

Barts Health NHS Trust

# Newham University Hospital

## Quality report

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Date of inspection visit:  
5-6, 11 and 14 November 2013  
Date of publication: January 2014

### Overall summary

Newham University Hospital is in Plaistow, East London, and serves the people of Newham and other areas. It provides a full range of inpatient, outpatient and day care services as well as maternity and accident and emergency departments. It also has a dedicated stroke unit for rehabilitation following initial urgent treatment. The area the hospital serves has the third most deprived local authority (out of 326 local authorities) and has been identified as one of the top 50 most deprived areas in the country.

Newham University Hospital is part of Barts Health NHS Trust (the trust). Barts Health is the largest NHS trust in England. It has a turnover of £1.25 billion, serves 2.5 million people and employs over 14,000 staff. The trust comprises 11 registered Care Quality Commission (CQC) locations, including six primary hospital sites in east and north east London (Mile End Hospital, Newham University Hospital, St Bartholomew's Hospital, the London Chest Hospital, the Royal London Hospital and Whipps Cross University Hospital) as well as five other smaller locations.

CQC has inspected Newham University Hospital twice since it became part of Barts Health on 1 April 2012.

Our most recent inspection was in June 2013, when we visited the stroke ward and an elderly ward to check that the trust had taken action to address issues identified in August 2012. We issued two compliance actions and asked the trust to provide us with an action plan showing how they would address the shortfalls. As part of this November 2013 inspection, we assessed whether the trust had addressed the shortfalls, and we took a broader look at the quality of care and treatment in a number of departments to see if the hospital was safe, effective, caring, responsive to people's needs and well-led.

Our inspection team included CQC inspectors and analysts, doctors, nurses, midwives, allied health professionals, patient 'Experts by Experience' and senior NHS managers. We spent two days visiting the hospital. We spoke with patients and their relatives, carers and friends and staff. We observed care and inspected the hospital environment and equipment. We held a listening event in Stratford Town Hall to hear directly from people about their experiences of care. Prior to the inspection, we also spoke with local bodies, such as clinical commissioning groups, local councils and Healthwatch.

# Summary of findings

## The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

### **Are services safe?**

Patients were protected from the risk of infection and the hospital was clean. There was an emerging focus on safety and quality, and on developing a more robust safety culture across the organisation. However, governance systems were not embedded through the clinical academic group (CAG) structures in all clinical areas.

There were concerns that patients' needs may not be met due to the hospital's reliance on bank staff (hospital staff working overtime) and agency staff in some areas.

Improvements are needed as medicines were not being stored safely.

Risks may be increased for patients when staffing levels were not maintained and senior staff not available on site. There is also a potential increased risk to patients following the introduction of yellow wrist bands to identify two different risks: the presence of a swab to prevent bleeding following a surgical procedure, as well as a patient who is at risk of falls.

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### **Are services effective?**

National guidelines and best practice were followed but not always consistently and in full. Patient pathways followed national guidance but on-site consultant support out of hours and at weekends did not follow professional guidance. The trust had taken steps to ensure departments were staffed appropriately and there was no evidence of an impact on patient care as a direct consequence. Junior staff in most specialities felt they were supported sufficiently by consultants.

We had concerns that children having orthopaedic surgery did not have input from the paediatric team and emergency surgical procedures on children under 10 were being carried out only occasionally. There were no pain protocols in use and children were not seen by the pain team.

Senior staff in medical services and surgical services were not available at weekends or at night in the Emergency Department, which could impact on decisions about patient care and treatment.

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### **Are services caring?**

We saw that staff were polite, kind and caring in their interactions with patients, visitors and colleagues. The majority of patients told us staff were caring and compassionate and they were treated with dignity and respect.

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### **Are services responsive to people's needs?**

Patients told us that services in the hospital had usually responded to their needs. We had concerns about the lack of information for patients about being transferred between surgical wards and about discharge arrangements. Information for the public was provided in English and not available in other formats, but there was good access to translation services.

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### **Are services well-led?**

We saw there was good local leadership and staff were committed to providing safe and effective services. The trust had established a clinical management structure and governance arrangements. However, we were concerned about a lack of visible leadership and adequate communication from the trust's board with staff to achieve effective working in clinical academic groups (CAGs) and communication upwards to the board.

The implementation and monitoring of safety and quality systems was not embedded and sufficiently effective through the management structures and needed to improve in some areas.

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# Summary of findings

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

### Accident and emergency

The majority of people were seen and treated within the national waiting time limit of four hours. Treatment plans were put in place for either discharge or transfer to inpatient services for further care and treatment. Senior nursing staff had specialist qualifications in treating adults and children within an emergency department setting. There were not enough consultants to provide night-time cover and this was managed via an on-call consultant rota. However, there was always senior medical cover provided by experienced doctors throughout the night.

People who walked into the department were initially seen by reception staff who referred them to either the emergency department (ED) or Urgent Care Centre (UCC) using set guidelines. This may present a risk as patients referred to the ED or UCC were not always seen within 15 minutes of arrival for further assessment. The assessment was completed by a registered nurse or doctor.

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

Overall care was safe and effective, and staff worked hard to ensure patient safety. The majority of patients were complimentary about their care and told us that most staff were kind and caring. There were concerns that nursing staff were sometimes unable to meet people's needs due to staff absence and bank staff (hospital staff working overtime in the trust) or agency staff cover could not be provided. Senior medical support to junior doctors at weekends was by a consultant on-call system and did not meet current professional guidance standards.

Quality and safety monitoring systems were in place and there was evidence that staff received some local feedback and escalated incidents appropriately. Staff were not aware of shared learning from incidents/investigations across the trust, which showed that the dissemination of learning across the organisation was not effective.

Staff were supported by their line managers and had mandatory training and annual appraisals. Staff morale was low following a recent staffing review but we were impressed that staff of all grades remained committed to providing good services to patients at Newham Hospital.

### Surgery

Patients were treated in accordance with national guidance – for example, for joint replacement surgery. Risk management processes were in place and staff were aware of how to report incidents. Staff were aware of learning in their own area but they were not aware of learning from incidents across the wider trust.

We saw that safety checks in theatres followed the World Health Organisation (WHO) checklist. However, we observed that not all surgeons participated in the safety checks at appropriate times in the patient pathway of care in theatres. We also noted there was a lack of consultant engagement in theatre planning meetings and in CAG management and leadership roles. We found there was no consultant presence on site out of hours and at weekends. Patients were transferred to other wards and junior staff covered 'outliers' (patients on wards that are not the correct specialty for their needs) around the hospital which created additional workload and patient care and discharge could be adversely affected.

There were sufficient staff available to provide care to patients, but they did not always have the skills to meet all types of surgical needs on the inpatient ward.

# Summary of findings

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

### **Intensive/critical care**

Patients received appropriate care and treatment in accordance with national guidelines. The critical care service performed as well as similar units across the country.

There were sufficient numbers of staff on duty to provide 24-hour care, however, this was only achieved with overtime (bank) or agency staff. There were five unfilled nursing vacancies on the unit. Out of hours and at weekends there was no specialist critical care consultant cover and a consultant anaesthetist provided support to the unit.

There were delays in discharges from the unit due to the availability of beds elsewhere in the hospital. The unit was small and lacked facilities and storage. Patient privacy could be compromised due to the close proximity of the beds.

### **Maternity and family planning**

The unit was refurbished two years ago and was bright, spacious and clean. The use of colour-coded signs helped people find their way around. There had been a number of 'never events' in the last year; these are events that are so serious they should never happen. The trust had undertaken much work on incident reporting, investigation, learning lessons and changing practice to prevent a recurrence.

There were a significant number of vacancies for midwives within the maternity service. Steps had been taken to address this, but staff expressed feeling "burnt out".

There were appropriate arrangements for obtaining medicines but management, storage, prescription and administration of these did not protect women against unsafe use. Although most staff were caring and respectful towards the women in their care, there were examples of women who had not consistently been treated with consideration and respect.

The service responded to patients' needs and was well-led.

### **Children's care**

We had some concerns about the safety of children's care. The orthopaedic surgeons were operating on children without input from the paediatric team. Emergency surgical procedures on children aged under 10 were being carried out only occasionally. Medicines were not being stored safely.

Children's care was not always effective. We had some concerns that there were no pain protocols in place and the pain service did not see children.

Staff were caring and responded to children's needs but there were no specific facilities for teenagers and the temporary accommodation used for children's outpatients did not meet the needs of the service.

We found the service was well-led. We were concerned that the trust only had one children's governance manager and there was no liaison with other governance managers across the trust

# Summary of findings

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

### **End of life care**

Staff were supported to provide safe and effective palliative and end of life care by the specialist palliative care team. Patients and relatives were supported during this phase of care and their wishes were taken into account and respected. There was good use of the 'do not attempt resuscitation' (DNAR) documentation and decisions were reviewed regularly. Interim guidance was available to replace the Liverpool Care Pathway (for delivery of end of life care) following its removal from use in 2013 according to national guidance.

### **Outpatients**

The Outpatients department provided safe and effective care. However, the consultation, assessment and treatment process in clinics were not regularly monitored by the trust.

Staff were caring and responded to patients' needs. We had some concerns about the leadership of the department. There was no evidence that performance was being checked on a daily basis and staff sometimes felt unsupported by their line manager.

# Summary of findings

## What people who use the hospital say

Newham University Hospital scored highly in the 'Friends and Family' test on the NHS Choices website with 291 out of 311 people who used the hospital being 'likely' or 'extremely likely' to recommend the hospital. However, individual comments on the same website

suggest that the staff in maternity services are uncaring and rude. People who spoke to us during the inspection were broadly satisfied with most aspects of the care they received.

## Areas for improvement

### Action the trust MUST take to improve

- Ensure medicines and fluids for infusion are stored securely.
- Ensure that members of staff follow national guidance for the management of children undergoing surgery and that they do this sufficiently to maintain their expertise.
- To promote a safety culture, the hospital must improve the visibility of management and embed clinical academic group structures and processes.

### Other areas where the trust could improve

- Consultant cover on site 24 hours a day, seven days a week in order to provide senior medical care and support for patients and staff.
- Increase the NHS Family and Friends survey response rate.

- Improve safety for patients by reducing reliance on bank and agency staff and improve critical care consultant cover on evenings and at weekends.
- Address the lack of high dependency unit facilities and the issue of patients being cared for in the coronary care unit, which are potentially compromising patients' safety.
- Provide accessible information for patients for whom English is a second language.
- Implement pain protocols for children and ensure that children are seen by the pain team.
- To mitigate the risk of potential safeguarding issues, the hospital should consider providing a separate waiting area for children waiting to be seen in the Urgent Care Centre.

## Good practice

Our inspection team highlighted the following areas of good practice:

- Play leaders in the children's service provided creative play opportunities for children to prepare them for surgery.
- The volunteer service had created a reminiscence room to provide a non-clinical environment for

patients with dementia, which was decorated and equipped with items from the past to stimulate their memories.

- The 'do not attempt resuscitation' (DNAR) forms were comprehensive and enabled medical staff to identify treatment and care options with patients.

# Newham University Hospital

## Detailed Findings

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

## Our inspection team

**Our inspection team for Barts Health NHS Trust was led by:**

**Chair:** Dr Andy Mitchell, Medical Director (London Region), NHS England Team Leader: Michele Golden, Compliance Manager, Care Quality Commission

**Our inspection team at Newham University Hospital was led by:**

**Team Leader:** Sue Walker, Compliance Inspector, Care Quality Commission

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

## Why we carried out this inspection

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

## How we carried out this inspection

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

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

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

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

Before visiting, we looked at information we held about the trust and also asked other organisations to share what they knew about it. The information was used to guide the work of the inspection team during the announced inspections on 5 and 6 November 2013. Two further unannounced inspections were carried out on 11 and 15 November 2013.

# Detailed findings

During the announced and unannounced inspections we:

- Held six focus groups with different staff members as well as patient representatives.
- Held two drop-in sessions for staff.
- Held four listening events, one of which was specifically for Newham University Hospital at which people shared their experiences of the hospital.
- Looked at medical records.
- Observed how staff cared for people.
- Spoke with patients, family members and carers.
- Spoke with staff at all levels from ward to board level.
- Reviewed information provided by and requested from the trust.

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

# Are services safe?

## Summary of findings

Patients were protected from the risk of infection and the hospital was clean. There was an emerging focus on safety and quality, and on developing a more robust safety culture across the organisation. However, governance systems were not embedded through the clinical academic group (CAG) structures in all clinical areas.

There were concerns that patients' needs may not be met due to the hospital's reliance on bank staff (part-time workers or hospital staff working overtime) and agency staff in some areas.

Improvements are needed as medicines were not being stored safely.

Risks may be increased for patients when staffing levels were not maintained and senior staff not available on site. There is also a potential increased risk to patients following the introduction of yellow wrist bands to identify two different risks: the presence of a swab to prevent bleeding following a surgical procedure, as well as a patient who is at risk of falls.

## Our findings

### Patient safety

Patients told us they felt safe in the hospital and the majority had experienced good care. Comments from across services included: "The A&E doctor examined me thoroughly and told me they needed to carry out some tests, and I'm just waiting for the results." In medicine they told us: "I can't complain"; "they treat me well". In surgery, patients told us: "I have always felt safe here, I can't praise them [hospital staff] enough"; "I have had excellent care and feel safe".

The trust was trying to promote a strong safety culture and this was seen to be developing but was not embedded. Staff were encouraged to report incidents and did so. Staff received feedback on incidents but this was not always consistent. Incidents were analysed locally and used to improve the quality and safety of services.

Serious incidents were reported to the National Reporting and Learning Service. The trust had reported six serious incidents classified as 'Never Events' at Newham University Hospital in the last 12 months, five of which related to the retention of packing/swabs. Never Events are serious, largely preventable incidents that should not occur. The Never Events had been appropriately investigated to identify the cause of the error and the trust had taken action and implemented a new policy and identification system to alert staff. Unfortunately not all staff outside of maternity (where most of the events had occurred) were aware of the changes. We also found the same identification system (a yellow wrist band) was being used elsewhere in the trust to identify people at risk of falling.

The hospital did, at times, experience bed pressures and surgical patients were moved between the Gateway Surgical Centre and main hospital wards to create spare beds. This potentially increased the risks to patients as they did not always receive appropriate specialist care. The trust held daily bed/site management meetings to review the availability of beds and so that staff in all areas could identify 'outlier' and any operational issues that may have an impact on patients.

Medical staff handovers were scheduled twice a day, providing a detailed overview of patients admitted in the speciality ward. However, we did observe some medical staff arriving on the wards without attending the handover meeting and so they were not fully aware of changes in patients' conditions or plan of care.

Patients who became critically ill were managed effectively by the critical care team. Staff used early warning systems to assess patients at risk and patients received timely intervention.

### Staffing

We looked at staffing levels in all the areas visited. The trust had recently completed a review of nursing staff and had set ward levels based on the Royal College of Nursing guidelines. Staff told us they were, at times, understaffed, usually when an absence had occurred at short notice. There was a system for staff to request replacement or additional staff; however, staff reported frequent occasions when shifts were unfilled across the surgical and medical wards. There were vacancies on most wards that had not been filled and there had been an increase in the number of staff resigning following the nursing review.

# Are services safe?

Junior doctors told us they were very well supported by their more senior colleagues but consultant presence out of hours and at weekends was through an on-call at home rota. Junior doctors reported that the majority of consultants were responsive and provided support but this was not the experience of some juniors in Surgery. The General Medical Council's National Training Survey, completed by junior doctors in training, showed that they rated their workload and whether they felt forced to cope with clinical problems beyond their competence or experience to be 'within expectations'.

## Managing risk

The trust was managing patient safety risks. There were safety measures in place to monitor patient falls, development of pressure ulcers, blood clots in veins and catheter urinary tract infections. There was ward-based quality monitoring to improve patient safety and, where care was assessed to be falling below standards, remedial measures were implemented.

## Medicines management

Medicines were prescribed and administered correctly. Medicines were not always securely stored and clinical rooms with stores of intravenous infusion fluids were left unlocked and doors were propped open. We observed cupboards where medication was stored left unlocked.

## Cleanliness and hospital infections

Patients were protected from the risk of infection. The infection control rates for *Clostridium difficile* (C.difficile) and methicillin-resistant staphylococcus aureus (MRSA) in Newham were within expectations. The hospital was clean and cleaners used appropriate equipment and followed cleaning schedules. Patients and visitors were provided with information about preventing infection and there was antibacterial hand gel available in all areas for patients, staff and visitors to use. We observed staff using personal protective equipment (such as gloves and aprons) and washing their hands in-between seeing patients. Patients were screened for infection on or before admission and side rooms were available to isolate patients with a spreadable infection.

## Safeguarding patients

Staff were aware of and understood how to protect patients from abuse and restrictive practices. The majority of staff had attended safeguarding training to the appropriate level. Procedures were safe and effective and especially robust in paediatrics.

## Patient records

We reviewed patient records on every ward visited and the majority were adequately and appropriately completed. However, on one ward (Silvertown Ward) we observed point-of-care records, such as fluid balance charts and observation charts, were incomplete and not adequately maintained. We found one patient with dementia who did not have a care plan relevant to their diagnosed need. This put patients at risk of inappropriate or unsafe care.

## Medical equipment

Most equipment in the hospital had been serviced and maintained. In one surgical ward there was an outstanding repair request for a macerator (used for waste management) that had been out of use for three days. Emergency equipment was available in all areas and records showed that daily checks were carried out. This meant emergency equipment was available and ready for use.

# Are services effective?

(for example, treatment is effective)

## Summary of findings

National guidelines and best practice were followed but not always consistently and in full. Patient pathways followed national guidance but on-site consultant support out of hours and at weekends did not follow professional guidance. The trust had taken steps to ensure departments were staffed appropriately and there was no evidence of an impact on patient care as a direct consequence. Junior staff in most specialities felt they were supported sufficiently by consultants.

We had concerns that children having orthopaedic surgery did not have input from the paediatric team and emergency surgical procedures on children under 10 were being carried out only occasionally. There were no pain protocols in use and children were not seen by the pain team.

Senior staff in medical services and surgical services were not available at weekends or at night in the Emergency Department, which could impact on decisions about patient care and treatment.

## Our findings

### Clinical management and guidelines

Patients received care according to national guidance. The trust used National Institute for Health and Care Excellence (NICE) and professional guidelines. The trust participated in national audits and there were staff in place to ensure these were implemented and monitored. There were enhanced recovery models of care in surgery and pathways of care were seen in use in most areas to ensure patients received appropriate care and treatment to optimise their recovery. We observed multidisciplinary team working – for example, in the stroke unit, elderly care and end of life care.

Professional best practice guidance relating to the onsite availability of consultants at all times was not always followed. However, the majority of junior doctors felt adequately supported by their immediately senior colleagues and they had good access to on-call consultant advice.

### Staff skills

Staff did have appropriate skills and training but there were concerns about the number of specialisms being admitted to one ward (Silvertown Ward). The trust supported staff to have the appropriate skills, knowledge and training. Staff attendance at training was monitored and reminders sent when an update was due. We saw records showing that the numbers of staff attending mandatory training had increased from August 2013.

# Are services caring?

## Summary of findings

We saw that staff were polite, kind and caring in their interactions with patients, visitors and colleagues. The majority of patients told us staff were caring and compassionate and they were treated with dignity and respect.

## Our findings

### Patient feedback

The majority of patients we spoke with in all wards and departments at the hospital told us staff were kind, caring and treated them with dignity and respect. Patients on the surgical wards told us, "All the staff are wonderful, I can't thank them enough for the care they have given me" and, "The staff are worth their weight in gold". These comments were echoed by patients on other wards, however, one person visiting the elderly care ward told us "... only XX listens to us, none of the others do. When we try to explain they just say 'yes, yes, yes'". Another person at the listening event told us that, in their experience, staff were "rude" and answered their mobile phones while providing care.

Information on the NHS Choices website included a number of positive and negative comments. Feedback was acknowledged by the trust and people were offered further contact with a member of staff to discuss any problems they had experienced.

### Patient treatment

Patients were supported to ensure their care needs were met. We saw patients had food and drink when they needed it. They were supported with their personal care and pain management. We saw examples of care rounds taking place in some wards to ensure patients' needs were being met. Staff were observed to be kind, compassionate and caring. They were also honest about when the quality of care did not meet their standards.

### Staffing levels

Nursing staff told us that sometimes there were not enough staff to deliver timely care to patients. The trust had systems in place to replace staff through bank (overtime) or agency staff. However, shifts were not always filled. A 'bed management' meeting was used to review staffing across the hospital and to move staff to provide cover if possible. We also saw that matrons based themselves on wards that were short of staff to assist.

### End of life care

Patients at the end of life were being managed in accordance with interim guidance and the Liverpool Care Pathway was no longer in use, in line with national guidance.

### Patient privacy and rights

Staff respected patients' privacy and dignity and their right to be involved in decisions and make choices about the care and treatment.

### Food and drink

Patients were given a choice of food and drink to meet their nutritional and religious and cultural needs. There were menus available and staff to help patients make appropriate choices. Patients gave mixed reviews about the quality of food – ranging from "satisfactory" to "not good enough". We saw staff helping patients to eat and water was freely available and, in most cases, within reach of the person.

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

## Summary of findings

Patients told us that services in the hospital had usually responded to their needs. We had concerns about the lack of information for patients about being transferred between surgical wards and about discharge arrangements. Information for the public was provided in English and not available in other formats, but there was good access to translation services.

## Our findings

### Patient feedback

Patients told us that services responded to their needs. They said they had been seen fairly promptly in the Emergency Department (ED) and Outpatients. Comments included: "I didn't have to wait too long". Several patients told us they were waiting for investigations, and one inpatient said, "I was told I'd have a scan at 8am, but it's 10am now and I'm still waiting".

At our listening event we heard that some patients had received good, prompt attention when admitted to the hospital as an emergency. We were also told there was good communication and coordination between the various medical teams involved in the person's care.

Information on NHS Choices website included a number of positive and negative comments. We also had people contact us using our Share Your Experience forms. Comments were mixed. Positive comments highlighted that staff were kind and caring and provided prompt attention. Negative comments related to staff attitude, care delivery issues for patients with dementia and waiting times experienced in the Emergency Department.

The trust used the NHS Friends and Family questionnaires to gather patient feedback and results were displayed in all areas. The information published on the NHS Choices website showed that the vast majority of people using the hospital would recommend it to people they knew.

### Discharge of patients

The majority of patients were discharged appropriately. However, several patients on surgical wards told us they had not been given any information about when they were due to be discharged, and there was no information about discharge arrangements on their medical records.

### Waiting times

Patients in the Emergency Department told us they were seen reasonably quickly, however, a few patients being treated in surgery said they had waited too long to be admitted for their procedure.

The hospital had met the national target and seen 95% of patients in ED within four hours of arrival. There were times when the department had fallen below the target and the number of people attending and availability of beds in the hospital had caused delays. The department had also met the 15-minute target for accepting handover of patients from ambulances and had experienced one breach of the target in the first six months of the year.

There was an Urgent Care Centre (UCC) next to the Emergency Department (ED) which was run by another trust and patients for the UCC and ED sat together in the same waiting area. Waiting time information was displayed for ED but not for the UCC. Staff reported that patients did not know who was waiting to be seen in which service. Patients being seen earlier than those waiting could lead to tension between patients.

### Outpatient care

Patients told us they were normally seen within 30 minutes of their appointments and staff kept them updated with the waiting time and reason for any delays.

The facilities in the temporary children's outpatient building were not conducive to providing high standards of outpatient care.

### Accessible information

Information was readily available in wards and departments but only in English. Information could be produced in other languages. Patients we spoke with did not see this as an issue as they had relatives to help them. The hospital had a translation and advocacy service and the multi-ethnic workforce were able to speak several languages which patients valued.

# Are services well-led?

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

## Summary of findings

We saw there was good local leadership and staff were committed to providing safe and effective services. The trust had established a clinical management structure and governance arrangements. However, we were concerned about a lack of visible leadership and adequate communication from the trust's board with staff to achieve effective working in clinical academic groups (CAGs) and communication upwards to the board.

The implementation and monitoring of safety and quality systems was not embedded and sufficiently effective through the management structures and needed to improve in some areas.

## Our findings

### Leadership

Staff told us they had access to good, local management and leadership. They said they usually felt supported and valued by their colleagues and direct line managers. There had been a recent staffing review, a process that was on-going. Staff morale was described as low and staff told us they thought the impact of the changes on service provision had not been properly assessed.

The CAG management structures were not operating effectively in all areas. Staff were not engaged with the trust leadership and the majority told us they worked for Newham Hospital not Barts Health NHS Trust. There was an obvious disconnect between staff working in the hospital and the senior management of the trust. There was little recognition of the trust Board members and senior leaders in the CAGs, suggesting that senior managers were not visible.

Managers in most areas had a good understanding of the performance of their wards and departments and most staff demonstrated a willingness to respond to change.

### Managing quality and performance

The trust Board had established the CAGs and devolved the management for performance, quality and governance to the CAG leadership board. There was evidence that quality and performance monitoring data was reported at the CAG leadership meetings and senior managers in the hospital reported they attended.

We observed safety and quality of care was monitored and action taken in response to concerns at ward level. Staff's understanding of the clinical governance framework, how risks were managed, controlled and mitigated against was variable. Communication of performance, quality and governance information was not consistent across all CAGs.

# Accident and emergency

## Information about the service

The accident and emergency department (A&E) (known as the emergency department (ED)) is open 24 hours a day, seven days a week and is a designated major incident centre. The department sees approximately 137,000 patients each year. The department included a separate paediatric emergency department and eight beds as a clinical decision unit (CDU) and 17 beds as a medical assessment unit (MAU). The CDU is used for people at lower risk who may need further assessment or tests for up to a 12-hour period prior to either being admitted into hospital or discharged home.

People with minor injuries and ailments were seen in the Urgent Care Centre (UCC), which was co-located within the department but managed by another provider and therefore did not form part of this inspection process.

We spoke with 23 patients and 20 staff including doctors, consultants, nurses, senior managers and four ambulance personnel. We observed care and treatment and looked at treatment records. We reviewed information from patient surveys and performance information about the trust. At our listening event, one person provided positive feedback about the care they had received at Newham A&E.

## Summary of findings

The majority of people were seen and treated within the national waiting time limits of four hours. Treatment plans were put in place for either discharge or transfer to inpatient services for further care and treatment. Senior nursing staff had specialist qualifications in treating adults and children within an emergency department setting. There were not enough consultants to provide night-time cover and this was managed via an on-call consultant rota. However, there was always senior medical cover provided by experienced doctors throughout the night.

People who walked into the department were initially seen by reception staff who referred them to either the emergency department (ED) or Urgent Care Centre (UCC) using set guidelines. This may present a risk as patients referred to the ED or UCC were not always seen within 15 minutes of arrival for further assessment. The assessment was completed by a registered nurse or doctor.

# Accident and emergency

## Are accident and emergency services safe?

Services were safe but there were issues that children were not segregated while waiting to be seen in the urgent care centre (UCC).

### Patient safety

People who arrived by ambulance told us they felt safe while being treated in the department and that they were seen promptly. However, some people felt they were not always kept informed about the treatment they needed.

People told us they felt staff knew what they were doing and were very good. One person said, “the doctor examined me thoroughly and told me they needed to carry out some tests, and I’m just waiting for the results”.

Staff told us they felt supported to deliver safe and appropriate care. All new nurses and junior doctors were supported and supervised by either the practice development nurse or more senior medical and nursing staff. Support was provided until they were deemed competent to work independently and provide safe care. A new member of staff confirmed they had been given support by someone more senior and that there was an excellent training programme in place for all team members.

### Caring for children

Staff had the appropriate qualifications to care for children in an emergency setting. All staff had qualifications in paediatric life support and two senior consultants had experience and specialist interests in caring for children. All children with life-threatening conditions were initially treated within the resuscitation room specially equipped for children.

There was a separate waiting area for children waiting to be seen by the paediatric ED staff. However, children waiting to be seen by UCC nurse practitioners were not segregated from other adult patients waiting to be seen, either in adult ED or as patients in the UCC. Staff we spoke with expressed their concerns about maintaining the safety of children in this area. Staff also reported that suggestions to address this had been made to the UCC provider but had not been acted on.

### Staffing

The consultant team provided on-site medical cover during the week days and at weekends. There was a consultant on call at night and junior doctors were supported by sufficient numbers of middle-grade, experienced doctors during the busy night shift. However, this could potentially place patients at risk during the night as there were insufficient consultants employed to provide continuous cover.

There were sufficient numbers of nursing staff with the appropriate qualifications to provide both senior and junior cover for the day and night shifts. Staffing numbers remained consistent over a 24-hour period. Staff had all received training regarding the safeguarding of children and vulnerable adults. The senior consultant was nominated as the department lead for safeguarding.

Patients assessed as low risk were admitted to the 25-bed CDU/MAU for further observation. The unit was staffed by registered nurses and support workers. Medical cover was provided by the ED consultants for the CDU beds and they aimed to review patients within 12 hours of admission to the unit for either admission or discharge home. Medical cover for the remaining MAU beds was mostly provided by the physicians as well as the ED consultants. Patients told us that care was generally good but they were not always provided with information about their care.

### Managing risks

There were systems in place to report and review incidents.

### The environment

The department was new and the adult emergency department was divided into four main areas: the UCC for minor injuries; assessment/ triage area; major injuries or serious conditions; and the resuscitation room. The major treatment cubicles gave privacy to patients being examined and having further tests carried out, with good visibility for staff to maintain observations of all patients in that area.

# Accident and emergency

## Infection control

The emergency department was clean and tidy. We found there were sufficient sinks, towels and hand gel available for staff to use. Patient toilets were clean and soap and hand towels were available. Cleaning support was available at all times.

## Are accident and emergency services effective?

Patients were seen and treated effectively by appropriate staff.

## Clinical management and guidelines

Patients received diagnostic tests promptly and treatment was not delayed. There were plans in place for discharge or transfer to specialist teams for further care and treatment.

People told us they had not waited long periods for blood test results. One person said, "The doctor met the ambulance and I went into a cubicle and was treated quickly, I didn't wait at all". Some people told us that, although they were assessed quickly, they were not kept regularly informed about their treatment.

The ED had met national targets relating to patients being assessed, treated and admitted within four hours. Patients received care according to specific care pathways which were developed in line with national guidelines and best practice. The care pathways were consistently applied and updated with ongoing improvements and reflected guidance from the National Institute for Health and Care Excellence (NICE) and other professional bodies. For example, the department demonstrated that they had improved the quality and safety of the management of patients with problems during pregnancy and patients with fractured hips. The department participated in national audits used by the College of Emergency Medicine (CEM) audits as well as the Trauma Audit and Research Network (TARN). This ensured that patients with serious traumatic injuries were managed safely and effectively.

The department worked in partnership with other professionals to ensure patients received appropriate care and support. There was support for referring patients with mental health issues by a psychiatric liaison team which was based in the department. The department and CDU also had access to social workers and physiotherapists to enable and support safe discharges for patients. GPs also worked in the department seven days a week to manage patients with conditions that would normally be treated in a primary care setting.

## Staff skills

Senior nursing and medical staff working in the department had specific qualification in the treatment of emergency care. This included Advanced Life Support (ALS), Paediatric Life Support and Advanced Trauma Life Support (ATLS). However, some nursing staff told us they had not been able to secure funding for either the emergency care course or some of these additional specialist courses.

## Are accident and emergency services caring?

Patients received safe care from staff that were kind and caring.

## Patient feedback

The majority of people we spoke with told us they had received good care from kind and caring staff. We observed staff responding quickly, professionally and politely to patients and visitors across all of the areas in ED. This included ambulance crews and other speciality teams visiting the department. Comments included: "Staff are very competent and have treated me with respect," and, "I am happy with the day-to-day care I have received". We saw some 'thank you' letters and cards the department had received which were very complimentary about the care and compassion people and relatives had received.

# Accident and emergency

Some patients in all areas of the emergency department and the CDU commented that staff did not always keep them informed about delays in treatment, or when they were going to be discharged or moved to a ward. Some patients in the waiting area were not sure who they were waiting to see and how long the wait would be. The patient experience was reported to be generally good on the days we visited, although the response rates to the trust 'Friends and Family' questionnaires was comparatively low at 11.6% compared to the national average of 16.9%. Staff told us they were aware of the low response rate to the Friends and Family test and felt that some people were too unwell to complete the questionnaire when they were admitted to the emergency department.

## Pain relief

Patients received pain relief at their initial assessment and then when required. We observed pain killers being dispensed to a patient in a safe manner at the initial assessment/triage. We did not see staff use a pain assessment tool to determine the patient's level of pain. The department held a stock of simple medication, such as pain relief, for patients being discharged when the hospital pharmacy was closed. For patients whose first language was not English, or who had dementia, staff had access to advocates and interpreters. Some senior nurses who had undertaken specialist training were able to prescribe pain relief for patients to ensure there were no delays in the administration of medication. The paediatric ED used a specific tool for assessing and administering pain relief for children and staff told us this was considered a priority.

## Privacy and dignity

The major injuries (majors) area had single cubicles that ensured patients' privacy and dignity were maintained during examinations. We saw staff ensured they closed cubicle doors and knocked and waited prior to entering. Patients told us they felt staff respected them and treated them with kindness at all times. The department had a bereavement room where relatives could spend time with family members following an unexpected death.

## Food and drink

Patients received adequate nutrition and hydration in the department. We saw patients being offered snacks and hot drinks. Staff told us they used the facilities on the CDU and could always make hot drinks and toast for people at any time of day.

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

Services were responsive to patients and had established protocols to respond to emergency situations.

The ED had a major incident plan in place. We were told the plan had been reviewed and the department could respond quickly if needed. However, we were told by staff that the trust had not carried out a major incident practice exercise of the plan within the last three years to ensure the whole system could respond appropriately. The trust told us that an exercise was carried out in March 2012.

Staff responded promptly to emergency situations. We observed several emergency situations following calls from the London Ambulance Service (LAS). Staff were dispatched to meet and treat the patients immediately. We confirmed that resuscitation trolleys and equipment were checked on a daily basis within the ED and CDU/MAU. However, we did note that the majors area did not have dedicated emergency equipment. And, although it was in close proximity to the resuscitation area, the lack of emergency equipment in the majors area may have an impact on the staff's ability to respond quickly.

## Waiting times

In the last nine months the department had met the national target of seeing 95% of patients within four hours of arrival in the department. There had been instances when this did not happen – for example, in August 2013, due to high number of people attending the department. The department had also met the target for accepting handover of patients from ambulances within 15 minutes. and had one ambulance 'black breach' (where patient handovers took longer than one hour) documented within the first two quarters of 2013–2014.

# Accident and emergency

On the two days we visited the department, all patients were seen within the national target times and the department had a total of 700 people attend for treatment. The department was performing better than the other two emergency departments within the trust.

The department was under pressure at times and the staff were responsive to fluctuating numbers of patients attending the department. Senior staff monitored patient flows and ensured that patients were seen promptly. The department was made aware of ambulances that were en route to the hospital and the approximate time they were expected to arrive. Staff told us this enabled them to respond to a sudden influx of ambulances. We observed, during an evening visit to the department, how staff responded to the early closure of the UCC which had resulted in a large increase of patients. We saw that staff took immediate action and additional staff were allocated to the assessment area to ensure that patients were assessed as promptly as possible.

## The CDU/MAU

The CDU/MAU provides 25 beds for patients either needing admission by specialist teams or monitoring by the ED consultants. The senior staff monitor 'decisions to admit' times and move patients as quickly as possible.

Staff told us that they always maintained 100% single-sex bays within the unit. We saw staff responding to the need to create 'male' beds for patients waiting in the ED by liaising with bed managers and moving patients to other wards to ensure that admissions from ED were not delayed.

## Caring for children

Staff were able to respond quickly to the needs of children in an emergency situation. The paediatric ED had a high-dependency cubicle which was equipped to deal with children who became unwell. Staff told us that, if they were alerted to a child coming in by ambulance, staff from the paediatric department, senior consultants and

paediatricians responded to the emergency call. There was also an intercom system between the adult and paediatric areas for staff to get immediate assistance if required.

## Accessible information

There was a variety of information available for patients. However, all the literature and signs were only in English, including signs directing people to the ED and other areas in the hospital. Newham had a high ethnic population and staff told us that they were able to access interpreters easily if required.

## Are accident and emergency services well-led?

The emergency department was well-led and there was sharing of practice across the trust's emergency department units. There were some issues about the IT systems in use.

## Leadership

Staff were motivated and worked well as a team. We saw that all grades of staff communicated well internally as well as with other departments across the hospital. The department was jointly managed with the Emergency Departments at the trust's other hospitals. We saw evidence that, following the merger, the departments had begun to work more closely together. Recent consultant appointments had been cross-department and some initiatives, such as the 'How to guides', were being shared. The guides had been developed to inform staff on the appropriate actions and care/treatment pathways to follow and the contact numbers for referring patients to other services. Clinical leads were working clinically and managerially across hospitals. Learning was also beginning to be shared between the departments. However, staff we spoke with acknowledged that it will take time to develop this relationship to its full extent.

# Accident and emergency

## **Managing quality and performance**

The service monitored safety and the quality of care, and action was taken to address concerns. There was an electronic process for reporting and reviewing incidents or concerns. Although the department had not had a 'Never Event' (serious safety incidents that should not occur) and only one serious incident within the last three months, we saw that the appropriate investigations were carried out, learning identified, and any changes required implemented. For example, we saw an incident relating to the lack of follow-up on a young patient with a hand injury. The learning from this incident was reported in the department's monthly governance report and shared with all the nursing and medical staff. The learning and appropriate care was clearly identified and protocols for the future management of such patients was highlighted.

Regular quarterly joint clinical governance days took place across the three emergency departments in the trust to share learning and discuss improvements. We saw the attendance list from a recent day. This showed that staff from a range of nursing and medical backgrounds and grades had attended. Discussions had included a session on learning from recent serious incidents. Monthly clinical governance meetings were also held.

## **Information and technology system**

There were some concerns raised by staff about the information-collection system for patient arrival and treatment times. We were told that, when the department is busy, data is not accurately recorded by staff. The system was described as "slow" and there were inaccuracies noted in the records. For example, we saw that one person had been seen within seven minutes of arrival by a doctor, but the assessment time on the computer showed a time some two hours later. Staff did not always record when a patient had left the department when it was very busy. Also, the three emergency departments within the trust did not share the same computer system across the sites.

# Medical care (including older people's care)

## Information about the service

We inspected Medical Care (including services for older people) at Newham University Hospital. We spoke to patients, relatives and staff in every area visited over the course of the two-day inspection. We visited seven medical wards including a stroke rehabilitation ward, elderly care wards and speciality specific wards.

## Summary of findings

Overall care was safe and effective, and staff worked hard to ensure patient safety. The majority of patients were complimentary about their care and told us that most staff were kind and caring. There were concerns that nursing staff were sometimes unable to meet people's needs due to staff absence and bank staff or agency cover could not be provided. Senior medical support to junior doctors at weekends was by a consultant on-call system and did not meet current professional guidance.

Quality and safety monitoring systems were in place and there was evidence that staff escalated incidents appropriately and received some feedback locally. Staff were not aware of shared learning from incidents/ investigations across the trust, which showed the dissemination of learning across the organisation was not effective.

Staff were supported by their line managers and had access to mandatory training and annual appraisals. Staff morale was low following a recent staffing review but we were impressed that staff remained committed to providing good services to patients at Newham Hospital.

## Are medical care services safe?

Services were generally safe but there were issues around safe levels of staffing to meet patient dependency and safe storage of medicines.

## Patient safety

There were electronic reporting systems in place and staff said they were encouraged by managers to use them to report incidents. There was a variable response from staff about the ease of use of the system. Staff told us that managers investigated incidents and they did receive feedback but this was variable. Some staff demonstrated that they were aware of learning from serious incidents or Never Events – incidents which should never happen. For example, they were able to explain changes in the procedure for checking the position of nasogastric tubes post insertion. They were not aware of incidents that had happened outside of their clinical academic group (CAG) or at other sites in the trust, showing that systems to share and spread learning from incidents across the whole trust were not effective.

Patients told us they felt safe and had confidence in the staff. Comments included: "I can't complain," "they treat me well" and "they are always here and they are good". Most patients were complimentary about the care they received, with comments including, "they help me in every way" and "the staff are brilliant".

Patients' medical and nursing needs were initially assessed in the medical admissions ward and they were then moved to the appropriate ward for ongoing care and treatment. We saw examples of records that were fully completed and risks identified, including those relating to malnutrition, skin integrity and pressure damage, moving and handling, falls and (if needed) the use of equipment. Patients all had a care plan to manage their risks.

## Staffing

There were sufficient medical staff to meet the needs of patients; however, there were fewer medical staff on duty at night and weekends. Junior doctors reported that they were well supported by their consultants and registrars. There was an on-call consultant at weekends which junior staff said was "no problem", however, this did not follow professional guidance which required 12-hour onsite consultant presence. Staff told us that consultants did come in to support junior medical staff if they had concerns. We were also told there were structured handovers twice a day for medical staff to discuss patients, but we also saw evidence of doctors coming on to wards

# Medical care (including older people's care)

with no formal handover. We saw the patient list provided at handover which detailed the patient's name, medical history, reason for admission, results of most recent tests, their progress and outstanding tasks relating to the patient's care. It also noted those patients who were not for resuscitation or were receiving end of life care. The list also included an expected date of discharge.

There had been a recent review of staffing and we were told that nurse staffing levels met professional guidelines. Staff told us there was a process in place to book overtime (bank) or agency nurses to cover short notice staff absence. Staff reported the system had recently changed and was fairly onerous. They said by the time permissions and bookings had been made, the additional staff were often unavailable to fill the shift. We were told that shifts identified early were more likely to be filled. Weekend absence and short notice bookings were those least likely to be filled.

Staffing levels on the wards did not always meet the number needed to provide safe care to patients, especially when shifts had not been filled. For example, on one ward we observed the matron was based on the ward to provide care to patients and 'plug the gap' as three staff had called in sick at short notice and the shifts couldn't all be filled. Nurse handovers were ward-based and included discussions about all patients in detail. There was a daily matron's bed meeting to review bed management, share staff around the wards if needed, and any other site management concerns.

Ward-based staff worked in partnership with other professionals to ensure patients received appropriate care and support, including physiotherapists, occupational therapists, dietitians, pharmacists and speech and language therapists. We saw there was a ward-based gym and occupational therapy kitchen on the stroke ward to facilitate patient recovery.

There were systems in place to ensure patients received appropriate help and support with their nutritional intake. All of the wards we visited had established protected mealtimes, and red trays were used to identify those patients who needed support to eat and drink. Patients had a choice of food and there were menus to meet the religious and cultural requirements of the patient population. Patients were referred to appropriate

specialists when needed – for example, the dietitian or speech and language therapists for dietary advice and swallowing assessments.

## Managing risks

There were systems in place to monitor the risks to patients. Patient's records showed the risks of developing pressure-related skin damage, and blood clots and infections were appropriately managed. We saw the hospital had implemented the Newham Quality Assurance System (NQAS) to monitor and report on a range of safety indicators. Charts were used with green and red crosses to indicate good or poor performance ratings (the Safety Cross system) relating to falls, hospital acquired pressure ulcers and other criteria. These were displayed on noticeboards in every ward we visited, although it was noticeable that, in some wards, only the positive (green cross) results were made public. The results of this monitoring was discussed weekly at a meeting of ward managers and matrons to share best practice and learning. We also saw the results were fed into an integrated performance report so the CAG and ward managers could access all the metrics for their area.

## Hospital infections

Patients were protected from the risk of infection. Medical wards were clean and standards were monitored. Notices at the entrance to wards advised visitors to use hand gel prior to entry and on leaving. There were hand-washing facilities with soap and towels in every area and hand gel was stationed at sinks and at each patient's bed as well as on notes trolleys. We observed that staff washed their hands and used gel in-between attending patients. Personal protective equipment such as gloves and aprons was available. There was signage displayed on side room doors where patients were being isolated and staff were observed to follow the associated instructions.

## Medical equipment

Medical equipment was adequately maintained, although staff reported there were some delays and equipment was taken out of use for extended periods of time. We found staff had access to pressure-relieving mattresses for patients identified as being at risk of developing pressure ulcers. It was noted on one ward that the medical store room door was propped open as agency/bank staff did not have a 'swipe card' to access the room and permanent staff were not always available to open the door.

# Medical care (including older people's care)

## Safeguarding procedures

The trust had processes in place to identify people at risk – for example, the use of flags on the patient electronic record and 'passports of care' for people with learning disabilities. There were also established processes to refer safeguarding concerns to the local authority. The Chief Nurse was responsible for safeguarding in the trust and there were regular meetings held with safeguarding leads to review policies and procedures, safeguarding training and ongoing safeguarding concerns. We saw the trust had developed assurance frameworks for safeguarding processes and the trust had discharged its duties to complete a Section 11 audit and action plan demonstrating its compliance with Section 11 of the Children Act.

## Medicines management

We visited Plashet Ward and looked at medicines storage and supplies, records relating to people's medicines and talked to pharmacy staff and nurses.

Medicines were prescribed and given to people appropriately. Appropriate arrangements were in place for the recording of the administration of medicines. All allergies were documented and we saw no missing doses. There was provision for nursing staff to record if a dose had been missed or delayed and the reason.

Medicines were available when people needed them. Appropriate arrangements were in place for obtaining medicines. We saw that prescribed medicines were available; there was a weekly pharmacy top-up service and a daily weekday visit from a ward pharmacist. The pharmacy was open at weekends between 10am and 2pm and there was a pharmacist on call out of hours. There was evidence of medicines reconciliation on admission. There is no policy to allow patients to self-administer their own medicines if they request to do so, however, we saw patients self-administering their own insulin. Medicines were available on the ward and suitably labelled to allow nursing staff to discharge patients out of hours. Emergency medicines were kept on the ward and they were being checked regularly. There was evidence of routine checking of controlled drugs and a register of patients' own controlled drugs.

There was a risk that unauthorised people could access some medicines. Medicines were not securely stored. There was no control of access to the clean utility room where infusions solutions were kept in boxes below the bench. Oral medications and injections were in locked cupboards. Medicines requiring cold storage were kept in a fridge and the temperature was monitored, however, the fridge was not locked. One patient's medicines were stored on top of the fridge and not in the designated locked cupboard.

## Are medical care services effective?

Services were generally effective, patient treatment and care followed national guidelines.

## Clinical management and guidelines

Patients received care according to national guidelines. The trust participated in national audits and standards of care were 'within expectations' for the majority of specialities in medicine, for example, respiratory conditions care and stroke.

We looked at a number of patient records across the medical wards. Patients had all been assessed and had a plan of care to meet their identified needs and mitigate risks. There were records of all staff interventions in patient notes. The majority of patients we spoke with said they were happy with their care and knew what was happening. Patients were aware of the next steps in their treatment/care. For example, one person told us they were to be transferred to another site for a procedure, another said they were being discharged and staff had discussed their ongoing ability to manage at home.

There was evidence of multidisciplinary working and meetings to coordinate care and treatment across the medical specialities. Staff of all disciplines attended and relatives on the stroke ward told us they were also invited to participate in the discussions about their relative with the multidisciplinary team. Junior medical staff reported they spent a lot of time arranging intersite transfers for patients with deteriorating health. They told us there were delays to patient's treatment at times because the bed managers could not identify a bed in a suitable ward.

# Medical care (including older people's care)

## Patients with dementia

The Older People's Liaison Service (OPLS) was jointly provided with the neighbouring mental health trust and gave advice, support and carried out assessments for patients over the age of 65 with memory problems. Patients were referred directly to OPLS and, in addition, the Consultant Nurse Lead attended the elderly care multidisciplinary team meetings and identified patients who would benefit from their input. The team provided support to patients and their carers to ensure they had access to specialist services and support once discharged into the community. Staff valued the support OPLS provided in the ward setting to enable them to provide care to patients with a diagnosis of dementia.

The trust had published a dementia strategy developed by the Dementia Strategy Group led by the Consultant Nurse for Older People. The group had ambitions to implement a trust recognition symbol which would alert staff to patients with special needs due to dementia. We were told the electronic patient record at Newham would identify when patients had a diagnosis of dementia or any other type of special need.

## Patient mortality

We reviewed our surveillance information about the trust and the data showed there was no evidence of risk identified at Newham University Hospital. We were told that Mortality meetings were due to commence in the CAG to review patient deaths.

## Are medical care services caring?

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

## Patient feedback

The majority of patients and visitors we spoke with felt they were treated with kindness, dignity and respect. Most were complimentary about staff and mentioned staff who were particularly kind to them. We were told staff were abrupt on occasion and appeared not to listen to people. Relatives of one elderly patient told us, "Only XX listens to us, none of the others do. When we try to explain they just say 'yes, yes, yes'".

At the listening event we held for Newham Hospital, one person told us of staff talking over their relative while delivering care. They also said staff were, on occasion, rude and answered their personal mobile phones while with a patient. People told us they "weren't in a position to complain".

## Patient treatment, privacy and dignity

Staff treated patients with dignity and respect. Staff interactions with patients were observed to be overall kind, patient and professional. Personal care was delivered discreetly behind closed curtains. Care records showed some people had been involved in planning their care, but not all.

Patients told us they were able to talk to staff about their treatment and care. Comments included: "They asked lots of questions and did tests, then told me what was wrong and what the treatment could be if I agreed".

## Food and drink

Patients had adequate nutrition and hydration and, if required, were supported to eat meals. We observed breakfast and lunch in several wards. Patients were supported to choose their meal. We saw drinks were available and most were left within reach of the patient. A red tray was used to identify patients who needed help to eat or needed their intake monitored. Staff were observed providing assistance and food and fluid records were completed when required. Patients told us, "I can choose what I want to eat and it's very good, no complaints". Another patient required a halal meal and said, "there's a good choice" although relatives felt the portions could be more generous. People who had contacted us were less complimentary about the food, particularly halal meals and said, "they are all curry based, not everyone likes curry".

## Are medical care services responsive to people's needs?

Services were responsive to people's needs and they told us staff responded to their requests for assistance.

## Patients' feedback

Patients told us they were cared for and staff responded to their needs and requests for assistance. They told us it sometimes took staff longer at night to answer call bells.

# Medical care (including older people's care)

One patient told us they were frequently admitted to the hospital, and said on this occasion it had taken a "long time" to find the clinical records but overall they were happy with the treatment provided.

## Ward environment

We visited seven wards and they were appropriate for patients. All wards had single-sex bays and side rooms. Bathroom and toilet facilities were also single-sex designated. One patient told us they had asked to move away from a disruptive patient and were given a side room on another ward.

## Patient records and end of life decisions

We looked at patient records in every ward visited and saw they were completed in accordance with professional guidance. There were details of medical, nursing and allied health professional's assessments in the notes and plans for discharge formed part of the record for some patients. 'Do not attempt resuscitation' (DNAR) forms were appropriately completed and were reviewed every seven days; the decisions were discussed with the patient and relatives.

## Accessible information

Services were provided to a varied multi-ethnic population and a very large number of languages were spoken in the vicinity. The Trust website allowed patients to choose their preferred language to view the information about Newham University Hospital.

Information was readily available on medical wards but only in English, although it could be made available in different formats and languages if needed. Interpreting and advocacy services were available to help patients using services.

## Complaints

The Patient Advice and Liaison Service office at the hospital was closed at the time of the inspection. There was a contact number displayed, which we rang, but it wasn't answered. We heard the service was being reorganised and the office was no longer permanently manned. We saw posters and leaflets were being distributed at the time of inspection to inform people of the changes.

## Are medical care services well-led?

Services were well led locally but not at a senior level and there were issues about the involvement, recognition and visibility of leaders in the trust.

### Leadership

Medical services were part of a CAG with a management and governance structure across all sites in the trust. The CAG had devolved responsibilities from the trust Board to manage all activity and performance.

Staff at Newham Hospital told us they felt well supported by their managers at a local level and valued by their senior nursing and consultant colleagues. The majority of staff did not identify themselves as being part of Barts Health NHS trust and could not provide examples of when executive and director level staff had visited their area. Staff morale was low following the recent staffing review and consultation, although staff were committed to providing a good standard of care to their patients despite this.

We were told senior nursing staff undertook 'Clinical Fridays' to provide support and work alongside staff on wards. Some staff described the senior staff attendance as a "short ward round" and said that senior nurses were "not that visible".

### Managing quality and performance

Ward managers, matrons and heads of nursing met regularly to report on quality, safety and performance in the service. Senior staff confirmed they attended CAG managerial and governance meetings to represent the services at Newham Hospital. Performance and quality data was collated into an overall CAG integrated performance report which allowed managers to look at the data in-depth. Ward staff were provided with verbal updates at ward meetings or handovers.

There were risk registers for each CAG which contributed to the overall trust risk register. Risks were being identified and there was some evidence that the document was regularly updated and action was being taken to mitigate the risks. Untoward incidents, complaints and concerns were monitored and discussed at a local unit level, there was some evidence the information was considered by the CAG leadership.

# Surgery

## Information about the service

The surgical care services are provided in two areas of the hospital. In the main hospital building, Silvertown Ward receives emergency and trauma patients and patients undergoing elective major surgery and Jasmine Ward provides day care surgery. In a separate building, the Gateway Surgical Centre, elective surgery is carried out on Maple Ward for patients who require an inpatient stay and Clover Ward for day care patients. Both sites have their own theatres. The hospital provides a range of surgery which includes orthopaedic, trauma, urology, gynaecology and general surgery.

During our inspection we visited Silvertown Ward, Jasmine Ward and Maple Ward, along with theatres in both areas; this included the pre-assessment area for surgical patients.

We talked with a number of patients and staff working in the surgical areas including nurses, doctors, senior managers, therapists and support staff. We observed care and treatment and looked at care records.

## Summary of findings

Patients were treated in accordance with national guidance – for example, for joint replacement surgery. Risk management processes were in place and staff were aware of how to report incidents. Staff were aware of learning in their own area but they were not aware of learning from incidents across the wider trust.

We saw safety checks in theatres followed the World Health Organisation (WHO) checklist. However, we observed that not all surgeons participated in the safety checks at appropriate times in the patient care pathway in theatres. We also noted there was a lack of consultant engagement in theatre planning meetings and in clinical academic group (CAG) management and leadership roles. We found there was no consultant presence on site out of hours and at weekends. Patients were transferred to other wards and junior staff covered 'outliers' (patients on wards not the specialty for their needs) around the hospital which created additional workload and patient care and discharge could be adversely affected.

There were sufficient staff available to provide care to patients, but they did not always have the skills to meet all of the types of surgical needs on the inpatient ward.

# Surgery

## Are surgery services safe?

Services were generally safe but there were issues around safe levels of staffing cover and safe storage of medicines.

### Patient safety

Patients repeatedly told us they “felt safe” in the surgical wards. Their comments included: “I have always felt safe here, I can’t praise them enough”; “I have had excellent care and feel safe”; and “The staff are always respectful to me and my family”.

There was a computerised system in place for reporting incidents, and we saw the system in operation on Maple Ward where incidents had been recorded. There had been a recent serious patient incident called a ‘Never Event’ on Maple Ward relating to a retained swab. The ward manager told us she had been involved in investigating the serious incident and putting in place recommendations to change practice to minimise the risk of the incident happening again. We asked for a copy of this report but we did not receive it, as the investigation was still ongoing.

Staff in both theatre sites told us they used the WHO checklist and we saw evidence of this. We observed a theatre team undertaking a surgical procedure but the checklist was not completed at the appropriate times which could have increased the risk to patients. We observed computer-generated theatre lists which did not specify the particular surgery an individual was to receive. For example, the list included one patient who was listed for ‘joint replacement’. It was not clear which particular joint this referred to. This lack of detailed information increased the risk for potential mistakes. We raised this with the manager who told us they did not schedule the patient for surgery until the detail was clarified.

### Managing risks

Staff we spoke with were unaware of any learning from mistakes or serious incidents that had occurred in the trust other than those related to their specific ward or area of practice. This meant that staff did not have the opportunity to learn from mistakes and improve standards of safety.

### Hospital infections and hygiene

Patients were protected from the risk of infection. We observed hand hygiene gel in all ward areas and at the end of each patient’s bed. All patients waiting for elective surgery were pre-assessed and had swabs taken to screen for methicillin-resistant staphylococcus aureus (MRSA). Patients were not admitted for surgery until clear swab results had returned. Staff were observed to wear colour-coded aprons for different activities and gloves appropriately. Infection control audits had been completed on Silvertown Ward in March and July 2013. The audits reflected that improvements were needed in some aspects of infection control and a further audit is to be carried out within six months. Overall, patients were cared for in a clean environment and the patients we spoke with confirmed this.

### Equipment

Resuscitation trolleys in all areas of surgery were checked on a daily basis and this was recorded. The contents of the trolley were complete and in date. On Silvertown Ward we observed the ward macerator was out of order and staff confirmed the machine had been broken for several days. This meant that cardboard bedpans used by patients were collected in plastic bags prior to removal from the ward. The sluice area was full of plastic bags containing used cardboard bedpans and this could potentially compromise patient safety.

### Staffing

At the time of our visit the staffing levels were safe and met national guidance, however, nursing staff told us that the staffing levels were not usual. The majority of the patients on Silvertown Ward had complex needs and there was no indication of how the patients’ changing dependency levels had been taken into account in determining appropriate numbers of staff on duty. Junior doctors reported that they were unsupported by their consultant surgeons, although this was not having an effect on patient care.

# Surgery

## Medicines management

We visited Silvertown Ward and looked at medicines storage and supplies, and at records relating to people's medicines. We talked to pharmacy staff and nurses.

Medicines were available when people needed them. Appropriate arrangements were in place for obtaining medicines. We saw that prescribed medicines were available; there was a weekly pharmacy top-up service and a daily, weekday visit from a ward pharmacist. The pharmacy was open at weekends between 10am and 2pm, and there was a pharmacist on call out of hours. There was evidence of medicines reconciliation on admission.

Medicines were prescribed and given to people appropriately, with proper recording of the administration of medicines. All allergies were documented. There was provision for nursing staff to record if a dose had been missed or delayed and the reason. There were no missing doses.

There is no policy to allow patients to self-administer their own medicines if they request to do so. Medicines were available on the ward and suitably labelled to allow nursing staff to discharge patients out of hours. Emergency medicines were kept on the ward and they were checked regularly. There was evidence of routine checking of controlled drugs, although the date of opening of a liquid morphine medicine had not been recorded.

Medicines were not securely stored. There was no control of access to the clean utility room where infusions solutions were stored in trays and the door was left open. One cupboard containing tablets was open. Other oral medications and injections were in locked cupboards. Medicines requiring cold storage were being kept in the fridge which was locked and the temperatures of fridges were being monitored. There was a separate storage cupboard for epidural infusions. Therefore unauthorised people could access some medicines.

## Are surgery services effective?

Services were generally safe but there were issues around staff skills and communication between the multidisciplinary team.

### Clinical management

Patients received care in accordance with national guidance. Pathways of care were referenced to National Institute for Health and Care Excellence (NICE) guidance (for example, for joint replacement surgery).

We looked at a number of patient records across the surgical areas. Patients who were receiving elective surgery under a general anaesthetic had a pre-assessment appointment where investigations had been completed prior to admission to hospital. Overall risk assessments were completed and patients in Maple Ward followed an integrated care pathway. There was an enhanced recovery programme in place for patients who received joint replacements and patients receiving care in Maple Ward reported being happy with the care they received and felt well informed.

We observed regular ward rounds taking place. On Silvertown Ward these were not multidisciplinary and medical staff then had to go back to a member of nursing staff after the ward round was completed to inform them of any changes to patient care. Potentially, this could mean that patients did not receive planned care changes.

### Staff skills

Staff had completed mandatory training and we saw records to verify this. Other training for staff was limited and we were told by nurses that they did not always have staff on duty with the appropriate skills to meet the needs of the patients. This was particularly evident on Silvertown Ward which looked after patients with multiple specialities. For example, a patient with dementia was being cared for on the ward but not all staff had received dementia training. We asked to see records of staff training on Silvertown Ward but only mandatory training records were available.

# Surgery

## Patient Mortality

We reviewed our surveillance information about the trust and the data showed there was no evidence of risk identified at Newham University Hospital.

## Are surgery services caring?

Services were generally caring but there were issues about maintaining people's privacy and dignity and the quality of food available.

## Patient feedback

Patients we spoke with were happy with the care they had received and described the staff as "kind and caring".

Their comments included: "The staff are very good, very caring"; "All the staff are wonderful, I can't thank them enough for the care they have given me"; and "The staff are worth their weight in gold". We observed staff talking to patients in a calm and friendly manner. They were respectful and polite, even at times when the wards were very busy.

Staff told us that they used the NHS Family and Friends test to obtain feedback from patients. However, there were very few comments cards in the ward areas for patients or their families to complete. Staff were unable to identify any areas of change as a result of patient feedback. We did see noticeboards displaying large numbers of 'thank you cards' from patients to the staff on the wards.

## Patients privacy and dignity

We observed that patients' privacy and dignity were maintained. Curtains screening beds were closed when required and staff spoke with patients in private. People described staff as "always respectful" and said they were treated well.

Patients were cared for in mixed-sex wards. Overall, the wards were designed to have male and female segregated bays with toilet and bathroom signage indicating male or female. The exception to this was on Silvertown Ward which had segregated male and female bays, however, washing and toilet facilities did not have signage indicating male or female. In addition, the side room on Silvertown Ward, next to the female bay, was occupied by

a male patient and staff confirmed that it was not always possible to allocate a female patient to the room. Lack of clear, single-sex designated areas meant that patients' privacy and dignity may be compromised.

## Food and drink

Patients told us they were able to choose their meals according to their religious and cultural preference. Patient's comments included: "The food's OK", however, one person told us, "The food is awful, I don't expect too much, it's not a hotel but it's not good enough".

Meal times were flexible and food trolleys on each ward meant that the food could be served warm. Most patients thought the food was satisfactory. The hospital operated a 'red tray system' which indicated the patient required assistance to eat their meal. We observed one person in Silvertown Ward: the tray was placed on a bed table out of reach of the patient and the food was untouched. We raised this with the manager during the inspection and action was taken to ensure the patient received a meal.

## Are surgery services responsive to people's needs?

Services were generally responsive to people's needs but there were issues about communication with people about transfers and discharge plans.

## Patient records and discharge planning

We reviewed patient records on every ward visited and the majority were adequately completed. However, on Silvertown Ward we observed patient records which were incomplete. There were gaps in the recording of observations of blood pressure monitoring, fluid balance charts were not always accurately maintained, and the P-vital handover tool was not always followed. We found one patient with dementia who did not have a care plan relevant to their diagnosed need. This meant that effective processes were not always in place to meet patients' needs.

There were no records of discharge planning taking place. The patients we spoke with confirmed they did not know when they might be discharged or any arrangements that had been made. This meant there was not an effective process in place to manage patient discharge.

# Surgery

## Patient journey/flow

We spoke with patients in the Gateway Surgical Centre (Maple Ward) who told us they had originally been admitted to Silvertown Ward, in the main hospital, and had been transferred. We spoke with staff on both Maple and Silvertown Ward who confirmed that patients were often transferred to create beds on Silvertown Ward for emergency admissions. Staff also told us patients were transferred from Maple Ward if their medical condition deteriorated. There were patient transfer arrangements in place. Managers confirmed that the hospital patient transport service was used to transfer patients during the day and out-of-hours transfers were transported by the London Ambulance Service. There was no data available to confirm the number of patient transfers between the wards as the information was not collected by the trust.

We were told there were a number of surgical patients who had been transferred to other, non-surgical wards in the hospital due to bed shortages on Silvertown Ward. Medical staff confirmed this and said they continued to manage the care of surgical patients wherever they were in the hospital. Patients we spoke with had not been informed that they may have to transfer to a different ward during their stay and the number of patients who were outliers meant there was a potential risk that patient care was not reviewed in a timely manner.

## Accessible information

Patients told us they had received information about their planned admission to hospital. Patients' comments included: "I was sent the letters but didn't read it all, I was too frightened", and another said, "The information sent out was fine and easy to understand. Others reported they had been fully involved in discussions about their care and had received sufficient information.

Newham University Hospital had a high percentage of patients where English was not their first language. Staff explained that translating and interpreting services were available. Patients confirmed this and did not have any concerns about the services available. The trust website allowed patients to choose their preferred language to view information about the hospital.

## Are surgery services well-led?

Services were generally well led locally but not well led at senior management level and there were issues about the involvement, recognition and visibility of leaders in the trust.

### Leadership

There was a management structure in place. Overall, at a local level, nursing staff on Maple Ward, Jasmine Ward and theatres said they felt well supported by their direct line manager. Managers had a good understanding of the performance of their wards and there was a willingness to respond to change. Silvertown Ward was a very busy surgical ward and there was a lack of cohesiveness in the team. The Senior Manager was aware of this and measures had been put in place to address shortfalls.

The surgical staff we spoke with in all areas told us they had not been visited by a senior member of the trust management team. They did not recall any visits taking place and did not feel well supported by senior management above their direct line manager. The CAG management structure was not embedded and staff we spoke with confirmed this.

Staff told us that the consultant surgeons worked very much in isolation and did not participate in operational meetings. For example, we attended a theatre meeting and there was no consultant surgeon representative. The focus group we held for consultants during the inspection was not represented by a member of the consultant surgeon body. Other departments in the hospital also raised concerns about the difficulty in obtaining a surgical opinion for their patients when requested. This meant that the consultant leadership within the surgical team was not visible.

### Managing quality and performance

Safety and quality of care was monitored and action taken in response to concerns at ward level. Staff did input information regarding incidents when they were able to access a computer but staff reported that this was sometimes difficult because of the IT systems which were slow.

# Surgery

There as evidence that quality and performance monitoring data was reported on at the CAG leadership meetings.

Staff told us they did not receive information about governance meetings that took place. Staff we spoke with were unaware of the governance framework, how risks were managed, controlled or mitigated against. This meant that the governance framework was not embedded and this could potentially have an impact on the safety of patients.

# Intensive/critical care

## Information about the service

The critical care service at Newham University Hospital comprised an eight bed intensive therapy unit (ITU) delivering care to patients with serious life-threatening illness. Six beds are within one area and there are two cubicles. There are no high dependency unit (HDU) beds at the hospital.

We spoke with one patient and their relatives, nursing and medical staff and looked at care records.

## Summary of findings

Patients received appropriate care and treatment in accordance with national guidelines. The critical care service performed as well as similar units across the country.

There were sufficient numbers of staff on duty to provide 24-hour care, however, this was only achieved with overtime (bank) or agency staff. There were five unfilled nursing vacancies on the unit. Out of hours and at weekends there was no specialist critical care consultant cover and a consultant anaesthetist provided support to the unit.

There were delays in discharges from the unit due to the availability of beds elsewhere in the hospital. The unit was small and lacked facilities and storage. Patient privacy could be compromised due to the close proximity of the beds.

## Are intensive/critical services safe?

Services were generally safe but there were issues about the reliance on bank/agency staff to provide safe staffing level and the lack of critical care consultant cover at evenings and weekends.

### Patient safety

Patients' care needs were assessed and plans were in place to meet those needs. The consultant carried out a daily round and we observed staff caring for patients on the unit in a timely manner. The unit collected relevant patient safety and quality metrics data and acted on the findings and the records we looked at confirmed this. This meant that patients' needs were being met. There was a warning system on all wards to enable early identification of deteriorating patients and alert intervention by medical staff.

The unit had systems and processes in place for recording adverse incidents. We observed monitoring taking place at local level. We saw staff handovers taking place and that they were used to share learning.

### Equipment

The resuscitation trolley was checked daily and the contents were in date and records completed. There was a security system in place on the entrance to the unit which meant people were protected from the risk of unauthorised people accessing the unit. Equipment was adequately maintained.

### Staffing

There were sufficient numbers of qualified nursing staff on duty to meet the needs of the patient on the day of our inspection. However, nursing staff reported that vacancies were not being filled and the unit was reliant on bank and agency staff to maintain adequate levels. We were told by staff that there was no critical care consultant available after 5pm and at weekends and the service consultant cover was by a consultant anaesthetist. The trust told us that there was an intensive care consultant on duty between the hours of 9am and 5pm at weekends.

The reliance on bank and agency staff may potentially compromise the safety of patients.

The patient we spoke with said they were happy with the care they received and said that staff were 'attentive'.

# Intensive/critical care

## Environment

The environment in ITU did not ensure the safety of patients. The unit was small and the beds were close together. There was a lack of facilities and storage space. We observed this and staff we spoke with confirmed this. The Operations Director at Newham Hospital was aware of the environmental concerns in ITU and told us that they were a priority for action.

There was no provision of HDU facilities and patients who no longer required ITU level care were transferred to either the coronary care unit (CCU) or to Silvertown Ward. This could potentially compromise patient safety.

## Are intensive/critical services effective?

Services were generally effective although discharges from the unit were sometimes delayed.

## Clinical management and guidelines

Mechanisms were in place to manage the quality and effectiveness of service provision. Patients received care and treatment according to national guidelines and this was monitored. The trust submitted data to the Intensive Care National Audit & Research Centre (ICNARC) which aims to improve the practice of critical care in the UK. We also saw reports monitoring information related to venous thromboembolism (VTE) or blood clots, infection rates and falls.

## Patient mortality

A national independent survey by ICNARC highlighted that the number of unplanned readmissions to ITU was relatively low. The comparative figures showed that Newham Hospital had a higher number of delayed discharges to other wards than similar units. The patient mortality rate in ITU was the average expected, given the area, age and health of the population the hospital serves. Meetings with medical and nursing staff took place to monitor and understand why people might die on the ward so improvements could be made.

## Outreach team

We received positive feedback from staff about the support provided by the hospital's outreach team. The response to requests for support were prompt and staff felt supported by the team.

## Staff skills

Staff had the appropriate training to provide effective care. We saw records to verify this. Patients received one-to-one care from nursing staff.

## Transfer

We observed delays in the transfer of patients out of the ITU environment once the patient's condition had improved. This was due to difficulties in finding a bed on Silvertown Ward and led to transfer delays in excess of four hours on some occasions. The medical and nursing staff we spoke with confirmed this.

## Are intensive/critical services caring?

Services were caring and patients were treated with dignity and respect but there were issues with the environment.

## Patient and relative feedback

The patient we spoke with and their relative confirmed the care they had received was "excellent". They reported the staff as being "kind and caring".

There was a system in place to capture patient feedback. A collection box for comment cards was available for patients and their families. The completed cards were analysed by the Patient Advice and Liaison Service. Staff confirmed they received the analysis of the patient's experience and the information was used to inform practice and make changes.

## Privacy and dignity

The patient we spoke with said the staff had maintained their privacy and dignity. We observed staff treating other patients as such and speaking with patients in a polite and respectful way. However, the environment in the unit compromised the ability to maintain privacy and dignity due to the close proximity of beds and the lack of space in the unit.

# Intensive/critical care

## Are intensive/critical services responsive to people's needs?

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

### **Management of complaints.**

Patient experiences and complaints were used to inform and improve practice. Patients and relatives had identified there was a lack of general information available about the unit. As a result a notice board was set up for the use of professionals, patients and their relatives which provided general information about the unit, 'do's and don'ts' and the safety thermometer information.

The unit holds a multidisciplinary meeting each month to discuss any complaints. We saw the meeting advertised on the unit's noticeboard and staff confirmed they regularly took place. There is an average of one complaint received each month.

### **Patient care**

Patients were monitored closely in the unit and staff responded quickly to any changes in patient care and treatment. The records we looked at supported the monitoring we observed. The unit operated seven days a week, 24 hours a day and was supported by medical staff of differing grades.

## Are intensive/critical services well-led?

### **Leadership**

The ITU was well-led. Senior managers and clinicians were well-informed about the performance within their department. However, senior management in the trust were not visible and staff reported that, as far as they were aware, they had not been visited by senior management.

### **Managing quality and performance**

The ITU carried out a range of audits. Information was provided to the ICNARC which helped to ensure services are delivered in line with good practice. Regular meetings ensured that staff openly discussed concerns about the service and critical care.

# Maternity and family planning

## Information about the service

Newham University Hospital maternity services delivers more than 6,850 births a year and this number is increasing. The maternity unit includes: booking and antenatal clinics; a labour ward; an induction of labour suite; maternity assessment unit; high dependency unit; a postnatal ward; and a birthing centre. There are two dedicated operating theatres and a level two neonatal intensive care unit.

We spoke to 16 women and over 40 staff including midwives, doctors, consultants, senior managers and support staff. We observed care and reviewed performance information about the service.

## Summary of findings

The unit was refurbished two years ago and was bright, spacious and clean. The use of colour-coded signs helped people find their way around.

There had been a number of 'never events' in the last year; these are events that are so serious they should never happen. The trust had undertaken much work on incident reporting, investigation, learning lessons and changing practice to prevent a recurrence.

There was a significant number of vacancies for midwives within the maternity service. Steps had been taken to address this, but staff expressed feeling "burnt out".

There were appropriate arrangements for obtaining medicines but management, storage, prescription and administration of these did not protect women against unsafe use.

Although most staff were caring and respectful towards the women in their care, there were examples of women who had not consistently been treated with consideration and respect.

The service responded to patients' needs and was well-led.

## Are maternity and family planning services safe?

Improvements are required in the maternity services to ensure women are safely looked after.

### Patient safety

In the 12 months from October 2012 to September 2013, seven Never Events occurred at the trust, four of which were at Newham University Hospital. These four events related to swabs or packs being left in patients following obstetric or gynaecology procedures. Much work had been undertaken to analyse these events and learn lessons to prevent them happening again. A few days prior to the inspection, a new process for the recording of retained packs was introduced which included a yellow card within the patient's records and a yellow wrist band to alert staff to the need to remove a pack or swab. There was clear communication of this at handover meetings, information on noticeboards and good staff awareness. It was too early to audit the effectiveness of this new process.

Staff reported that there has been an increased focus on safety. Staff reported incidents, received feedback and learned lessons for improvement. Each month "hot topics" or key information was communicated to staff, and we observed discussion of these at handover as well as information on noticeboards.

### Medicines management

Medicines were available when people needed them, and there were appropriate arrangements in place for obtaining medicines with a pharmacist on call out-of-ours.

Medicines were not secured or managed safely and there was a risk that unauthorised people could access some medicines. There was no control of access to the clean utility room. Two medicine trolleys were in the clean utility room, one of which was not locked and neither trolley was secured. Other oral medications and injections were in locked cupboards. There was no evidence that pharmacists had seen medicine charts or of medicines reconciliation on admission. Expired medicines were found in the fridge which was not locked.

# Maternity and family planning

Medicines were not prescribed and given to people appropriately. Allergies were not always appropriately documented. In two cases, no allergy status had been filled in on patients' records. Appropriate arrangements were in place for the recording of the administration of medicines, however, we saw that there were two cases of delayed administration of intravenous antibiotics without explanation and staff did not always check patients' wrist bands.

## Infection control

Both the maternity unit and neonatal unit were visibility clean. In the antenatal clinic, hand gel was not available in every area, however, in all other areas it was readily available. There was access to personal protective equipment (such as gloves and aprons) as required.

## Equipment

Staff within maternity felt that the availability of some basic equipment such as blood pressure monitoring equipment was not adequate and said they wasted time looking for equipment that may have been borrowed by other areas. They stated that they had received no response to their raised concerns.

On the delivery suite, there were three resuscitation trolleys, one for adults and two for newborn infants. There were records that these were checked daily, however, the contents were not consistent with the checklists, it was difficult to see the expiry date on some packs, and the blood culture bottles had expired. Some plastic containers on the trolleys for newborn infants were labelled but the contents did not match the label. The box with drugs and equipment for caring for women with pre-eclampsia contained the relevant items but also unnecessary equipment which could delay treatment in an emergency. The trolley for managing postpartum haemorrhages was kept locked in the drug cupboard and there were some labelling errors – for example, the list showed that one drug was kept in the controlled drug cupboard whereas it was (correctly) kept in the fridge. Many of these issues were addressed during the inspection, however, the trolleys were not clearly labelled as to their purpose and there was confusion from staff over which trolley to use in each emergency.

## Security

Access was restricted in all clinical areas. The neonatal unit adhered to these restrictions, however, on the maternity unit, visitors were seen gaining unauthorised access to the unit. In the postnatal ward, it was common to see the curtains drawn around the beds all the time; while this maintained privacy and dignity, it also meant that staff did not have patients and babies easily in their sight. Babies had name bands on but there was no electronic tagging.

## Staffing levels

During our inspection there were sufficient numbers of midwives to meet the needs of the women, with one-to-one care for women in established labour. The ratio of midwives to births was one midwife for every 32 births which is less than the national recommended level of one midwife to every 28 births.

There were a significant number of vacancies for midwives and staff told us that they had concerns about the staffing levels. We were frequently told that staff felt "burnt out". There was access to overtime (bank) and agency staff, although it could be difficult to secure them at short notice. Senior managers were aware of these challenges and a number of midwives had recently been interviewed and further posts were being advertised.

There was good medical cover, with consultants available on site 74 hours per week, which is above the 60 hours per week as recommended by the Royal College of Obstetricians and Gynaecologists. Junior doctors felt well supported. There were dedicated lists for elective caesarean sections and a second theatre for emergencies with dedicated staff.

## Are maternity and family planning services effective?

Treatment in maternity services was effective.

## National guidelines

Currently guidelines were in use. Following the merger of the trust and the three maternity units, much work had taken place on reviewing the clinical guidelines to promote consistency and best practice. While a significant number

# Maternity and family planning

had been approved, none had been published at the time of inspection, although this was expected soon. Many staff were unable to find copies of the existing guidelines on the intranet and advised that they asked a colleague or looked on the Royal College website. This meant that care may not be appropriate to meet local needs.

## Collaborative working

Multidisciplinary meetings were held each week to review cases and incidents for learning purposes, and staff said they found them very useful.

## Improvements

In the last two years, the number of emergency caesarean sections being undertaken for this service was above the national average. There had been much work to promote normalising birth and a newly opened induction suite was having a positive impact on reducing the number of emergency caesareans.

## Staff skills

Midwives had access to a Supervisor of Midwives and met the statutory requirement to have an annual meeting with their Supervisor. Midwives told us that they were well supported to attend mandatory training and records confirmed this. This training included “skills and drills” sessions that included simulation and learning events and management of incidents. There was mixed feedback on additional professional development.

Staff had recently started to be rotated from day to night duty and throughout clinical areas. This aims to ensure that patients benefit from their skills which are not limited to one area.

Staff who were on the preceptorship programme of practical experience and training stated they felt well supported and valued the time they spent getting to know the unit and understand its policies and procedures. As a result, they felt better prepared to care for the women in the unit.

Concerns were expressed by both midwives and doctors regarding a lack of specialist midwives. For example, there was very limited focus on breastfeeding and no specialist midwife to lead this. On the maternity services dashboard dated September 2013 the percentage of women starting

breastfeeding within 48 hours of delivery ranged from 80% to 89%. During the observation of a handover on the postnatal ward, the majority of women were noted to be “mixed feeding”. There was a lack of promotion of breastfeeding with only information leaflets found in the room where bottled milk was prepared.

## Are maternity and family planning services caring?

Maternity services in Newham University Hospital were caring although some improvements are required.

### Involvement

Midwives spoke with compassion about wanting to provide the best care, but frustration that staffing levels meant they could only just provide the basic care. Staff were not consistently developing trusting relationships or communicating effectively, therefore women and their partners did not always understand what was happening and why it was happening. Feedback from women and their partners was mixed: some were very happy with the support and explanations they received; but others felt explanations were lacking and therefore they were unable to make informed choices. Many women could not tell us who their named midwife was and some did not know what one was.

### Privacy and dignity

The maternity unit was refurbished about two years ago and was bright and spacious. All the rooms in the delivery suite had ensuite facilities and each room had a fixed birthing pool. We observed that staff knocked on the doors prior to entering and also checked with the women before allowing any visitors in. In the postnatal ward, the curtains were drawn around to maintain privacy and dignity but frequently left drawn all the time, meaning that women and their babies could not be easily observed by maternity staff.

### Respect

All the interactions we observed were polite and respectful, however, some women felt that their care was minimal and the attitude of some staff was abrupt

# Maternity and family planning

and rude. These issues had been recognised by the trust and actions were in progress to address this, including a project called 'Great Expectations' which aimed to make every contact between staff and patients worthwhile. There were examples of investigations into individual instances, however, staff were concerned that the culture was so embedded that it went unnoticed at times.

There was a dedicated room for bereaved parents which was located in an appropriate position in the unit, with an additional room for parents to be by themselves. There was a multicultural bereavement service offered through the chaplaincy.

## Are maternity and family planning services responsive to people's needs?

Maternity services at Newham University Hospital were responsive to the needs of women.

### Planning of services

The service had seen a significant growth in the number of deliveries in the last few years with 6,850 deliveries in the last year. This was expected to rise to 7,200 next year. The maternity unit was designed with the need for growth taken into account so there was the physical space available to meet growing demand. In addition, new ways of working and the increasing use of the birthing centres would help with capacity issues.

All signage was in English but each area within the maternity unit was colour-coded to help people find their way around more easily – the result of community consultation when the unit was planned. The system was clearly displayed outside the unit.

Following a review of a higher-than-expected number of admissions to the intensive care unit, a high dependency unit had been opened within maternity. As a result, admissions to intensive care had reduced.

Women who attended triage but were not in established labour were usually sent home, however, it had been recognised that some women did not feel confident to go home and so access to a pre-labour room was being offered. While anecdotally this was meeting women's needs, it had not been monitored for effectiveness.

### Access to information

The local population was very diverse. There was access to an interpreter advocacy service on site for the most commonly spoken languages and telephone support for others. In practice many women relied on their partners for translation and, while this worked well, staff were aware of the issues of privacy and possible safeguarding implications.

Information was not readily available throughout the unit, with few leaflets available. For example, the only information seen on breastfeeding was in the room where bottled milk was prepared.

## Are maternity and family planning services well-led?

### Leadership and governance

Leadership within the maternity was visible and staff knew how to escalate issues and report concerns.

Overall leadership for maternity services was provided by the women's and children's clinical academic group (CAG) who oversaw monitoring of the quality and safety of care. Leadership within the maternity unit was visible and staff knew how to escalate issues and report concerns.

It was a time of change in the trust and a number of senior midwifery roles had been reviewed. The change had resulted in the introduction of a Head of Midwifery post for the hospital with the post due to be filled in December 2013. Further changes were expected and this was resulting in a period of instability and uncertainty and many staff commented on the poor effect this was having on their morale.

There was a maternity performance dashboard produced monthly – a computerised indicator of issues such as delivery rates, caesarean section rates, number of antenatal bookings, number and percentage of women who smoked at booking and number and percentage of women who started breastfeeding in the first 48 hours.

There were meetings across the CAG which focused on quality, safety and assurance. We saw evidence of the review of training, risks, incidents, complaints, themes and trends. While the meeting attendance aimed to be multidisciplinary, a review of the minutes showed that attendance by medical staff was minimal.

# Maternity and family planning

## **Accuracy of information**

Some staff advised us that the IT systems were complicated, with different systems not being able to communicate with each other. As a result, data entry sometimes had to be duplicated and searching for information was difficult.

We reviewed 10 sets of patient records, and we found them difficult to follow as information was provided in different sections, not all entries were legible and, although dated, were not always timed. Not all papers were secure within the folder and could be lost.

At handover we observed that staff took notes which were discarded at the end of the shift. Some staff were very clear that these notes contained personal information and disposed of them in the confidential waste; others had not recognised this and disposed of them in the normal waste bins.

# Children's care

## Information about the service

Newham University Hospital paediatric service has a dedicated day ward, one inpatient ward for children, a neonatal unit and an outpatient service.

We talked to four parents (or relatives) and their children and 11 staff including nurses, doctors, consultants, senior managers and support staff. We observed care and treatment and looked at five care records. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

## Summary of findings

We had some concerns about the safety of children's care. The orthopaedic surgeons were operating on children without input from the paediatric team. Emergency surgical procedures on children aged under 10 were being carried out only occasionally. Medicines were not being stored safely.

Children's care was not always effective. We had some concerns that there were no pain protocols in place and the pain service did not see children.

Staff were caring and responded to children's needs but there were no specific facilities for teenagers and the temporary accommodation used for children's outpatients did not meet the needs of the service.

We found the service was well-led. We were concerned that the trust only had one children's governance manager and there was no liaison with other governance managers across the trust.

## Are children's care services safe?

Services were generally safe but there were issues about the involvement of paediatric medical staff in the care of children having surgery and the storage of medicines.

### Patient safety

Paediatric services monitored and minimised risks effectively. For example, there was a screening protocol for methicillin-resistant staphylococcus aureus (MRSA) for children admitted to the unit and all children admitted with diarrhoea and vomiting were automatically tested for *Clostridium difficile* (*C. difficile*). Children who were admitted to the inpatient ward were risk assessed on admission and care was planned accordingly.

There were effective systems for identifying and learning from incidents. This was important for promoting safety. The department followed the hospital's incident reporting processes. The Matron told us that staff within the service were "very good" at reporting incidents. We saw that 20 incidents had been reported since August 2013 and learning was fed back to staff via regular ward meetings. Any serious incidents were reviewed at the weekly multidisciplinary team meeting.

### Staffing

There were adequate numbers of appropriately skilled staff on duty on the children's ward and neonatal unit. The matron told us the unit was over 95% established, with their own staff from the hospital doing any bank (overtime) shifts available, so that no agency staff were required. Staffing levels met the recommended Royal College of Nursing requirements of one nurse for every four children aged over two years and one nurse for every two children younger than two years old.

Normally each child was seen by a specialist registrar within the quality standard timeframe of four hours of admission and by a consultant within 12 to 24 hours. There was a daily ward round by the paediatric team to review each child's care. However, we were told the paediatric team did not review children who had

# Children's care

orthopaedic surgery. This was confirmed when we spoke with the parent of a child who had recently had this type of surgery. The parent told us she had been waiting over three hours to see the orthopaedic team and was unsure when they would be coming to see her child. The Matron told us it was always difficult to get the orthopaedic team to review children on the ward in a timely manner.

Data provided by the trust showed that nine children under the age of 10 had emergency general surgical procedures between 1 April and 31 October 2013. This is considered to be occasional practice as surgeons do not operate frequently enough on children to maintain their expertise.

## Safeguarding children

The children's unit had a named safeguarding lead. All qualified staff had completed level three training and support staff level one. We spoke with three nurses who were very clear about the process they had to follow if they had any concerns. The trust's IT system flagged up if a known 'at risk' child was admitted to the hospital. This meant children at risk were cared for appropriately.

## Infection Control

All areas in the children's unit were visibly clean. The neonatal unit was spacious, bright and well equipped. Hand hygiene gel was available and used by staff, parents and visitors on the ward. The children's unit environment was well maintained. There were toys and activities available for children. They were clean and in good condition.

We saw examples of regular audits completed, including a hand hygiene audit, a weekly cleanliness audit and a weekly bedside audit. We saw an action plan developed from the infection control audit with dates when the actions had been completed.

There had been a serious incident in the neonatal unit and there was a particular focus on infection control. We observed staff who did not adhere to infection control policies being challenged and asked to rectify this immediately.

## Medicines management

We visited Rainbow Ward and looked at medicines storage and supplies, records relating to children's medicines and talked to pharmacy staff and nurses.

Medicines were available through appropriate procedures when children needed them. We saw that prescribed medicines were available; there was a twice-weekly pharmacy top-up service and a daily visit from a ward pharmacist. The pharmacy was open at weekends between 10am and 2pm and there was a pharmacist on call out of hours. There was evidence of medicines reconciliation on admission. There is no policy to allow parents to administer medication to their children if they request to do so. Medicines were available on the ward and suitably labelled to allow nursing staff to discharge children out of hours. Emergency medicines were kept on the ward and they were being checked regularly.

Unauthorised people could access some medicines as they were not securely stored. There was no control of access to the clean utility room where infusions solutions were kept in an open rack system. Oral medications and injections were in locked cupboards. The two fridges were locked.

Medicines were not being kept safely. The temperature of the room was 27°C on the day of the inspection. Staff told us they had repeatedly reported that the room was too hot. Medicines requiring cold storage were being kept in the fridge and the temperatures of fridges were being monitored. The record showed that, on three occasions, the maximum temperature of the fridge had reached 12°C and there was no record of action being taken. There was evidence of routine checking of controlled drugs. We noted the cytotoxic spillage kit had expired.

Children received their medicines as prescribed, with appropriate records of medication administration. Allergy status had not been documented in one case. We did not see any missing doses.

## Are children's care services effective?

Services were not always effective and there were issues about management of children's pain.

## Clinical management and guidelines

The parents and children we talked to said they received prompt care and attention. We saw each child had a pain chart in their care record, and there was a limited range of medicines used to control pain. However, there was no pain protocol or regular pain audits in place for children

# Children's care

and the pain service did not see children. Staff told us they were working to standardise guidelines after the trust merger using a multidisciplinary approach.

## Staff skills

Children were normally cared for by staff specially trained to care for and treat children. However, children who had orthopaedic surgery were not cared for by a team of doctors which included a paediatrician. This does not comply with national guidelines.

## Are children's care services caring?

Parents and children said the service was caring and their needs were met.

## Patient and parent/carer feedback

Parents and children said staff were very caring and kind, and responded well to their needs. Parents told us their children's treatment and care was explained to them in a way they could understand and they felt comfortable discussing concerns with staff. They said they felt well supported and could get help from staff when they needed it. Parents of children who had surgery were given information about any risks involved with the procedure, how to prepare for their child's operation, and what to expect after discharge. The children we talked to said they enjoyed the food.

## Support for children and their families

There were arrangements to ensure children felt secure and comfortable, and less anxious about being in hospital. Parents were able to stay with their children overnight on the ward. Toys, books, and other forms of entertainment were available for children of all ages. The ward had a play specialist who showed us photographs and toys they used to help prepare children for different procedures. Parents were given information about any risks, how to prepare for their child's operation, and what to expect after discharge.

Staff and services met patients' physical, social, psychological and emotional needs. Nursing care records showed that staff had assessed children and families according to their individual needs.

## Are children's care services responsive to people's needs?

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

## Hospital premises

Parents were able to stay with their children overnight on the inpatient ward. There were also single rooms that could be used for parents with babies or children with special or complex needs. Older children were separated from younger children where possible by using different bays, however, there were no specific facilities for teenagers.

The Children's Outpatient Department was situated in temporary accommodation accessible via a large metal gate at one side of the main building. The facilities were very cramped and crowded when we visited. There was no soundproofing and noise could disturb consultations.

## Discharge arrangements

We looked at the discharge planning process. For complex patients, there were discharge planning meetings. Most children were discharged within a couple of days of admission. All the parents we talked to said that the doctors had discussed when their children might be discharged, and they felt well informed about this.

## Are children's care services well-led?

Services were well-led and safety and quality measures were in place.

## Leadership

Children's services were part of the women's and children's clinical academic group (CAG). The Group Director reported directly to the Chief Executive. There were weekly delivery group meetings and monthly performance review meetings. The Matron on the children's ward confirmed there was a monthly meeting with all the matrons from the other hospital sites, the Group Director and the Head of Nursing of the CAG.

# Children's care

Staff on the children's ward showed a high level of enthusiasm for their work and the service was clearly developed around the needs of children. Staff worked together as a team and told us the matron was very supportive but they were worried the matron may move with the planned reorganisation.

## **Managing quality and performance**

Safety and quality of care was monitored and action taken to respond to concerns. This included reporting on performance indicators via patient safety metrics, including incidents, falls, pressure ulcers and infection control, which were reviewed at monthly performance meetings.

Complaints came in through a central team and were reviewed by the Children's Governance Manager who determined the response required. However, the trust only had one Children's Governance manager who told us most of their activity was involved in crisis management with serious incidents and complaints requiring travel between sites. We were told there was liaison with the governance managers in maternity and neonatal care. This would suggest there was no overall trust liaison between governance managers outside of the CAG.

# End of life care

## Information about the service

We observed end of life care provided in the elderly care and general medical wards supported by a specialist palliative care team comprising appropriately qualified and experienced medical and nursing staff. The chaplaincy service was also very involved in providing a multi-faith coordinated service to patients. The team worked across the trust and had permanent staff based at Newham Hospital to provide a local point of contact.

## Summary of findings

Staff were supported to provide safe and effective palliative and end of life care by the specialist palliative care team. Patients and relatives were supported during this phase of care and their wishes were taken into account and respected. There was good use of the 'do not attempt resuscitation' (DNAR) documentation and decisions were reviewed regularly. Interim guidance was available to replace the Liverpool Care Pathway (for delivery of end of life care) following its removal from use in 2013 according to national guidance.

## Are end of life care services safe?

### Patient safety

Patients received safe end of life care. The records of several patients on the elderly care wards who were receiving palliative or end of life care, demonstrated they were being appropriately treated for their condition, and in accordance with their wishes. Pain relief, nutrition and hydration were provided according to their identified needs. Patients' wishes for their end of life care were clearly documented.

Patients' care was coordinated by a multidisciplinary team. The palliative care specialist team supported staff to ensure ongoing care, including pain management advice, discharge or transfer were appropriate. We saw that patients were discussed within the multidisciplinary team meetings and care decisions were agreed and actioned to ensure patients were cared for and their relatives were supported appropriately.

### Patient records and end of life decisions

Information about end of life care was fully documented. Decisions about resuscitation were also well documented and the DNAR form in use ensured other treatment decisions were recorded – for example, the use of antibiotic therapy and administration of nutrition and hydration. Records showed the forms were reviewed every seven days and decisions were discussed with the patient and relatives. The trust had not conducted a formal audit of DNAR forms at the Newham Hospital site to assess the standard of record-keeping across the hospital.

## Are end of life care services effective?

Patients' end of life care was managed effectively.

### Clinical management and guidelines

Patients received effective support from the palliative care team. There was a lead consultant and palliative care nurses who worked five days a week and provided 'on call' telephone cover at weekends. A multi-faith chaplaincy team provided spiritual support and attended the weekly palliative care multidisciplinary team meeting. A bereavement coordinator ensured the families of patients received personal belongings and essential documents following a patient's death and provided information about bereavement services. There were reported delays in families receiving death certificates which impacted particularly on the religious and cultural requirements of a proportion of the patient population. There were however, examples given of medical staff coming into the hospital out of hours on their own initiative to sign certificates to ensure families were able to make arrangements to meet their religious requirements.

The end of life care followed government guidelines. The hospital had undertaken a review of all patients on end of life care plans in response to a request from the Department of Health following the publication of a national independent review, More Care, Less Pathway: A review of the Liverpool Care Pathway in July 2013. An interim process had been introduced to replace the Liverpool Care Pathway, (previously been used to deliver end of life care) in line with national guidance. The palliative care team were consulting on a new policy.

# End of life care

## Are end of life care services caring?

The palliative care services were supportive, caring and enabled staff to provide patients with dignified, caring and kind end of life care.

Staff were very appreciative of the palliative care team and valued their advice and support. We did not see any specific patient feedback that directly related to the end of life service. We saw the wards had comment cards for the NHS Friends and Family test and the results were displayed and in the main positive.

### Support for patients

Patients' spiritual and emotional needs were met by a team of chaplains, volunteers and staff. We spoke with the bereavement lead for the hospital who was a member of the chaplaincy team. The chaplaincy service covered all faiths and there was an onsite multi-faith prayer room with religious services four times a week. Staff could refer to the chaplains at any time and there was an on-call rota which staff were aware of. The chaplains regularly attended the multidisciplinary team meetings and were aware of people who required end of life care. There were posters displayed around the hospital advertising the service and how to contact a member of the team. The hospital also had a team of volunteers led, by a coordinator, available to support patients.

Staff told us bereaved families were able to stay with their relative for up to several hours on the ward. We did view the mortuary and family viewing facilities available at the hospital. At the time of inspection these were not fit for purpose and were used to store equipment and specimens due for disposal. Managers accompanying us took immediate action to clear the viewing room and ensure the area was cleaned and made ready for use. There was also a garden area available for people to reflect on their loss. Staff we spoke with were not aware that the mortuary and viewing facilities were available.

There was a Macmillan cancer support drop-in area at the main entrance where relatives and patients could access advice and additional support if required.

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

Services were responsive to people's needs and involved them in decisions about their care.

Patients at end of life were seen promptly after referral. Ward staff told us the team was very responsive to referrals and saw patients as soon as possible. They talked to patients and families and explained end of life care, the options available and pain control.

### Patients' rights and wishes

Patients received care and support and were able to make choices about their end of life care. Their needs and wishes were discussed at the palliative care multidisciplinary team meeting.

### Patient records and end of life decisions

Information about end of life care was fully documented. Decisions about resuscitation were also well documented and the DNAR form in use ensured other treatment decisions were recorded – for example, the use of antibiotic therapy and administration of nutrition and hydration. Records showed the forms were reviewed every seven days and decisions were discussed with the patient and relatives.

### Support on the wards

Patients received good support and information on wards providing end of life care. The palliative care service was available Monday to Friday, 9am to 5pm, and there were designated team members on site at Newham Hospital to provide the service. Consultant on-call advice and support was provided at weekends. The team also supported staff training in end of life care and symptom control.

# End of life care

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

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

### **Leadership**

The palliative care team was led by an experienced lead consultant and were managerially responsible to a clinical academic group (CAG). The trust had conducted a review of staffing and there was a rebanding exercise in progress which could affect staff working in the service.

### **Managing quality and performance**

The palliative care team monitored the quality and safety of the end of life service. The team published an annual report and there was an established trust-wide end of life care steering group to develop common policies and promote consistent practice across the trust.

# Outpatients

## Information about the service

A wide range of outpatient services were available at Newham Hospital.

We visited the main outpatients department that hosted a wide range of clinics and the fracture clinic.

We talked to 12 patients and eight members of staff.

## Summary of findings

The outpatients department provided safe and effective care. However the consultation, assessment and treatment process in clinics were not regularly monitored by the trust.

Staff were caring and responded to patient's needs. We had some concerns about the leadership of the department. There was no evidence the performance was being checked on a daily basis and staff sometimes felt unsupported by their line manager.

### Are outpatients services safe?

Patients received safe and appropriate care.

#### Patient safety

Patients had consultations, diagnostic tests and assessments with appropriately qualified staff and advice was sought from other healthcare professionals where necessary. Staff knew what to do in the event of an emergency and the department had appropriate equipment.

#### Safeguarding patients

Staff understood safeguarding processes and what to do if they needed to raise an alert. Staff we talked to said they had received training on safeguarding children and vulnerable adults and knew how to access policies and procedures. We saw training records which showed all staff had completed their mandatory training.

#### Hygiene and the environment

The outpatient service was provided in a clean, safe and accessible environment. We observed hand hygiene gels

were available and used throughout the department by staff and some patients. All clinics were on the ground floor, making access safe and easier for patients with mobility difficulties.

#### Staffing

There were adequate numbers of appropriately skilled staff on duty in outpatients. We saw there was a daily staff meeting in the morning where the staffing levels for each clinic was checked and any changes made if required. However, we were told that a qualified nurse on long-term sickness was not being covered by agency or bank (overtime) staff which meant sometimes patients had to wait longer for tests and procedures.

### Are outpatients services effective?

Services were generally effective but there were issues about monitoring key performance information to demonstrate the efficiency of the service.

#### Clinical management and monitoring

Patients were allocated sufficient time with staff when they attended clinics. The reception staff explained to us how clinics were organised. Patients were normally booked in when they arrived and new patients had any routine tests done before they saw the doctor.

Patients told us that the outpatient service was effective. For example, one patient said, "The booking system was efficient and so far we have been seen quickly. My son has received wonderful care". Another patient told us, "The nurse checked the appointment times for all the patients waiting. All the staff are friendly and professional".

Outpatient services – consultation, assessment and treatment process in outpatient clinics – were not regularly monitored by the trust.

#### Staff skills

Staff received training, support and supervision to enable them to provide a caring environment in the outpatient department. We saw all staff had completed an annual appraisal. Staff also attended clinic meetings and supervision sessions to review their learning and competencies in dealing with patients.

# Outpatients

## Are outpatients services caring?

### Patient feedback

Patients considered the outpatient service to be caring and supportive and told us about positive experiences. Comments included: "I am very happy with the service". Another patient told us, "Staff are always friendly, professional and reassuring".

### Patients' privacy

Staff respected patients' privacy and dignity and patients' religious and cultural beliefs were considered. We observed patients had consultations in private rooms and clinic doors were closed during clinical examinations. Staff did not discuss patients in public places and reception areas were separate from waiting areas so that private conversations were possible. Where any intimate personal care and support was being given by a member of the opposite sex, the patient was offered the option of a chaperone – a healthcare professional, where possible, the same sex as the patient.

The reception staff provided clear information and advice. Patients were advised about follow-up appointments, and transport that could be arranged if required.

## Are outpatients services responsive to people's needs?

Services were responsive to people's needs and ensured patients were kept informed of waiting times and reasons for delays.

### Patients' feedback

Patients told us that the outpatient department communicated well with patients. There were waiting time announcements and a good booking system and treatment choices.

The trust had just introduced a new booklet, Tell us what you think about services – a guide to making comments, compliments or complaints, which explained to patients how they could give feedback.

### Waiting times

The patients we spoke with told us that normally they were seen within 30 minutes of their booked appointment. We saw that staff informed patients if there were going to be any delays. The receptionists and outpatients manager told us that some consultants overbooked their clinics but this was the individual consultant's decision. Staff told us that, although clinics were due to finish by 5pm, on average, three out of five days per week they overrun by between 30 and 60 minutes. We could see no evidence of how this was being recorded or managed.

### Meeting patients' needs

Outpatient services were responsive to patients' needs. One patient told us that specific appointment times could be changed if needed. Another patient, with visual problems, said staff were helpful in guiding her where to go. One staff member explained how they contacted some patients the day before the clinic to remind them to drink one litre of water prior to their appointments so tests could be successfully completed. Patients found this very helpful.

### Accessible information

For patients whose first language was not English there was an advocacy service which provided interpreters. We spoke with the health advocacy service who explained there was a high-quality interpreter service available mainly within office hours but accessible via a telephone service 24 hours a day. We were told that, across the whole trust last year, there had been 100,000 face-to-face contacts and 15,000 telephone episodes. Staff told us they could easily access this service. This was confirmed when we spoke with a patient whose first language was Portuguese. They told us they sometimes brought a friend to interpret but there was an interpreter available if they requested.

On the day we visited, the outpatients department was very busy, with adults seated in an area reserved for families waiting for children's clinics. There were no toys or books in the children's waiting area.

# Outpatients

## Are outpatients services well-led?

Services were not always well-led as staff felt unsupported and there were issues with monitoring the performance of the service.

### **Leadership**

Staff confirmed they were up to date with mandatory training and they had completed their annual appraisal. Staff told us there were limited opportunities for continuing professional development because of financial constraints.

We observed the staff worked well as a team but it was apparent when talking to them that they sometimes felt unsupported by their line manager. Access to training and cover for absent staff was a concern for them.

### **Managing quality and performance**

Staff were aware of how to report any incidents on the trust information system and told us any complaints were discussed at staff meetings. However, there was no evidence that the performance of the department was being routinely monitored. The Outpatient Manager told us there had been a previous method of data collection, but it had stopped in 2012.

# Good practice and areas for improvement

## Areas of good practice

Our inspection team highlighted the following areas of good practice:



- Play leaders in the children's service provided creative play opportunities for children to prepare them for surgery.
- The volunteer service had created a reminiscence room to provide a non-clinical environment for patients with dementia, which was decorated and equipped with items from the past to stimulate their memories.
- The 'do not attempt resuscitation' (DNAR) forms were comprehensive and enabled medical staff to identify treatment and care options with patients.

## Areas for improvement

### Action the hospital MUST take to improve



- Ensure medicines and fluids for infusion are stored securely.
- Ensure that members of staff follow national guidance for the management of children undergoing surgery and that they do this sufficiently to maintain their expertise.
- To promote a safety culture, the hospital must improve the visibility of management and embed clinical academic group structures and processes.

### Other areas where the trust could improve

- Consultant cover on site 24 hours a day, seven days a week in order to provide senior medical care and support for patients and staff.
- Increase the NHS Family and Friends survey response rate.
- Improve safety for patients by reducing reliance on bank and agency staff and improve critical care consultant cover on evenings and at weekends.
- Address the lack of high dependency unit facilities and the issue of patients being cared for in the coronary care unit, which are potentially compromising patients' safety.
- Provide accessible information for patients for whom English is a second language.
- Implement pain protocols for children and ensure that children are seen by the pain team.
- To mitigate the risk of potential safeguarding issues, the hospital should consider providing a separate waiting area for children waiting to be seen in the Urgent Care Centre.

This section is primarily information for the provider.

# Compliance actions

## Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury.	<p>Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Management of Medicines.</p> <p>Patients and others were not protected against the risks of unsafe use and management of medicines, by means of the making of appropriate arrangements for the safe keeping of medicines used for the purpose of the regulated activity because medication was not kept in secured locations and could be accessed by unauthorised persons. Regulation 13.</p>
Treatment of disease, disorder or injury.	<p>Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, Assessing and monitoring the quality of service provision.</p> <p>Patients and others were not protected against the risks of inappropriate or unsafe care and treatment by means of the effective operation of systems to assess and monitor the quality of care provided and identify, assess and manage risks relating to the health and welfare of patients and others. Regulation 10 (1)(a)(b) (2)(c)(i)</p>
Treatment of disease, disorder or injury.	<p>Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services.</p> <p>Patients were not protected from the risks of receiving care or treatment that is inappropriate or unsafe in such a way as to reflect published good practice guidance from professional and expert bodies. Regulation 9(b)(iii)</p>