laser procedures took place. The Radiation Protection Supervisor ensured all expected safety checks were undertaken.
- There was access to emergency equipment, oxygen and resuscitation items including 'hypo box' system for the treatment of patients with hypoglycaemia in all outpatients and diagnostic imaging areas.
- All mobile electrical equipment that we looked at had been safety checked. We saw that the resuscitation trolley was checked and maintained ready for use in an emergency.

- Instruments used for patient treatment, requiring decontamination and sterilisation were processed through the on-site sterile supplies department. Single use items of equipment were readily available and stored appropriately in most areas.
- The radiology manager showed us the equipment maintenance logs for a range of imaging equipment. The logs were completed, signed and dated by the appropriate person to indicate that maintenance of the equipment was safely carried out.
- In the diagnostic imaging department, risk assessments were carried out for all clinical areas. CT risk assessments were carried out when new equipment was delivered, if a new technique was introduced in an area, the area was risk assessed to ensure the radiation dose was not above permissible levels.
- The MRI suite was restricted to authorised personnel only. Doors to the MRI scanners had regulation warning signs on the door.
- We saw that the arrangements for managing waste kept patients safe. Waste bins used appropriate coloured bags for classes of waste which we saw being used correctly.

Medicines

- We noted that maximum and minimum fridge temperatures were not recorded and this meant that there was a risk that medicines were stored outside of the recommended range.
- We saw medicines such as oily phenol injections as well as syringes and needles in clinic 3 were stored outside of their normal packaging.
- In ophthalmology clinic, we saw medicines were not locked in the locked medicine cupboard, we saw medicines in the laser treatment room and the laser machine, which were meant to be locked away in a medicines cupboard.
- We also saw an expired dermatology cream at the dermatology drug medicines cupboard which had expired in August 2015.
- No controlled drugs were stored in the main outpatients departments. Small supplies of regularly prescribed medicines were stored in locked cupboards and locked fridges where applicable.
- Pharmacists managed stock control on a weekly basis and staff told us that the pharmacists provided good support to the departments when requested.
- Staff followed systems that demonstrated compliance with the Medicine Act 1968 and the Misuse of Drugs Act 1971. All intravenous infusions and contrasts were stored in their original boxes or in appropriately labelled containers. Medical gases were stored safely in separate rooms.
- Patient group directions (written instructions for the supply or administration of medicines) for use in X-ray had been completed and reviewed.
- Medicines, which included steroids and local anaesthetics used within the outpatients department were secured within a locked cupboard in a treatment room. Staff told us the everyday medicines were topped up weekly by pharmacy.

Records

- The Royal London Hospital (RLH) Health Records Library was located in the basement of an old disused building, accessed by going outside the main tower building where the main hospital was located. The Health Records Library was manned out of hours and staff in the main hospital building could contact the health records out of hour's team to request medical records (notes) and have them delivered.
- The medical records storage facility was not fit for purpose, with some records stored in different rooms and some records were in cages waiting to be tracked, processed and shelved. We counted 15 cages full of medical records waiting to be tracked and shelved.
- It was reported by nursing staff that patient records were not always available, particularly when patients attended a number of different departments. A recent audit showed 3% of patients were seen in outpatients without their full medical record available.
- Staff in all outpatient areas we visited reported they did not always have some patient's hospital records in advance. Where medical records had not been provided temporary records were made up for staff to use. These contained where possible printed off copies of test results and clinic letters. On average 3% of medical records were unavailable between the periods of January 2016 – June 2016.
- Where patient's records were unavailable, we were assured that sufficient clinical information was available to the clinician to see the patient, as records were accessible electronically including doctors' letters, X-rays, MRI, CT and pathology results.

- We looked at the medical records of patients attending the ophthalmology outpatient clinic. We found these were of a good standard. They contained sufficient up to date information about patients including referral letters, copies of letters to GPs and patients, medical and nursing notes.
- We reviewed referral records in x-ray department. All of them were fully completed with patient demographics, relevant clinical information and detailed the investigation requested.
- At the time of inspection, we saw patient personal information and medical records were managed safely and securely at the imaging department. The service used a combination of paper referrals, from GPs, and electronic referrals.

Safeguarding

- Nursing staff we spoke with were clear of their responsibilities in reporting safeguarding concerns. The nurses were able to explain their role in raising safeguarding concerns, and how they would escalate concerns where necessary. It was explained to us that there were safeguarding link nurses, and that staff could contact the safeguarding link nurse for adults or children for advice if they had any concerns. All staff we spoke with knew the safeguarding lead for the trust and where to seek advice if required.
- Training data provided to us prior to inspection showed 100% compliance with safeguarding adults and children training level 1 and level 2 in all outpatients' areas. The matron accessed a tracking system which tracked mandatory training and alerted staff of their mandatory training dates. Nursing staff were able to talk to us about the insight and knowledge they had gained from this training. They were also able to show us the trust safeguarding policies on the intranet.
- There was no evidence to suggest that all staff working with children had completed level 3 safeguarding training, however all of them had up to date level 1 training. The hospital did not meet the requirement, which requires all staff working with children to have level 3 children safeguarding training.
- An OPD staff nurse was able to give us an example of when staff in the department had followed the trust safeguarding policy and made an appropriate referral.
- Nursing and other clinical staff we spoke with had a good understanding around the vulnerability of children and adults and were able to explain what indicators they would be concerned about. The reporting route was understood and nursing staff were aware of the availability and access to the safeguarding leads.

Mandatory training

- Mandatory training was available for all staff and delivered in e-learning modules and some study days. Compliance with mandatory training attendance was monitored by senior managers. Subjects included health and safety, fire safety, basic life support, hand hygiene, infection prevention and control, essence of care, learning disabilities, mental capacity act level 1 and 2, moving and handling and risk management.
- Managers made sure staff attended training and allocated time in staffing rotas. The training department produced and distributed monthly reports on mandatory training and departmental managers checked compliance regularly. All members of staff we spoke with told us they had completed mandatory training.

Assessing and responding to patient risk

- The hospital had systems and processes in place for responding to patient risk. Staff were available in all the waiting areas of the clinics so that they would detect patients who appeared unwell and needed assistance. 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.
- There were clear procedures in place for the care of patients who became unwell or patients who deteriorated whilst waiting at the clinic. Staff we spoke with told us about emergency procedures and the escalation process for unwell and deteriorating patients. However, they stated these had not been used regularly as the department did not often have acutely unwell patients.
- Ward based patients who required CT, X-ray or MRI services, or other patients who may potentially be unwell, were closely monitored by staff whilst being scanned. Nursing staff had clear protocols to call for assistance in the event of patient deterioration. We were informed that if a patient was particularly unwell, medical and nursing staff would stay with that patient.

- Within interventional radiology, the staff used the World Health Organization's (WHO) checklist on safer surgery techniques, to ensure that safe care was provided to patients prior to each intervention.
- Imaging staff followed the radiation protection policy and procedures in the diagnostic imaging department. Managers ensured that roles and responsibilities of all staff including clinical leads were clear and therefore managed and minimised risks to patients from exposure to harmful substances.
- Diagnostic imaging policies and procedures were written in line with the Ionising Radiation (Medical Exposure) 2000 regulations IR(ME)R.
- In the diagnostic imaging department, staff we spoke with knew who their radiation protection advisor and radiation protection supervisor was. 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.

Nursing and allied health professional staffing

- There was a dedicated team of outpatient nurses, receptionists and support workers working in the outpatients department. The outpatient clinics were staffed by registered nurses and health care assistants.
- Each clinic was run by registered nurses and was supported by health care assistants. The outpatient matron told us that nursing staff were flexible to ensure they provided cover for each clinic and department. Senior staff could adjust the number and skill mix of nursing staff covering clinics to help those that were busy or where patients had greater needs.
- All of the nursing staff that we spoke with felt that staffing was not an issue in the department and felt that there were enough staff of a suitable skill mix to manage the workload.
- Clinical nurse specialists led their own clinics and supported clinics throughout the outpatient departments.
- There were sufficient numbers of appropriately trained and skilled staff to meet patients care and treatment needs in the imaging department. We were told that imaging department did not use any agency staff.
- Radiology staffing information submitted by the trust was for radiology across Royal London Hospital site. The total number of staff working at the imaging department was 300 including medical staff and non-medical staff included radiographers, qualified nurses, healthcare assistants and clerical staff. The radiology manager told us the department did not use any bank or agency staff.

Medical staffing

- We observed there were a sufficient number of doctors to run all scheduled outpatient clinics. Clinics were consultant led.
- Medical staffing was provided by the relevant clinical specialty running the clinics in the outpatient department. Medical staff were of mixed grades, ranging from consultants to junior doctors. There was always a consultant to oversee the clinics, and junior doctors felt supported by the consultants.
- Trust policy stated medical staff must give six weeks' notice of any leave in order that clinics could be adjusted in a timely manner.The outpatient department monitored and audited compliance regarding short notice cancellations.
- There was sufficient number of radiographers, radiologist and other staff supporting delivery of diagnostic imaging services to meet patients' needs.

Major incident awareness and training

- There were business continuity plans to ensure that essential services were not disrupted as a result of emergencies and when internal incidents were declared. It was informed by national guidance such as the NHS Commissioning Board's 'command and control' and 'business continuity management framework'.
- The plan established a strategic and operational framework to ensure the hospital was resilient to a disruption, interruption or loss of services.
- The hospital major incident plan covered major incidents such as winter pressures, fire safety, loss of electricity, loss of frontline system for patient information, loss of information technology systems and internet access, loss of staffing, and loss of water supply.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

There were not sufficient evidence to rate this domain, however we found:

- Care and treatment was evidence based and patient outcomes met national targets and guidelines.
- Nursing staff were competent and multidisciplinary teams met regularly across a range of services and specialties and included both medical and non-medical staff.
- Staff at all levels felt supported by their line managers, who encouraged them to develop and improve their practice.
- All the staff we spoke with were aware of the trust's policies to protect patients and people with individual support needs. Staff asked patients for their consent before treating them.
- Nursing staff were clear about who could decide on behalf of patients when they lacked, or had changes in, mental capacity.
- Diagnostic imaging provided services for inpatients seven days a week and services offered were increasing and continuously improving in line with new technologies.
- Staff undertook regular departmental and clinical audits to check practice against national standards. They also developed and checked action plans regularly to improve working practices when necessary.
- Diagnostics imaging department policies, procedures and audits complied with national regulations and standards. The service monitored radiation exposure, participated in relevant audits and held disciplinary team meetings.
- The entire staff group within the outpatient and diagnostic imaging department had received appropriate training and professional development to carry out their roles and there was evidence of good multidisciplinary team working.
- The diagnostic imaging service operated a seven-day 24-hour service. Radiologists provided an on-call service outside normal working hours. The service had clear consent procedures, which the staff followed.
- The consent process for patients was well structured and staff demonstrated a good understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards.

Evidence-based care and treatment

- We were told that guidelines, such as the National Institute for Health and Care Excellence (NICE) guidelines were followed where appropriate. Staff told us they worked in line with NICE guidance and local policies and protocols.
- We noted that best practice guidance was followed in the fracture clinic with the use of virtual clinic service. Staff had access to evidence based protocols and pathways based on NICE and Royal Colleges' guidelines.
- Relevant clinical guidelines, technology appraisals, interventional procedures, quality standards and diagnostic guidelines that are published by NICE, were noted in the directorate performance report. There were treatment protocols and proforma's available for staff reference.
- There was a policy on radiation safety which included dose optimisation policy, which was in line with current regulations such as the Ionising Radiation (Medical Exposure) Regulations and the Environmental Permitting (England and Wales) Regulations 2010 (EPR10). It set risk management strategies and incident reporting procedures. It also highlighted duties and responsibilities of various staff in relation to radiation safety.
- In the interventional radiology department, we observed the World Health Organisation (WHO) checklist for interventions was routinely completed.
- Diagnostic reference levels (DRL) were monitored and audits of the levels were completed. Where levels were raised the equipment was re-checked and tested in line with the manufacturer's recommendations. The staff in the department had regular contact with the radiation protection advisor.
- Ionising radiation audits had been completed to comply with IR(ME)R safety policy. The annual radiation protection advisor's (RPA) report showed compliance with radiation regulations.

Pain relief

- Nursing records included a pain assessment chart. We did not observe its use in outpatients department on the day of the inspection, however staff told us they asked if patients needed any pain relief following procedures carried out in the department.
- There was a dedicated pain clinic, which took referrals from GPs, consultants and other departments within the hospital. We were told that this service was well used, with a range of medical and physiotherapy input. Nursing staff told us the pain clinic had implemented the Faculty of Pain Medicine's Core Standards for Pain Management (2015) at the pain clinic.
- We observed FP10 prescription pads were available in clinics and we saw prescriptions for pain relief were recorded in patients' notes.
- Pain relief (analgesia) and local anaesthetics were available for patients who needed this during procedures.

Nutrition and hydration

- The trust provided water fountains for patients' use and there was a shop and a hospital café where people could purchase drinks, snacks, and meals.

Patient outcomes

- Did not attend (DNA) rate was consistently higher than the national average from January to December 2015.
- An average of 18% of clinics were cancelled each month from January – April 2016, the main reasons for clinic cancellations were junior doctor's strike, staff leave, study leave and appointments brought forward.
- The follow up to new rate for this trust was above the England average. The trust's follow up to new rate of 2.43% was consistent throughout the year from January – December 2015.
- All diagnostic images were quality checked by radiographers before the patient left the department. Staff followed national audit requirements and quality standards for radiology activity and compliance levels were consistently high.
- Radiology reporting times for GP referrals and accident and emergency referrals were monitored. The diagnostic imaging department key performance indicators included waiting times in various modalities for both in and out patients as well as general practitioner (GP or family doctor) patients and all met national standards.
- Staff carried out audits throughout the imaging department. Audits included themes on correct completion of consent forms and health records including patient assessments. Where audits produced results different from what was expected or needed, managers made changes to procedures accordingly as per the audit results and findings.
- All diagnostic images were quality checked by radiographers before the patient left the department. Staff followed national audit requirements and quality standards for radiology activity and compliance levels were consistently high.
- Waiting times within the clinic were monitored and there was a clear escalation plan in place with actions assigned for staff to follow if waiting times reached 15 to 30 minutes and from 30 minutes and above. Staff informed patients of waiting times.
- We saw the waiting times at one of the clinics had risen and the staff followed the escalation plan and patients were kept informed of the waiting times. The waiting times for this clinic did improve and the clinic managed to finish on time.

Competent staff

- The outpatients and diagnostic imaging department appraisal report shows majority of the outpatient's staff were up to date with their appraisals. Staff we spoke with told us they had received appraisals. Managers discussed training needs at annual appraisals and staff told us opportunities to develop and receive trust support was available. Nursing staff were encouraged to attend courses to update their skills and knowledge.
- Nursing staff were encouraged to widen their understanding of different aspects of the service with a rotational shift pattern in outpatients.
- Specialist nurses worked within the outpatients department providing nurse-led clinics alongside medical colleagues.
- Nursing staff were supported in their role through appraisals and were encouraged to participate in training and development to enable them to deliver good quality care.
- Nursing staff completed trust and local induction which was specific to their roles. We saw completed

documentation in staff files showing successful completion of local induction. An induction plan was in place for all new staff to gain competencies for their job role, and continuous professional development was promoted in the departments.

- Nursing staff were encouraged to question practice if they had any concerns. The outpatients department had agreed competencies for all staff bands, and all clinical staff were required to undertake competency assessment. Managers held staff competency packs within the departments and staff were encouraged to attend courses to update their skills and knowledge.
- All the radiographers had completed their annual appraisals for the year 2015/2016. Radiographers followed the trust competency framework where staff must perform a number of observed procedures to gain competency in that particular area. Designated supervisors approved and signed off the competency framework.

Multidisciplinary working

- We saw evidence of positive multidisciplinary (MDT) working in a variety of clinics. For example in the fracture clinic, clinics were organised with input from physiotherapy and occupational therapy teams. Nursing staff and healthcare assistants we spoke with in other clinics, such as ophthalmology, ENT, dermatology and renal, told us the teamwork and multidisciplinary working was effective and professional.
- In the renal outpatient, clinics were organised according to each patient group specialty for example, transplant clinic, haemodialysis clinic and pre-dialysis clinic. Consultants were supported from a medical perspective by middle grade junior doctors and advanced nurse practitioners. Many of the clinics were multidisciplinary which reduced the amount of clinic visits for patients.
- Some outpatient clinics offered one stop services in some specialties such as breast clinic. During the clinic, patients could receive an ultrasound, mammogram, and aspiration dependant on clinical need. The clinic was staffed by a specialist nurse alongside a medical consultant.
- We observed good multidisciplinary team meetings (MDT). MDT meetings were attended by the full range of professionals and information and action points from these meetings were circulated to all staff in the department.

Seven-day services

- All outpatient clinics operated from Monday to Friday from 9am to 5pm. There were no evenings or weekend clinics.
- The x-ray and other clinical imaging services were available Monday to Friday, 9am - 5pm. Others, such as CT scan, provided services for inpatient department and were available seven days a week 8am to 6pm. The imaging department had systems in place to ensure 24hours, seven-day access to diagnostic imaging.

Access to information

- All staff we spoke with said they had access to policies, procedures, NICE and specialist guidance through the hospital's intranet. Most of the staff we spoke with said their managers communicated with them very well.
- Patients reported to us during the inspection that they had no concerns regarding access to information relating to their care or treatment.
- The outpatients department used both paper and electronic patients' records. All the clinicians we spoke with said they had easy access to electronic records system. The electronic record system allowed for storing all clinic letters, external letters, diagnostic information and discharge summaries about patients. The trust data showed the percentage of patients seen in outpatients without the full medical records was at 3%.
- Nursing staff were able to access medical records as and when required which were available to ward staff. Test results including radiology and blood tests were usually received promptly according to the nursing staff we spoke with.
- The medical records department had quality indicators which they monitored performance against their set targets to ensure effective provision of services. The RLH site used an external company for the longer term offsite storage of health records.The terms and condition of the service and the performance of the company was closely monitored by the service level agreement between the company and the trust through monthly/ regular meetings with the company.
- The hospital was working towards full digitisation of patient paper records to ensure consistent availability of records across departments and reduction in incidents where records were unavailable, misplaced, or damaged.

Outpatients and diagnostic imaging

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The staff demonstrated confidence and competence in seeking verbal and written consent from patients. Verbal consent was observed in the x-ray room and the gynaecology outpatient clinic. We saw that there was a policy and protocols in place for obtaining consent before medical treatment was given.
- Patients were asked for consent before any examination or procedure was carried out. Six patients we spoke with told us they had been asked for their consent before they received treatment.
- Consent forms for some procedures were available and two records we reviewed showed that they had been completed properly and that risks associated with a procedure had been clearly identified and explained to patients.
- Nursing staff were aware of their duties and responsibilities in relation to patients who lacked mental capacity; they demonstrated a knowledge and understanding of Mental Capacity Act (MCA) and Deprivation of Liberties Safeguards (DoLS). Staff reported they had received training in MCA and DoLS.

Are outpatient and diagnostic imaging services caring?

Good

We rated caring as good because:

- People were treated with kindness, dignity, respect and compassion whilst they received care and treatment at the hospital. Nursing staff offered assistance to patients without waiting to be asked.
- Patients and relatives commented positively about the care provided to them by the staff from all the clinics visited. Staff ensured that patients understood what their appointment and treatment involved.
- Consulting and clinical treatment room doors were kept closed, and staff knocked before entering clinic rooms to maintain patients' privacy.
- The patients we spoke with told us staff were very caring and respectful, and patients felt they were supported emotionally. 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.
- Patients understood the care and treatment choices available to them and were given appropriate information and support regarding their care or treatment
- 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 decisions about their care and treatment.

Compassionate care

- Nursing staff were compassionate and caring towards all patients. We saw staff talking to patients explaining all aspects of their care and treatment. We witnessed people being spoken to with respect at all times.
- Nursing staff we spoke with were aware of their responsibilities to ensure privacy and dignity was maintained for people using the outpatients and diagnostic imaging services. We saw that staff were mindful of patient's privacy and dignity including awareness of chaperoning policies and procedures.
- The outpatients department provided a chaperone service during physical or intimate care. The service offered same sex chaperones when intimate personal care and support was being given by a member of the opposite sex.
- Throughout our inspection we observed care being provided by nursing, medical and other clinical staff. We saw examples of staff being friendly, approachable and professional. For example, when people became lost staff would accompany people to the area in which they should be.
- We spoke with 38 patients about the care and treatment they received. All were positive about the care and compassion they received from staff. Patients and their families we spoke with told us the care they had received was "fantastic" and that the nurses went "above and beyond the call of duty to make them feel valued and respected". Relatives we spoke with gave us examples of where staff had gone beyond their role to provide compassionate care to patients.

Outpatients and diagnostic imaging

- Friends and family test scores for patients recommending the service was better than national average from April 2016 – July 2016. The survey results showed 90.55% would recommend the service to friends or family against the national average of 90%.
- Patients were very positive about the care that they received and the information provided to them. Patients were treated with dignity and respect while they attended the hospital.

Understanding and involvement of patients and those close to them

- Patients and relatives who spoke with us in the outpatient clinics reported feeling involved and understood what they were attending the departments for, the types of investigations they were having and the expected frequency of attendance. One patient commented on the consultant, describing them as "very good" and noted how they put them at ease.
- The patients we saw did not require support with communication. Staff were aware that they needed to communicate with patients so that they understood their care, treatment and condition. They gave examples of when they had communicated with patients who had difficulty understanding for example patient's living with dementia. Some staff said they would rely on family members for translation. This could lead to situations where patients' needs and wishes were not properly known.
- All of the patients we spoke with told us that their care was discussed with them in detail, and in a manner that they were able to understand. They said, if they had any queries regarding appointments, they would contact individual clinics or medical secretaries.
- Patients told us that they felt included in decisions that were made about their care and their preferences were taken into account. One patient said, "I like the afternoon appointments and staff try to make sure that I get them, I feel that the staff here are very good at their jobs".

Emotional support

- We observed and heard staff speaking with patients in a kind and caring manner. Patients told us they were happy with the care and support from staff. One patient said, "The staff are open to me asking questions."
- Medical and nursing staff were heard introducing themselves to patients. We observed all staff (radiologists, radiographers and support workers) talked kindly to patients and reassuring them during their procedures.
- The service had access to the range of clinical nurse specialists employed by the trust including dementia, stoma care, chronic obstructive pulmonary disease (COPD) respiratory nurses and cancer nurse specialists.
- Patients spoke highly of the emotional support they received in the urology and nephrology clinics. Staff told us of the support available within the hospital.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

We rated responsive as requires improvement because:

- The percentage of patients with suspected cancer being seen by a specialist within two weeks of urgent GP referral was worse than the England average of 94%, the hospital score was averaging at 90% from April 2014 – December 2015. Since November 2015 the RLH site had consistently achieved access targets in relation to 2 week wait referrals.
- The percentage of patients waiting less than 31 days from diagnosis to first definitive treatment for all cancers was worse than the England average of 98%. The hospital score was on average 92%.
- The hospital target for admitted (closed) pathways was 92%; however the average score for the hospital was 80%.
- The hospital cancellation rate for clinics from January 2016 – April 2016 was 18% on average, and did not attend rate was at 10%, both of these figures were similar to the England average and the trust target.
- The trust was not meeting referral to treatment times (RTT) and was working collaboratively with stakeholders to actively resolve the issue of RTT.

- There were significant issues with appointment slot; there were over 2 weeks of backlog of appointment waiting to be booked during the onsite inspection. Routine appointments were booked within acceptable timescales.
- There were long backlogs of outpatient appointments. Some patients waited for over a year for follow up appointments, or not getting one when they needed one. This meant there was a risk of delays in patients receiving care and treatment.
- Results of a recent audit of waiting times within clinics showed that 35% of patients had experienced delays of more than 30 minutes.
- Medical records storage was not fit for purpose; and there were issues with tracking and prepping of medical records at the hospital.
- The outpatient and diagnostic imaging service received a low number of formal and informal complaints about the service because of problems with appointments and follow up.

However;

- Some outpatient clinics and related services were organised so patients only had to make one visit for investigations and consultation or, if possible did not have to return to hospital for unnecessary appointments.
- Clinical staff made sure services could meet every patient's individual needs especially those in particular, those living with dementia, people with learning or physical disabilities, or those whose first language was not English.

Service planning and delivery to meet the needs of local people

- The departments were accessible for people with limited mobility and people who used a wheelchair. The reception area had a designated hearing loop. The reception area was bright and modern and designed to promote private conversation at the desk area.
- Multiple specialist services offered one-stop clinic appointments to enable patients to attend on one day for consultation and investigations. Some departments had re-organised clinics so that specialist services and tests could be performed on the same day.
- Staff held informal daily meetings (huddle) and formal, minuted, monthly meetings to plan for the days and weeks ahead. They discussed each specialty and the clinics taking place and staffing requirements for each clinic.
- The virtual fracture clinic was a consultant led non-patient attended clinic where the team reviewed the patient's injury, diagnosis, and considered treatment options. A consultant orthopaedic surgeon and staff nurse reviewed the patient records and planned care and treatment accordingly. Staff informed patients by telephone and followed up in writing.
- We were told by the central booking office that, there were issues with appointment slot, and that made it difficult to book appointment on time. Appointment slot issues were escalated to the central booking office manager for resolution. At the time of the inspection, there was two weeks backlog of appointments waiting to be booked by the central appointment booking office. Bookings staff sent out letters to all patients to confirm their appointment.
- Due to poor data quality, the hospital had stopped reporting data on their referral-to-treatment standard (RTT) for non-admitted patients. The hospital had failed to meet the national waiting time targets. The trust had suspended reporting of their RTT since August 2014. A recovery plan was in place but staff were not confident that the plan timescales were going to be met.
- In the diagnostic imaging department we saw separate changing facilities for male and female patients. There were separate cubicles with curtains screened across to help to preserve privacy and dignity. The diagnostic imaging department waiting area catered for patients referred from inpatient wards, outpatient clinics and those referred directly by their GPs. The department operated mainly from Monday to Friday, with Saturday, Sunday and on call cover.
- The staff we spoke with had a good understanding of the population they served and they were all able to explain with confidence the requirements of the people they cared for. The hospital catered for higher than average proportion of Black and minority ethnic group (BME) patients.
- There was sufficient seating available to patients in general outpatients and diagnostic imaging waiting areas. Patients had access to water and could purchase other snacks and refreshments at the hospital café when needed.

Outpatients and diagnostic imaging

Access and flow

- We spoke with 38 patients and three relatives in various outpatients department waiting areas, including ophthalmology, dermatology, orthopaedic, fracture and ENT. Most of the patients we spoke with told us they had experienced at least one cancelled appointment. They also told us appointment times regularly ran late. Staff and patients we spoke with also told us, sometimes patients turned up for an appointment which had been cancelled, because they had not been informed of the cancellation.
- Hospital Episode Statistics data for outpatients showed that of 688,353 appointments made between 1 January 2015 and 31 December 2015, 74% were for first and follow-up appointments. Out of the total appointments made, 20% had been cancelled by the hospital and 10% by patient. Both these figures were similar to England average. Staff we spoke with gave reasons for the hospital cancellations as junior doctor's strike, sickness and doctors leave and study days.
- The hospital did not attend (DNA) rate was at 10%, which is also similar to the England average and the trust target.
- The percentage of patients with suspected cancer being seen by a specialist within two weeks of urgent GP referral was worse than the England average of 94%, the hospital score was averaging at 90% from April 2014 – November 2015. Since November 2015 the RLH site had consistently achieved access targets in relation to 2 week wait referrals.
- The percentage of patients waiting less than 31 days from diagnosis to first definitive treatment for all cancers was again worse than the England average of 98%. The hospital score was on average 92%.
- The hospital target for admitted (closed) pathways was 92%; however the average score for the hospital was 80%.
- The percentage of patients (all cancers) waiting less than 31 and 62 days from urgent GP to first definitive treatment was below the England average and below the national standard.
- The incomplete pathways referral to treatment percentage within 18 weeks was below the standard. Percentage of people with an urgent cancer GP referral seen by specialist within 2 weeks was worse than the England average until October 2015.
- The Royal London Hospital had a low proportion of people waiting for more than six weeks for diagnostic tests when compared to the England average.
- Since the last inspection, outpatients had introduced a reminder system using text messages for patients to ensure patients were aware of their appointments. However, there was a lack of evidence to show this had achieved the desired impact on improving attendance rates (DNA).
- Some of the patients we spoke with told us that they not received their appointment letters on time, and others said their appointment letters arrived late, after the appointment date. Some patients felt they did not have the necessary information in a timely manner following their referral and were not offered choice and times for follow up appointments.
- A number of the patients told us their appointment times were running late by about one and half hours on average and staff did not always keep them informed about the length of delay or reasons for clinics running late.
- We found waiting times for patients once they have arrived in the department were variable. On the day, we spoke with patients several told us their appointments were running 30 to 60 minutes late. One patient told us, "If you come as an emergency patient it can be two or three hours." Staff told us patients regularly waited a long time, especially in urology clinic.
- Most patients told us that staff advised them when the clinics were running late. Several patients told us staff had informed them appointments were running late that morning. However, one patient said, "They don't normally tell you if they're running late, you just have to sit and wait".
- Staff at the central appointment bookings office were responsible for managing the bookings of clinics for most of the hospital specialities. They provided a point of contact for patients from 8am to 5pm Monday to Friday.
- The clinic booking staff worked in teams for medicine and surgery along with the referral teams responsible for managing cancer wait, urgent two-week referral, 18-week referrals and choose and book referrals. All the booking information was electronically stored. At the time of the inspection the central booking office was using NHS mail to manage all their booking, with few exceptions coming through their electronic fax system.

- Team members showed us how patient two-week referrals were monitored which included the request for appointment, any patients not attending booked appointments, patients requesting appointments after the two week targets and the reason provided for this request. We noted that, there were significant issues with appointment slots and backlogs of appointments waiting to be booked. These were managed operationally by the appointment slot issue team.
- Central appointment managers and clinicians within each of the specialities set the bookings rules and these included the schedules on the number and timings of patient appointments.
- Diagnostic investigations and procedures were organised to meet patients' needs. The imaging department worked together and specialist procedures, investigations and consultations happened on the same day. Doctors, nurses and therapists worked together to carry out joint assessment and treatment.
- Turnaround times for urgent radiology reports were 24 hours, two weeks for general scans and 30 minutes for urgent images such as those for suspected stroke patients. Management of routine radiology reports ensured completion within national target times.
- Reporting times for urgent and non-urgent procedures were consistently met. Staff reported images for patients with head injuries or trauma within one hour, inpatient images on the same day, and urgent outpatients on the 62 day pathway within two weeks, and CT scans within 48 hours. 97% of trauma and head injury images were taken within an hour.

Meeting people's individual needs

- Reasonable adjustments were made so that patients with disability could access and use the outpatient and diagnostic services. Clinic and reception areas were wheelchair accessible, reception desks had sections that were at wheelchair height and there were toilet facilities for patients with disabilities. We heard all staff speaking appropriately with patients which supported meeting their needs.
- The staff we spoke with demonstrated a good understanding of the needs of patients with dementia and those living with learning disabilities. We were assured the patient who may be distressed or confused would be treated appropriately.
- Staff told us when patients with a learning disability or who were living with dementia attended the outpatient departments their carers were allowed to assist, provided clear patient consent was given. They also ensured patients were seen quickly to minimise the possibility of distress to them.
- There was drinking water available in the waiting areas and patients had access to refreshments if required. We observed that there was sufficient seating in most of the outpatient clinics. Clinics appeared well attended.
- There was sufficient equipment to provide support to bariatric patients and those with mobility difficulties. For example we saw the physiotherapy department was equipped with a specialist bariatric couch and chair for the use of bariatric patients.
- Staff told us they had ready access to a translation service should they need it. This meant that patients for whom English was not their first language could engage fully in their consultation. There was an interpretation and translation services available at the hospital.
- Patients we spoke with were very positive about the outpatient and diagnostic imaging services and told us they received good treatment and were happy to attend these departments again. We saw the outpatient department kept a wide choice of patient information leaflets which meant that patients were supported to make informed choices about their care and treatment.
- Imaging staff were aware of the need to identify patients who were or might be pregnant and offered pregnancy tests for those who were unsure. Patients who were attending the imaging department who were breast feeding or planning to were given appropriate advice about having an X-ray during this time.
- We noted that signage from the main hospital area to the outpatient clinics was not as clear as it should be; patients could not easily attend the clinic without guidance or directions from people. The lifts to various outpatient clinics were confusing at times and often difficult to navigate.

Learning from complaints and concerns

- Staff told us complaints and incidents were discussed at the monthly clinical governance meetings and 30% of the complaints to the hospital were outpatient related. We were told that most complaints were about lack of timely appointment, cancelled appointments and delays in clinics. Staff we spoke with were aware of the local complaints procedure, and were confident in

dealing with complaints if they arose. Information about the Patient Advice and Liaison Service and how to make a complaint were available and displayed at the hospital.

- Information was displayed in outpatient areas informing people how they could complain or provide feedback on the service. One patient told us they would speak to reception initially if they had a complaint.
- The trust had systems and processes in place to learn from complaints and concerns and we saw evidence from weekly business unit governance meetings, departmental meetings, safety and quality meetings that staff discussed complaints during these meetings.
- Most of the staff we spoke with understood the local complaints procedure and were confident in dealing with concerns and complaints as they arose. Staff in all departments told us they received very few verbal or informal complaints. They could identify patterns and themes from patient concerns and would help patients to use patient advice and liaison service (PALS). Department managers shared lessons learned from complaints and concerns with their teams.

Are outpatient and diagnostic imaging services well-led?

Good

We rated well-led as good because:

- The strategy for outpatients and diagnostic imaging service was informed by the trust wide strategy.
- The leadership and culture of the senior management reflected the vision and values of the trust, delivering safe and compassionate care.
- The governance framework ensured staff responsibilities were clear and that quality, performance and risks were all understood and managed.
- The senior management team were aware of the risks in the department and there was an effective governance framework to support the delivery of good quality care through actions from meetings.
- There were clear lines of management accountability and responsibility within the outpatient's and diagnostic imaging departments. We observed most staff worked well as a team supporting one another.
- We saw senior managers visiting the outpatients department during our visit and we were told this was a normal occurrence.
- Staff in all the outpatients' clinical areas we visited stated that their managers were visible and provided clear leadership.
- Managers and staff told us there was an open culture and most of the staff we spoke with felt empowered to express their opinions and felt they were listened to by the management.

Leadership of service

- We saw staff had confidence in and respect for the management team. We saw positive and friendly interactions between staff and managers. Integrated teamwork was evident in all departments. Senior managers had strengthened nursing leadership of the outpatient's service with a matron and band seven senior nurses to support the matron.
- We found there were clear lines of management responsibility and accountability within the diagnostic imaging services. Staff we spoke with understood the departmental structure and knew who their line manager was. All staff within the diagnostic imaging spoke positively about their managers and said they were supportive and had regular contact with them.
- Imaging staff told us the radiologists were supportive and gave good feedback to the radiographers. We interviewed the diagnostic imaging management team during the inspection. They outlined their vision for the service and the improvement plan they had; we were told that this was shared with the staff during staff/team meetings.
- We spoke with nurses and healthcare assistants who said they felt well supported by their immediate managers. Staff working in the clinic told us they were encouraged in their professional development by their managers and supported to complete training. Appraisals were undertaken annually and all staff we spoke with confirmed that they have had their annual appraisals with their line manager.

- Most of the staff we spoke with were confident about approaching the matron, senior sister, service manager or overall manager to discuss issues or to gain support. Staff told us they felt very positive about the overall outpatients and diagnostic imaging management team.

Vision and strategy for this service

- Senior managers in the outpatient and diagnostic imaging services talked about visions and plans for their department, and the visions and plans were communicated to staff at all levels in the service. The senior management team were able to identify strengths in service delivery and areas that were noted for improvement.
- All staff we spoke with were aware of the trust's values, vision and strategies that included care being delivered with compassion, dignity, respect, and equality. Staff stated quality was a key priority for the hospital. They were committed to work towards achieving the trust's broad vision and strategy.
- Staff showed a good understanding of the values and vision of the trust and felt able to raise concerns. We noted that there were long term strategies in place for each of the divisions within the outpatients and diagnostic imaging department.
- The long term vision and strategy for the department took into account the trust's goals and allowed assessment of long term risks related to finances and the quality of the service for each service area, such as clinical outcomes and patients' experience.
- A strategy to deliver the vision of the service had been developed, and there was evidence of action plans and audits from minutes of meetings to monitor and improve the service in the department. We saw evidence of actions that had been taken which the senior management team felt would support a strategy for achieving their priorities and delivering good quality care.

Governance, risk management and quality measurement

- Regular governance and risks meetings covering the whole of the department were held and there were also separate departmental meetings for each specialty. Issues such as risk assessments, audits and service performance were discussed at these meetings. Minutes of these meetings showed that the meeting had discussed issues related to staffing levels, mandatory training, and availability of health records and data collection, risk management, complaints and incidents.
- A governance system was in place which allowed for summaries and themes on incidents, complaints, compliments and workforce data to be produced and shared with staff for learning.
- A monthly strategy meeting took place that discussed performance data, quality and safety issues, audits activities and changes to clinical practice. Staff were clear about challenges for the departments and were committed to improving the patient experience.
- There were monthly outpatient services management meetings attended by the service managers, senior nurses, outpatient service managers, the health records manager and the central appointments manager to discuss issues relating to outpatient services. Minutes of a meeting we saw confirmed that actions to improve outpatients' service delivery had been discussed and agreed.
- Managers shared learning from incidents across the organisation via regular directorate and operational service manager meetings, and staff emails.
- Diagnostic imaging was part of the clinical support services clinical academic group (CSS CAG), which managed radiology services across all the hospital sites. The head of radiology services and the head of outpatients' services were accountable to the hospital management board.
- The trust had adequate systems to monitor quality and performance. Nurses and healthcare assistants working in the outpatient department told us audits and quality improvement projects were discussed with them. Data collected by the trust was mostly used to improve service quality and patient experience.
- We saw evidence of audits undertaken locally in respect of medicines and infection control. There was evidence that audit reports had been fed back to staff at the local level. Staff we spoke with were able to provide us with evidence of actions been taken as a result of these audits.

Culture within the service

- There was a positive culture amongst staff. Staff were committed and proud of their work. Quality and patient experience was seen as a priority and everyone's responsibility.

- Doctors and nurses told us communication between different professionals was very effective. Nursing staff told us they felt able to raise concerns and discuss issues with the managers of the department.
- All staff we spoke with felt valued and said their managers were supportive and approachable. They felt that they were encouraged to be open about concerns. We observed a good working relationship between clinical and non-clinical staff.
- Staff told us the outpatients and diagnostic imaging department had an open culture, where staff were encouraged to report concerns, record incidents and take part in team meetings. We were told that managers were open to comments and suggestions for improvements from staff.
- We noted a culture of adaptable working. Staff would routinely rotate across different areas to develop new skills and be flexible in their approach. Staff in the diagnostic imaging department felt valued by their managers and enjoyed working as a diverse, multi-cultural team.
- Diagnostic imaging staff felt well supported and there were good opportunities for professional development. Most staff supported each other and there was good team working within the departments.
- Daily safety huddles (meetings) were held with the matron or senior nurse in charge and staff said they were all welcome to attend and participate in the discussions.

Staff and public engagement

- Staff meetings were held monthly where staff were updated on upcoming events, audits, appraisals, mandatory training and where achievements of the department were celebrated.
- Patients' views were obtained through variety of surveys including friends and family tests, and national cancer patient experience survey.
- The trust had undertaken a range of staff engagement activities including team building, staff meetings and one-to-one meetings to understand what are the key issues and challenges facing the service.
- Nursing staff engaged in regular informal and minuted development meetings. Diagnostic imaging and physiotherapy staff met with their respective leads regularly to discuss issues affecting their respective departments.
- Staff engaged at various levels in a range of meetings and views were shared on service development. Staff told us they could discuss any issues with the management team and felt they were listened to.
- The trust had produced an action plan and carried out a regular 'pulse check' survey to understand where they were with issues facing the service. We reviewed the action plan, which had been updated with monthly actions.

Innovation, improvement and sustainability

- The fracture clinic established a virtual clinic which did not require the patient to attend the hospital. This involved the consultant reviewing the patient's notes and X-rays from the previous day's attendance along with their medical histories. Following review, a management plan was proposed and a member of the virtual clinic team (a doctor or a specialist nurse) contacted the patient by telephone to advise them of the plan and treatment option. The virtual review reduced the need for patients to attend the fracture clinic.
- The outpatient and diagnostic imaging service management had been strengthened, staff morale had been improved and the service was being well led by an experienced and committed leadership team.
- Within outpatients department, there were many highly specialised clinical nurse specialists providing nurse-led care to patients around urology, orthopaedic, fractures, ophthalmology, dermatology and ENT.
- Senior managers told us of their plans to improve the referral-to-treatment (RTT) data quality and quality of the patient experience in the outpatient departments as a whole.
- The trust was positively engaging with stakeholder, NHS improvement team and the Care Quality Commission on their improvement and transformation plans.
- The department action plan on improving appointment slot issues, cancelled clinics and appointments and delayed clinics was making good progress and this demonstrated that the trust was listening to staff feedback.

Outstanding practice and areas for improvement

Outstanding practice

- The emergency department was the only centre in the country and one of only two in Europe to offer the Resuscitative Endovascular Balloon Occlusion of the Aorta (REBOA) treatment for patients.
- The emergency department had introduced a 'Code Black' protocol for patients who had severe head injuries. This was the first of its kind in the country and meant that appropriate patients had care led by neurological surgeon from the first time that they arrived in the department.
- Having been part of a pilot study contributing to publication of results, the emergency department now routinely offered blood tests for early diagnosis of HIV and hepatitis.

Medical care

- Safeguarding practices in the Ambrose King centre, Graham Hayton unit and in HIV inpatient services were exemplary. This included multidisciplinary specialist input from community-based professionals or organisations that supplemented the trust's own safeguarding team. Specialists in trafficking, sexual exploitation and sexual violence were readily available and staff worked closely with local authority social workers to protect patient wellbeing.
- Research demonstrably contributed to improved patient experience in the stroke unit and sexual health and HIV services. This included in patient mealtime experiences in the stroke unit and in more targeted screening services in sexual health.
- Some services had worked specifically to meet the needs of the local population. This included the introduction of Bengali-speaking client support workers in the endoscopy unit and sexual health services and Polish and Bangladeshi-speaking patient advocates across the hospital. Staff in older people's services had improved resources and materials to care for patients with dementia through fundraising activities, including reminiscence areas to help stimulate memory and reduce anxiety.
- Staff in sexual health services had developed a flexible, highly-targeted portfolio of services aimed at meeting the complex needs of patients in the local population and reducing the pressure on walk-in screening services. This included the introduction of a 'clinic in a box' model to screen people remotely at special events. To date, 12,000 people had been screened. In addition, an innovative combined medical psychotherapy service provided specialised support and patients had benefited from a number of community services led by health advisers and clinical staff.
- Multidisciplinary working was exemplary in several areas and contributed positively to patient experience and outcomes as well as to improved working practices. This included combined meetings between clinical and non-clinical staff in the endoscopy unit and sexual health services, multidisciplinary pilot projects in the stroke unit and a highly diverse therapies team. Staff in the Ambrose King centre worked with the hospital imam to provide culturally-appropriate sexual health advice and support to young people in the local community.

Outstanding practice and areas for improvement

Surgery

- The surgery service was involved in the development of new surgery procedure checks and equipment counts as part of the National Safety Standards for Invasive Procedures (NatSSIPs) and the service disseminated learning to other surgery providers nationally.
- The hospital's pre-operative assessment unit was well designed and well managed. The service effectively engaged with patients to identify high risk individuals before their procedure.
- There was a very strong record of innovation in the hospital's trauma service and the trust was internationally recognised as an innovator and leader in research in this field.

Areas for improvement

Action the hospital MUST take to improve

- At the time of our inspection we found a number of babies on the postnatal ward had no identification labels. There was no systematic checking of babies' labels, creating a risk that a baby might receive medication intended for another baby, and mother might leave the unit with the wrong baby. The Service must ensure that security on the Maternity wards is robust, as well as ensure that the trust infant abduction policy, revised after the previous CQC inspection, is ratified and disseminated to all staff.
- Ensure that there are enough midwives on the delivery suite to provide safe care for all women.
- Ensure that the level of consultant cover on the delivery suite meets the recommendations made by The Royal College of Obstetricians and Gynaecologists.
- At the time of the inspection and during the unannounced we found the medications cupboards on critical care were left open. All staff who had swipe card access to the unit including non-clinical staff such as domestic staff could access the medications room. The Service must make arrangements to ensure the proper and safe management of medicines.
- Ensure sufficient availability of sterile surgical equipment in operating theatres at all times to ensure the safety of service users and to meet their needs.
- Ensure there are enough operating theatre recovery staff suitably trained in high dependency support and advanced life support to safely care for post-operative patients at all times.
- Improve bed management, operating theatre management and discharge arrangements to facilitate more effective flow of patients from theatres onto wards to ensure patients are not held in recovery for inappropriate lengths of time.

Action the hospital SHOULD take to improve

- Ensure provision is made so that the delivery suite coordinator is supernumerary, allowing for necessary oversight to provide support to staff.
- The trust should ensure that all staff compliance with children and adult safeguarding level two and three training reaches the trust target of 90%.
- The trust should consider making information and signs more readily accessible in languages other than English.
- Take further action to improve and address the perceived culture of bullying and harassment.
- Ensure that equal opportunities for BAME staff is addressed.
- Ensure a hospital palliative care lead nurse is available 7 days a week to meet the hospital palliative care team's managerial and supervisory needs

Emergency Department

- The trust should ensure that when patients enter the emergency department they are assessed within 15 minutes of arrival, and that all staff involved in the streaming of patients coming in to the emergency department are appropriately trained.
- The trust should ensure that patients are admitted, transferred or discharged within four hours of arrival in the emergency department.
- The trust should consider a robust policy for overcrowding with the emergency department in order to minimise the practice of patients being cared for in corridors.
- The trust should ensure an evidence based skin-assessment for patients is introduced for patients

Outstanding practice and areas for improvement

who are at risk of pressure ulcers and, if it is anticipated that they are due to be within the emergency department a long time, they are transferred to a hospital bed.

Medical care

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

Surgery

- Review trust incident governance processes to ensure learning from incidents is shared systematically across all trust sites.
- Improve trust recruitment processes to facilitate more rapid employment of new members of staff and reduce staff vacancies on surgery wards and theatres.
- Improve compliance and awareness of trust infection prevention and control policies and processes to ensure all surgery staff understand how to label and dispose of clinical waste safely.
- Improve awareness of major incident plans, policies and protocols for all staff groups and grades in the surgery service.
- Improve systems to ensure the nutrition needs of all surgery patients are met, for example, additional training for nurses and healthcare assistance on malnutrition awareness and assessment tools, and ensuring all relevant dietary information is properly recorded and shared.
- Investigate the introduction of enhanced recovery after surgery protocols to help patients achieve early recovery after surgical procedures.
- Take further steps to improve the patient experience of nursing care on surgery wards and ensure parity of care provision by all nursing staff and healthcare assistants.
- Improve provision of patient literature in community languages in the surgery service.
- Continue to reduce Referral to Treatment backlogs in surgery.
- Take further steps to improve the organisational culture within the surgery service (across all surgical specialties) to reduce instances of unprofessional behaviours, improve communication and information sharing and ensure all staff feel sufficiently supported in their roles.

Critical Care

Outstanding practice and areas for improvement

- Review consultant cover on critical care during nights and weekends to ensure they are meeting the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units recommended consultant to patient ratio of 1:8 to 1:15.
- Make arrangements to ensure staff in critical care side rooms have easy access to a call alarms should they require assistance when looking after patients.
- Consider ways to increase multidisciplinary ward rounds on critical care so they are happening on a daily basis.

Services or Children and Young People

- Ensure the removal of all potential ligature risks throughout children's services that would be a safety concern for young people at risk of self-harm.
- Ensure the development of a learning disability pathway in children's services, as well as ensure that staff have consistent access to input from specialist learning disabilities support.
- Ensure that a robust policy is in place to protect children and young people from sharing rooms with others of the same sex.

Outpatients and diagnostic imaging

- Ensure the tracking, processing and storage of patient records is timely to avoid delay in locating patient record when attending hospital appointment.
- Ensure all staff (including medical and nursing) working in paediatric outpatients receive and have regularly updated level 3 safeguarding training.
- Make necessary improvements on patient waiting times for treatment including referrals and emergency referrals from GPs.
- Ensure improvements to diagnostic waiting times.
- Improve the availability of appointment slot; there were over 2 weeks of backlog of appointment waiting to be booked.
- To ensure all medicines were kept as much as possible in their normal packing and kept secured in a locked cupboard in all outpatient clinics.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Maternity and midwifery services	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes were not established or operated effectively to ensure the provider was able to assess, monitor and improve the quality and safety of the services provided because; 1. The service was not maintaining complete and accurate records of babies' care 2. The service was not fully assessing and monitoring the risks to the health, safety and welfare of babies This was a breach of Regulation 17(2)(a) and 17(2)(b)

Regulated activity	Regulation
Maternity and midwifery services	Regulation 18 HSCA (RA) Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in maternity services reflecting the establishment agreed as appropriate for the acuity of the women. This was a breach of regulation 18(1): Providers must deploy sufficient numbers of suitable qualified, competent, skilled and experienced staff to make sure that they can meet people's care and treatment needs.

Regulated activity	Regulation
Surgical procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Requirement notices

Patients were held in recovery for inappropriate lengths of time and in an unsuitable environment. Patients frequently remained in recovery overnight.

This was a breach of regulation 12(2)(d): ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way.

Regulated activity	Regulation
Surgical procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing There were insufficient numbers of recovery staff in theatres with high dependency or advanced life support competencies to safety care for high acuity, high risk post-operative patients at all times. Some shifts did not meet the Association of Anaesthetists of Great Britain and Ireland (AAGBI) requirement for one member of recovery staff to have high dependency or advanced life support competencies to safely and effectively care for some groups of patients post-surgery or respond to serious concerns. In such case the recovery team requested agency nurses with HDU level qualifications, but suitably trained staff were not always available. This was a breach of regulation 18(1): Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part. - Providers must deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that they can meet people's care and treatment needs and therefore meet the requirements of Section 2 of these regulations (the fundamental standards).

Regulated activity	Regulation
Surgical procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Requirement notices

There was insufficient and inconsistent availability of sterile surgical equipment in theatres.

This was a breach of regulation 12(2)(f) where equipment or medicines are supplied by the service provider, ensuring that there are sufficient quantities of these to ensure the safety of service users and to meet their needs;

- Sufficient equipment and/or medical devices that are necessary to meet people's needs should be available at all times and devices should be kept in full working order. They should be available when needed and within a reasonable time without posing a risk

Regulated activity	Regulation
Maternity and midwifery services	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment There was no guideline on what action to take when baby labels were missing. Midwives were not checking labels routinely and documenting this. The infant abduction policy related to electronic tagging which is not in use. Staff could not confidently explain the controls and reporting process on abduction. The policy had not been tested. This was a breach of regulation 12(2)(b): Providers must do all that is reasonably practicable to mitigate risk. They should follow good practice guidance and must adopt control measures to make sure the risk is as low as is reasonably possible. They should review methods and measures and amend them to address changing practice.