

Barts Health NHS Trust

Whipps Cross University Hospital

Quality Report

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

Ratings

Overall rating for this hospital

Requires improvement



Surgery

Inadequate



End of life care

Requires improvement



Outpatients and diagnostic imaging

Requires improvement



Summary of findings

Letter from the Chief Inspector of Hospitals

Whipps Cross University Hospital in Waltham Forest is part of Barts Health NHS Trust, the largest NHS trust in the country, serving 2.5 million people across Tower Hamlets and surrounding areas of the City of London and East London.

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

This was a focused unannounced inspection to follow up on our previous inspection of Barts Health NHS Trust in July 2016 where we found a number of concerns around patient safety and the quality of care. At that time Whipps Cross University Hospital was rated overall inadequate.

We carried out an unannounced inspection between 10 and 11 May 2017 and inspected three core services: surgery, end of life care and outpatients and diagnostic imaging.

We found improvements in both end of life care and outpatients and diagnostic imaging, which have been reflected in the ratings. However, following concerns we found in surgery the ratings across each domain remain unchanged. We have written to the trust asking them to provide further information on how they are addressing the issues of poor care and treatment.

However, when considering the aggregated ratings across all eight core services, from both this inspection and last July, the hospital is now rated overall requires improvement.

Our key findings were as follows:

Safe

- The hospital's electronic incident reporting system was not always used effectively by staff to report, investigate and act upon incidents. Learning from incidents was not always identified or recorded. Feedback was not shared consistently with staff, as monthly ward meetings did not always take place.
- VTE screening compliance on surgical wards was consistently below the trust's 95% target.
- Surgical site infection (SSI) data was not followed up and therefore the service did not know how many wound infections occurred after patients were discharged.
- We observed a number of infection control issues related to the operating theatre environment including loose and exposed plaster on theatre walls and damaged flooring. Not all theatre areas had records of daily cleaning checks and some items of equipment labelled as clean had visible dust and/or damage. We did not see evidence of any theatre cleaning audits.
- Not all staff had completed mandatory training.
- The use of agency staff on some wards was high due to nursing staff vacancies. Nursing staff told us they were concerned about the quality of the agency nurses and gave us examples when this compromised patients' care and treatment.
- We found there was a lack of working equipment available within the mortuary.
- Palliative care staffing levels fell below nationally recommended standards.
- The environment of the in-patient diagnostic imaging area was poorly maintained.
- Safety equipment was not always maintained or replaced to ensure the safety of patients or staff.

Effective

- We did not see evidence of how national audit results were being used to drive local improvement programmes. The trust did not provide us with any action plans to demonstrate how national audit results were responded to.

Summary of findings

- Not all patients were screened for malnutrition as required by NICE guidelines. MUST compliance rates for surgical wards were still consistently below the trust target of 95%.
- Patient outcomes were not being measured for patients receiving end of life or palliative care.

Caring

- Most patients we spoke with told us their experiences of care were positive. We saw that staff treated patients with compassion and demonstrated a genuinely kind and caring attitude.

Responsive

- Theatre cancellations were happening on the day of surgery due to lack of available beds and over-running and late starting theatre lists. Theatre utilisation rates had improved but were still below the trust's target. Theatre lists were frequently delayed due to IT and equipment issues and last-minute list changes.
- Bed shortages on wards meant recovery areas were regularly used to nurse patients overnight. Staff were concerned that patients' needs were not being appropriately met.
- Many patients were discharged out of hours (after 8pm) due to delays. The hospital did not carry out discharge audits and did not monitor their performance against the 48hr rapid discharge target for patients receiving end of life care.
- Provisions for relatives who were at the hospital with their loved ones for long periods of time were not consistent and differed from ward to ward.
- The availability of single rooms was at a premium in the hospital, which made dignified care for people at the end of their lives harder.
- There were capacity issues in certain clinics and some clinics were cancelled due to lack of clinician availability.

Well-led

- We saw limited evidence of improvements to the surgical service to make it safer for patients and more responsive to their needs. Many of the areas of concern highlighted during our last inspection still needed to be addressed by the service.
- Governance systems were not always embedded in practice to provide a robust and systematic approach to improving the quality of services.
- The risk register did not reflect all current risks to the service. Some risks had been on the register for several years and it was not clear when these had last been reviewed. The risk register did not show what controls were in place or actions taken to mitigate risks.
- Staff we spoke with were not aware of a nominated non-executive director for end of life care, or of any representation at board level. There was a culture for end of life care in the hospital to be seen as the responsibility of the specialist palliative care team.
- There was limited oversight of the extent or depth of potential patient harm as a result of a recent information technology systems failure.

There were areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- The trust must ensure governance systems are embedded in practice to provide a robust and systematic approach to improving the quality of services. This should capture relevant elements of good governance including an adopting a positive incident reporting culture where learning from incidents is shared with staff and embedded to improve safe care and treatment of patients.
- The trust must improve bed management, theatre management and discharge arrangements to facilitate a more effective flow of patients across the hospital and to improve theatre cancellation and delayed discharge rates.
- The trust must improve its referral to treatment time performance in line with national standards.
- The trust must improve staff compliance with mandatory training including safeguarding training.

Summary of findings

- The trust must improve staff compliance and awareness of trust infection prevention and control policies and processes.
- The trust must improve compliance with venous thromboembolism (VTE) assessments.
- The trust must ensure all patients are screened for malnutrition as required by NICE guidelines.
- The trust must ensure that patient records are stored securely in line with information governance standards.
- The trust must ensure the hospital's physical environment, including operating theatres, is fit for purpose and meets required standards.
- The trust must continue to work towards improving the organisational culture to reduce instances of unprofessional behaviours and bullying and ensure all staff feel sufficiently supported by their managers.
- The trust must ensure there are sufficient numbers of qualified, skilled and experienced staff employed and deployed to meet the needs of patients. This should include ensuring staff have the right skills to recognise and manage the deteriorating patient.
- The trust must ensure all staff receive appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.
- The trust must ensure that risks to patient safety and service delivery are appropriately identified, recorded and escalated effectively.
- The trust must ensure governance systems are embedded in practice to provide a robust and systematic approach to improving the quality of services.
- The trust must ensure compliance with radiation protection regulations.
- The trust must ensure that timely arrangements are in place to replace diagnostic imaging equipment identified as at risk of failure.
- The trust must ensure there are functioning panic alarms across the outpatients department.
- The trust must ensure that the environment is safe where children and young people are treated in adult clinics.
- The trust must ensure that equipment used for moving deceased patients from the ward to the mortuary are properly maintained and suitable for the purpose for which they are being used.
- The trust must ensure that systems and processes are in place to enable proper management and oversight of the mortuary and are understood by staff who provide mortuary duties out of hours and in the absence of regular staff from the outsourced third party.
- The trust must have systems in place to assess and monitor their performance for rapid discharge and its effect on patient care.
- The trust must assess the quality of services provided (including the quality of the experience of service users in receiving those services) in relation to its current palliative care consultant resource and with consideration to meeting the national guidance ['Commissioning Guidance for Specialist Palliative Care: Helping to deliver commissioning objectives' (Dec 2012.)] which recommends a minimum requirement of 1 whole time equivalent consultant in palliative medicine per 250 hospital beds. The hospital has 586 beds.
- The trust must ensure that ward staff are provided with appropriate support and training in end of life and palliative care to enable them to carry out their role effectively.

In addition the trust should:

- The trust should ensure staff always have access to reliable equipment to minimise potential delay to treatment.
- The trust should ensure that timely arrangements are in place to replace ageing theatre equipment identified as at risk of failure.
- The trust should ensure the needs and preferences of patients and their relatives are central to the planning and delivery of care at the hospital.
- The trust should review, and take action to address, feedback from staff raised in the NHS staff survey.
- The trust should act upon the results of national audits to address areas of poor performance and to help drive improvement in services.
- The trust should ensure that surgical site infection (SSI) data is appropriately captured and reviewed.

Summary of findings

- The trust should ensure the safety of patients as they are transferred between CT and accident and emergency.
- The trust should ensure training is provided for the role of chaperone.
- The trust should ensure the physical environment is fit for purpose and maintained in a good state of repair.
- The trust should ensure the business continuity plan is updated to reflect systems failures in outpatients and diagnostic imaging services.
- The trust should ensure privacy for patients who attend the CT scanning unit.
- The trust should ensure best practice around the use of appropriate interpreters.
- The trust should ensure a consistent approach to sending reminders to patients about their appointments.
- The mortuary audit from March 2017 reported on the age and number of the fridges available and recommended it for entry onto the trust risk register. The trust should ensure this issue is given proper consideration.
- The trust should ensure that the second mortuary viewing room (in the accident and emergency department) is in a good state of repair.
- The trust should ensure that the new clinical records system that contains mechanisms for patient outcome data to be collected is utilised. The outcome measures had been on the new system since March 2017. The SPCT had used it for a matter of weeks and were not yet in use.
- The trust should ensure that work taking place to increase the limited multidisciplinary input in to the Margaret Centre and SPCT such as social work, therapy and psychological services, is continued.
- The trust should ensure that it conducts a review regarding the inconsistency of provision available for relatives who were at the hospital with their loved ones for long periods of time. For instance, in relation to items such as tea and coffee, and for relatives staying overnight.
- The trust should ensure that religious texts are readily available to patients of all major faiths who use the hospital.
- The trust should ensure that information gathered from both 'Have Your Say' and the bereavement survey are used to improve care.

Professor Edward Baker
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Surgery

Rating

Inadequate



Why have we given this rating?

We saw limited evidence of improvements to the service to make it safer for patients and more responsive to their needs. Many of the areas of concern highlighted during our last inspection still needed to be addressed by the service.

We were told that significant work had now been done to improve the hospital's clinical governance structures; however, we did not see evidence that this had been embedded in surgical specialities. The risk register did not reflect all current risks to the service. Some risks had been on the register for several years and it was not clear when these had last been reviewed. The risk register did not show what controls were in place or actions taken to mitigate risks.

The hospital's electronic incident reporting system was not always used effectively by staff to report, investigate and act upon incidents. Learning from incidents was not always identified or recorded. Feedback was not shared consistently with staff, as monthly ward meetings did not always take place. VTE screening compliance on surgical wards was still consistently below the trust's 95% target. Data provided by the trust for the period April 2016 to May 2017 showed overall monthly VTE screening rates on surgical wards varied between 75% and 86%. Three wards, Rowan, Sage and Sycamore scored consistently under 70%.

Not all staff had completed mandatory training. Overall compliance rates fell below the trust target. Competition rates for medical gas safety and infection prevention and control (IPC) were particularly low at 75% against the trust's 90% target.

Not all staff received an annual appraisal, appraisal rates were varied between 56% and 77% for different groups of surgical staff.

The use of agency staff on some wards was high due to nursing staff vacancies. Nursing staff told us they were concerned about the quality of the agency nurses and gave us examples when this compromised patients' care and treatment.

Summary of findings

Theatre cancellations were happening on the day of surgery due to lack of available beds and over-running theatre lists. Theatre utilisation rates had improved but were still below the trust's target. Theatre lists were frequently delayed due to IT and equipment issues and last-minute list changes. Data provided by the trust for the period November 2016 to April 2017 showed that 79% of lists did not start on time, with 39% of lists starting over 30 minutes later than planned.

During our previous inspection, we identified that poor collaboration, communication and lack of understanding between different clinical areas within the service resulted in staff blaming each other for poor patient flow. Staff told us that this was still a problem and we saw little evidence of improvement.

Bed shortages on wards meant recovery areas were regularly used to nurse patients overnight. Staff were concerned that patients' needs were not being appropriately met.

A number of staff in different areas told us about ongoing issues of bullying, favouritism or unfair treatment. Several staff told us they lacked confidence in the hospital's HR department and felt reluctant to raise concerns.

In the NHS staff survey 2016, the staff response rate for the surgical and cancer division was 29.4%, which was significantly worse than the overall trust response rate of 47.3%. The service performed significantly worse than the trust average in questions related to staff engagement with senior manager

Not all patients were screened for malnutrition as required by NICE guidelines. MUST compliance rates for surgical wards were still consistently below the trust target of 95%.

The hospital's performance in the 2016 Hip Fracture Audit was mixed. For five measures, the hospital performed significantly worse than the national average and fell within the lowest 25% of all trusts. Performance against four of these five measures was also worse than the result for 2015. The trust did not provide us with any action plans to demonstrate how these national audit results were being responded to.

Summary of findings

The overall 18-week referral to treatment time (RTT) performance for patients waiting for surgical specialties at the hospital was 69%. Performance was worse than expected but could not be accurately measured against the national average due to quality issues. There were significant data quality concerns that meant the trust could not provide assurance that referral to treatment times were being monitored effectively and the trust were not submitting national data.

We also found:

We saw that staff treated patients with compassion and demonstrated a genuinely kind and caring attitude. Most patients we spoke with told us their experiences of care were positive.

Morning and evening handover at shift change were relevant and focused on patient care and safety. Staff we spoke with knew how to report an incident and were aware of their responsibilities to report safeguarding concerns.

A nursing representative from each hospital area attended a daily safety huddle to enhance patient safety across the hospital.

Patients' pain was assessed and well-managed and ward staff had access to support from a specialist pain team.

Daily multidisciplinary team (MDT) board rounds took place on wards with input from range of allied health professionals.

Staff across wards and theatres spoke highly of their direct line managers and said they felt supported by the matrons who were visible and approachable. Most staff spoke highly of their team and colleagues. A junior member of staff said they felt their colleagues were "like an extended family."

The trust had held several 'listening into action' events to capture the views of staff.

End of life care

Requires improvement



Although ward staff felt well supported by the specialist palliative care team (SPCT) it was a widely held belief among senior staff at the Margaret Centre and SPCT that a barrier to promoting a positive culture of end of life and palliative care being everyone's responsibility and lay with the education of ward staff.

Despite issues regarding equipment being identified through audit and reported as acted on in March

Summary of findings

2017, we found there was a lack of working equipment available within the mortuary. Twenty fridge spaces were available in the mortuary and deceased patients were frequently transferred to other premises. There were no bariatric fridge spaces and the audit stated that fridges were quite old. It recommended this issue for the trust risk register. Out of hours mortuary viewings were arranged and managed by the porters. However, the porters had not been trained in any mortuary duties. More clinical nurse specialists and consultants had been recruited as part of investing in end of life and palliative care which was a positive step. However, not all posts had been recruited to and staffing levels remained on the risk register. Consultant levels had increased and were due to increase further. However, they were still below the national guidance [‘Commissioning Guidance for Specialist Palliative Care: Helping to deliver commissioning objectives’ (Dec 2012.)] which recommends a minimum requirement of one whole time equivalent consultant in palliative medicine per 250 hospital beds. Association for Palliative Medicine of Great Britain and Ireland recommendations and the National Council for Palliative Care guidelines of a minimum of one consultant per 250 beds. The hospital had 586 beds.

Provisions for relatives who were at the hospital with their loved ones for long periods of time were not consistent and differed from ward to ward. Some were provided with tea and coffee, others with tea, coffee and sandwiches. For relatives staying overnight, some wards could only provide chairs while others had fold down beds.

The availability of single rooms was at a premium in the hospital, which made dignified care for people at the end of their lives harder; this compounded the issue of patients being sent to the Margaret Centre, where care was provided in single rooms.

The discharge team told us they tried to meet a target of 48 hours for rapid discharge. However, although they monitored this on a day to day basis they did not measure this in any other way, such as over time or through any sort of audit and did not understand their effectiveness against this target or its effect on patient care.

Summary of findings

Staff from both the SPCT and Margaret Centre we spoke with were not aware of a nominated non-executive director for end of life care, or of any representation at board level.

There was a culture for end of life care at the hospital to be seen as the responsibility of the SPCT. There was also a culture of patients being admitted to the Margaret Centre to die rather than being cared for at home or on the wards.

The mortuary was managed by an outsourced third party on behalf of the trust. There were systems in place that were not effective and others that the trust had no oversight of.

We also found:

There were mechanisms in place for learning from incidents to take place through a multi professional, cross divisional hospital group who led on all matters that related to end of life and palliative care. The SPCT took working to resolve issues for patients receiving end of life care as something they took responsibility for within the hospital. They described being open, apologetic to people when things went wrong and resolving matters for patients.

Ward staff, the SPCT and staff at the MC were all able to describe the trust's safeguarding referral process. They also knew when it was appropriate to seek help and advice as well as escalate potential safeguarding issues. We came across one current example of this in practice.

A programme of refurbishment was taking place at the Margaret Centre. Updates had already taken place to the premises to improve infection control and protect peoples' privacy and dignity.

The compassionate care plan for the dying patient (CCP) was in use throughout the hospital. Staff we spoke with on hospital wards and at the Margaret Centre told us that the end of life care was hugely helped by having the CCP in place.

Patient deterioration, symptom management, continuing assessment and ongoing monitoring for each patient where appropriately discussed and reviewed in daily handover meetings at both the SPCT and MC.

We found plenty of examples where end of life care was being delivered to national guidelines and in compliance with National Institute for Health and Care Excellence (NICE).

Summary of findings

DNACPR forms were in place and fully completed, including discussions with the family where appropriate. There was only one DNACPR form in use now.

The Margaret Centre and the SPCT staff worked on relationships with services within the hospital to promote better end of life care. Ward staff we spoke with thought both the SPCT and the MC staff were helpful.

Patients and relatives were positive about the care they had received.

Family meetings were held soon after referral to the SPCT. Family involvement was discussed in handover meetings of the SPCT and the Margaret Centre.

There was a good meeting structure that enabled accountability and direction for end of life care. The deteriorating patient improvement group met on a monthly basis and was the principle governance meeting for the hospital that was concerned with end of life care. This group was now developing in to the end of life care group, which was to be led by the director of nursing at the hospital.

Outpatients and diagnostic imaging

Requires improvement



Incidents were not always reported or actioned in line with trust policy. The trust had identified capability issues with staff using the incident reporting system, however we were told this training was not included in induction training.

Risk registers did not reflect all areas of concern, for example; concerns about transfers of patients between the emergency department and imaging department or lack of accessible resuscitation equipment

The environment of the in-patient diagnostic imaging area was poorly maintained.

There were on-going capacity issues in certain clinics to meet patient demand

Staff did not have the available information to ensure non-medical referrers were compliant with the Ionising Radiation (Medical Exposure) regulations (IR (ME) R).

Safety equipment was not always maintained or replaced to ensure the safety of patients or staff. In particular lead aprons, which provided radiation protection.

Summary of findings

Radiation doses received by medical staff was routinely higher than that recommended by the radiation protection advisor when measured against staff who performed similar procedures using x-ray equipment with modern dose limiting technology for the patients and operators.

There was limited oversight of the extent or depth of potential patient harm as a result of a recent information technology systems failure.

Governance systems were not always embedded in practice to provide a robust and systematic approach to improving the quality of services.

Staff told us management was more visible.

There was an improved staff culture, some of which staff attributed to a greater willingness amongst managers and the human resources department to tackle bullying issues.

We also found:

Most patients were positive about the care they received and were treated with dignity and respect. Guidelines such as those published by National Institute for Health and Care Excellence (NICE) were in place and followed.

Booking centre staff consulted with patients to ensure the appointment slot was convenient for them and accommodated their needs.

Staff spoke positively of the newly appointed leadership team, and described an improved culture and better communication between staff and managers.

Most patients and relatives we spoke with were positive about how they had been treated and we observed consistently good interactions.

Staff had appropriate safeguarding awareness and understood their safeguarding responsibilities in and protected people from abuse.

Medicines were generally stored safely and there was robust management of medicines administration records and prescription stationery.

There were improved radiography staffing levels as a result of a recent recruitment campaign.

Systems were in place to maximise patient record availability for clinics which meant staff had the information they needed before providing care and treatment.

Whipps Cross University Hospital

Detailed findings

Services we looked at

Surgery, End of life care and Outpatients and diagnostic imaging.

Detailed findings

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Background to Whipps Cross University Hospital

Whipps Cross University Hospital in Waltham Forest is part of Barts Health NHS Trust, the largest NHS trust in the country, serving 2.5 million people across Tower Hamlets and surrounding areas of the City of London and East London.

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

This was a focussed unannounced inspection to follow up on our previous inspection of Barts Health NHS Trust in July 2016 where we found a number of concerns around patient safety and the quality of care.

We carried out an unannounced inspection between 10 and 11 May 2017.

We inspected three core services: Surgery, End of life care and Outpatients and Diagnostic Services.

Our inspection team

Our inspection team

Our inspection team was led by:

Head of Hospital Inspections: Nicola Wise, CQC

Inspection manager: David Harris, CQC

Our inspection team included CQC inspectors and analysts, doctors, nurses and allied health professionals.

How we carried out this inspection

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

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

- Is it well-led?

Before our inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included the clinical commissioning groups (CCGs), NHS

Detailed findings

Improvement (NHSI), Health Education England (HEE), General Medical Council (GMC), Nursing and Midwifery Council (NMC), Royal College of Nursing (RCN), NHS Litigation Authority and local branches of Healthwatch.

We held focus groups with a range of staff in the hospital, including doctors, nurses, midwives, allied health







professionals, and non-clinical staff. We interviewed senior members of staff at the hospital and at the trust. A number of staff attended our 'drop in' sessions to talk with a member of the inspection team.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Inadequate	Requires improvement	Good	Inadequate	Inadequate	Inadequate
End of life care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	N/A	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Surgery

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

Information about the service

Whipps Cross University Hospital provides a range of elective (planned) and emergency surgical services to the local population: including orthopaedics, general surgery, vascular surgery, colorectal surgery, urology, trauma, ear, nose and throat (ENT) and ophthalmic surgery. Between April 2016 and March 2017, the hospital performed 16,379 surgical procedures. The surgical specialities carrying out the most procedures were ophthalmology (3,474), trauma and orthopaedics (3,372), followed by general surgery (3,009) and urology (1,704).

There were 12 operating theatres, two of which were ophthalmic theatres, which were used for specialist eye surgery. Four theatres were dedicated to day-case procedures. Two theatres were designated emergency theatres, one available 24 hours a day and the other nine hours a day, both seven days a week.

At the time of our inspection, there were 131 surgical beds in the designated surgical wards and 28 patients could be accommodated on the surgery day case ward. Of these 131 beds, 86 were acute surgical inpatient beds, 27 trauma orthopaedic beds and 18 elective orthopaedic beds.

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

During our inspection spoke with 18 patients and looked at 21 care records.

We also spoke with 54 staff including allied healthcare professionals (AHPs), nurses, health care assistants (HCAs), doctors, consultants, ward managers, matrons and members of the senior management team. In addition, we reviewed a number of documents such as meeting minutes, audits, and performance and quality data.

During our last inspection in July 2016, we rated the service overall as inadequate. We rated safe, responsive and well-led as inadequate, the effective domain as requires improvement and caring as good.

Following the concerns identified during the inspection, we have written to the trust asking them to provide further information on how they are addressing the issues of poor care and treatment.

Surgery

Summary of findings

We rated this service as **inadequate** because:

- We saw limited evidence of improvements to the service to make it safer for patients and more responsive to their needs. Many of the areas of concern highlighted during our last inspection still needed to be addressed by the service.
- We were told that significant work had now been done to improve the hospital's clinical governance structures; however, we did not see evidence that this had been embedded in surgical specialities.
- The risk register did not reflect all current risks to the service. Some risks had been on the register for several years and it was not clear when these had last been reviewed. The risk register did not show what controls were in place or actions taken to mitigate risks.
- The hospital's electronic incident reporting system was not always used effectively by staff to report, investigate and act upon incidents. Learning from incidents was not always identified or recorded. Feedback was not shared consistently with staff, as monthly ward meetings did not always take place.
- VTE screening compliance on surgical wards was still consistently below the trust's 95% target. Data provided by the trust for the period April 2016 to May 2017 showed overall monthly VTE screening rates on surgical wards varied between 75% and 86%. Three wards, Rowan, Sage and Sycamore scored consistently under 70%.
- Not all staff had completed mandatory training. Overall compliance rates fell below the trust target. Completion rates for medical gas safety and infection prevention and control (IPC) were particularly low at 75% against the trust's 90% target.
- Not all staff received an annual appraisal, appraisal rates were varied between 56% and 77% for different groups of surgical staff.
- The use of agency staff on some wards was high due to nursing staff vacancies. Nursing staff told us they were concerned about the quality of the agency nurses and gave us examples when this compromised patients' care and treatment.
- Theatre cancellations were happening on the day of surgery due to lack of available beds and

over-running theatre lists. Theatre utilisation rates had improved but were still below the trust's target. Theatre lists were frequently delayed due to IT and equipment issues and last-minute list changes. Data provided by the trust for the period November 2016 to April 2017 showed that 79% of lists did not start on time, with 39% of lists starting over 30 minutes later than planned.

- During our previous inspection, we identified that poor collaboration, communication and lack of understanding between different clinical areas within the service resulted in staff blaming each other for poor patient flow. Staff told us that this was still a problem and we saw little evidence of improvement.
- Bed shortages on wards meant recovery areas were regularly used to nurse patients overnight. Staff were concerned that patients' needs were not being appropriately met.
- A number of staff in different areas told us about ongoing issues of bullying, favouritism or unfair treatment. Several staff told us they lacked confidence in the hospital's HR department and felt reluctant to raise concerns.
- In the NHS staff survey 2016, the staff response rate for the surgical and cancer division was 29.4%, which was significantly worse than the overall trust response rate of 47.3%. The service performed significantly worse than the trust average in questions related to staff engagement with senior manager
- Not all patients were screened for malnutrition as required by NICE guidelines. MUST compliance rates for surgical wards were still consistently below the trust target of 95%.
- The hospital's performance in the 2016 Hip Fracture Audit was mixed. For five measures, the hospital performed significantly worse than the national average and fell within the lowest 25% of all trusts. Performance against four of these five measures was also worse than the result for 2015. The trust did not provide us with any action plans to demonstrate how these national audit results were being responded to.
- The overall 18-week referral to treatment time (RTT) performance for patients waiting for surgical specialties at the hospital was 69%. Performance was

Surgery

worse than expected but could not be accurately measured against the national average due to quality issues. There were significant data quality concerns that meant the trust could not provide assurance that referral to treatment times were being monitored effectively and the trust were not submitting national data.

However:

- We saw that staff treated patients with compassion and demonstrated a genuinely kind and caring attitude. Most patients we spoke with told us their experiences of care were positive.
- Morning and evening handover at shift change were relevant and focused on patient care and safety. Staff we spoke with knew how to report an incident and were aware of their responsibilities to report safeguarding concerns.
- A nursing representative from each hospital area attended a daily safety huddle to enhance patient safety across the hospital.
- Patients' pain was assessed and well-managed and ward staff had access to support from a specialist pain team.
- Daily multidisciplinary team (MDT) board rounds took place on wards with input from range of allied health professionals.
- Staff across wards and theatres spoke highly of their direct line managers and said they felt supported by the matrons who were visible and approachable.
- Most staff spoke highly of their team and colleagues. A junior member of staff said they felt their colleagues were "like an extended family."
- The trust had held several 'listening into action' events to capture the views of staff.

Are surgery services safe?

Inadequate



We rated safe as **inadequate** because:

- The hospital's electronic incident reporting system was not always used effectively by staff to report, investigate and act upon incidents. Learning from incidents was not always identified or recorded. Feedback was not shared consistently with staff, as monthly ward meetings did not always take place.
- VTE screening compliance on surgical wards was consistently below the trust's 95% target. Data provided by the trust for the period April 2016 to May 2017 showed overall monthly VTE screening rates on surgical wards varied between 75% and 86%. Three wards, Rowan, Sage and Sycamore consistently scored under 70%.
- Surgical site infection (SSI) data was not followed up and therefore the service did not know how many wound infections occurred after patients were discharged.
- We observed a number of infection control issues related to the operating theatre environment including loose and exposed plaster on theatre walls and damaged flooring. Not all theatre areas had records of daily cleaning checks and some items of equipment labelled as clean had visible dust and/or damage. We did not see evidence of any theatre cleaning audits.
- Theatre equipment was old and needed to be replaced and timely servicing and maintenance did not always take place. Records of daily safety checks were not always maintained.
- We found out of date equipment in theatre 5 including nine epidural syringes which expired in February 2017.
- The recently outsourced sterile instrument service provided an inconsistent quality of service that meant appropriate instruments were not always available to theatre staff leading to delays.
- We observed some staff did not adhere to the infection prevention standards and protocols. Staff did not consistently follow the hospital's uniform and 'bare below the elbow' policies. Infection prevention and control (IPC) audits did not always take place on surgical wards.

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- Safeguarding compliance for all staff within the surgical service, with all required safeguarding training, was at 86%, which did not meet the trust's 90% target. Compliance with safeguarding adults level 2 training was at 75% and safeguarding children level 2 at 85%. Only a small number of senior staff (12) were required to complete level 3 children's safeguarding training however less than half (5) had done so.
- Not all staff had completed mandatory training. Overall compliance rates fell below the trust target. Competition rates for medical gas safety and infection prevention and control (IPC) were particularly low at 75% against the trust's 90% target.
- We found that patient records were not always stored securely in line with information governance standards.
- The use of agency staff on some wards was high due to nursing staff vacancies. Nursing staff told us they were concerned about the quality of the agency nurses and gave us examples when this compromised patients' care and treatment.
- There were concerns that staffing levels at weekends put patient safety at risk. This was on the hospital's risk register but it was not clear what action had been taken to address this.

However:

- Staff we spoke with knew how to report an incident and were aware of their responsibilities to report safeguarding concerns.
- Morning and evening handover at shift change were relevant and focused on patient care and safety.
- We observed most wards, recovery areas and operating theatres were clean and tidy. All staff and the majority of patients we spoke with told us the cleanliness on the wards was good.
- We observed drugs management, administration and disposal was generally good across all clinical areas. Medicines were stored securely and appropriately across wards and theatres.

Incidents

- The surgical service used the hospital-wide electronic incident system to report, investigate and act upon incidents and adverse events. Between June 2016 and May 2017, surgical staff reported 1,449 incidents. The majority (1,421) of these incidents were classified as 'no harm' or 'low harm'. The largest reported numbers of incidents related to pressure ulcers (199), delays in care

(145), medication (118), patient falls (117), communication issues (104) and equipment (92). Of the 1,249 incidents that had been reviewed and approved by managers, almost half (530) did not have any lessons learned recorded.

- The service had reported eight serious incidents (SIs) between May 2016 and April 2017. Of these, three related to patients developing grade 3 pressure ulcers on either Rowan or Primrose ward. Two SIs related to sub-optimal care of the deteriorating patient, one of which led to the potentially avoidable death of the patient. This incident was still being investigated by the hospital at the time of our inspection.
- The surgical service at Whipps Cross University Hospital reported no 'never events' in the 12 months prior to this inspection. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- We saw three examples of SI investigations that were completed according to the principles of root cause analysis (RCA). The reports outlined lessons learned and had action plans to address recommendations to prevent future incidents. However, although action plans had deadlines for compliance we did not see evidence that actions had been completed as this was not recorded on the action plan. No lead person was assigned to take responsibility for each action although the report stated that completion of the agreed actions would be monitored by the site Quality and Safety Committee. One of the serious incidents investigated was the unexpected death of a patient in March 2016, however the investigation report was dated March 2017 and it was not clear from the report why the investigation had not been completed sooner.
- Most staff we spoke with knew how to report an incident and could provide examples of when they had done so. However, some ward staff said they reported incidents infrequently and usually only pressure ulcers or patient falls were reported. One member of staff told us they "tried to avoid" having to report incidents if possible, due to both lack of time to complete them and feedback given.

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- In the 2016 NHS staff survey the surgical service performed significantly worse in the question about staff confidence that the organisation would address concerns about unsafe clinical practice (48% against trust average of 55%).
- Staff told us that learning from incidents was not shared consistently, as monthly ward meetings did not always take place. On some wards, staff took part in a daily safety briefing where recent incidents and risks were discussed. However, on other wards and clinical areas staff told us these did not take place and that they only ever heard about incidents informally. Two members of staff, in different clinical areas, told us they only heard about incidents that had taken place via “the grapevine”.
- We asked the trust to provide three sets of ward meeting minutes for each of the six surgical wards from the six-month period prior to the inspection. We received only three sets of minutes, two for Sycamore ward (February and April 2017) and one for Primrose ward (Feb 2017). Only one out of three sets of minutes (Sycamore ward, April 17) recorded discussion of any incidents however this was limited to a general reminder about pressure ulcer prevention and skin assessment. Agenda items were not standardised and incidents appeared as an item in only one of three sets of minutes.
- We heard that during an IT outage that took place prior to our inspection, the incident reporting system was unavailable and staff had to record incidents manually. Theatre staff expressed concern about whether these incidents had been followed up by managers, as they were unaware of any outcomes of investigations.
- Theatre staff told us that they learnt about incidents at their daily morning briefing. We observed a briefing take place and saw that all theatre staff attended. Staff were reminded to report any issues with surgical instruments as an incident. The session was fully interactive with all staff being encouraged to contribute and given the opportunity to raise issues.
- We saw examples of where staff had applied the principles of the duty of candour. The duty of candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. One ward

manager explained the trust process and showed us an example of a letter they had written to apologise to a patient and their family where the patient had developed a pressure ulcer.

- We were told that all patient deaths were reviewed at a monthly mortality and morbidity meeting. However, as the trust did not provide us with any minutes of meetings, it was unclear which staff attended these meetings or how lessons learnt were recorded and shared. We did see evidence that orthopaedics and ENT specialities held regular audit sessions to review patient cases but it was not clear where outcomes of these sessions were recorded.

Safety thermometer

- The NHS Safety Thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to patients, such as new pressure ulcers, catheter and urinary tract infections, falls with harm to patients and Venous Thromboembolism (VTE) incidents. Safety Thermometer data was available on safety cross boards located at the entrance to each ward. Staff updated these daily to demonstrate the number of days of harm-free care. The results of environmental and hand hygiene audits were also displayed on these boards, along with key metrics such as the numbers of cardiac arrests.
- Data from the NHS patient safety thermometer showed that the surgical service at Whipps Cross Hospital reported 25 new pressure ulcers, three falls with harm, 12 new catheter urinary tract infections and four VTEs between May 2016 and May 2017.
- The trust’s VTE screening target was 95%. Staff were required to complete both paper-based and electronic assessment records. During our 2016 inspection, we found that compliance with VTE screening was poor across all wards and none of the wards met the required target for completion.
- Data provided by the trust for the period April 2016 to May 2017 showed overall monthly VTE screening rates on surgical wards varied between 75% and 86%, which was consistently below the trust’s target of 95%. Individual wards varied greatly in their monthly performance, with Plane Tree ward scoring 100% consistently, and other wards scoring as low as 27% in some months. Three wards, Rowan, Sage and Sycamore scored consistently under 70% for the 12-month period captured.

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- The trust also provided us with its VTE improvement trajectory document (dated May 2017) which set out how the hospital planned to meet its 95% target by April 2018. An upgrade to the electronic patient record system was planned for shortly after our inspection. This would provide a visual prompt every time the patient record was accessed, reminding staff to complete or update the patient's VTE assessment. This system had proved successful in improving compliance with VTE assessment at another hospital within the trust.
- Patients at risk of falls were usually allocated a health care assistant (HCA) to provide one to one care, although staff told us this did not always happen due to staff shortages. The trust told us they had introduced 'enhanced care' to the wards, with the aim of involving patients' families directly in patients' day-to-day care. Primrose ward was one of the pilot wards for 'enhanced care' and the ward manager said they had had no falls on the ward for over four months.
- We saw that information relevant to skin assessments, pressure ulcers and falls risks were communicated between staff at handover. Ward meeting minutes we saw included discussions and reminders on basic practices for the prevention of pressure ulcers.

Cleanliness, infection control and hygiene

- During our previous inspection, we found that surgical site infections (SSIs) were not being effectively monitored or reviewed. An SSI is a type of healthcare-associated infection in which a wound infection occurs after an invasive (surgical) procedure. During the 2016 inspection, we found the SSI data collection was substandard due to a number of reasons, including poor follow-up of patients after discharge. During this inspection we found SSI data collection and monitoring had not improved.
- Service leads told us that SSI data was being collected and submitted to the national database for elective hip and knee procedures as required by Public Health England (PHE). However, theatre staff told us that SSI data was not yet being collected but there were plans in place to introduce a new staff post to take responsibility for this. We saw that there were surveillance sheets for elective patients that were used to record any post-surgery infection but that this was not followed up when the patient left the hospital.
- The hospital's SSI protocol set out how SSI data should be collected and submitted for elective orthopaedic

patients. The protocol stated that patients should be given a post-discharge questionnaire by the discharging ward. The trust provided us with copies of PHE's SSI surveillance reports from January 2016 to December 2016. The trust had submitted data for 132 elective knee operations and 73 elective hip operations during this period and reported no SSIs. However, none of these patients were recorded as being provided with a post-discharge questionnaire, demonstrating that follow-up procedures were not being adhered to.

- After our inspection, the trust provided further information on the hospital's SSI review process, which we were told had been in place at the time of the inspection. However, from the information provided we identified only three patients had received a follow-up review at the time of the inspection. Therefore, this process was very new and not well embedded.
- Senior staff told us Sycamore ward was dedicated to emergency orthopaedics and Sage ward was for elective (planned) orthopaedics patients. During our previous inspection, we found that Sage ward had a mixture of elective and emergency orthopaedic patients, as well as medical patients and patients from other specialities. This was not best practice as it potentially increased the elective patients' risk of infection. During our inspection, we saw that a standard operating procedure (SOP) had been introduced in April 2017 to ensure safe care for patients undergoing orthopaedic surgery, in line with the British Orthopaedic Association (BOA) guide to good practice (2006). The BOA guidance recommends that all elective orthopaedic patients should be nursed in dedicated elective orthopaedic wards, in order to ensure that the risk of cross-infection is kept to a minimum. Service leads told us that there had been one breach of this SOP since it had been introduced, where an elective patient from another surgical speciality had been admitted to the ward due to bed pressures. However, service leads said this was a one-off exception and the matron told us that the risk of cross-infection had been minimised by identifying a suitably low-risk patient for admission to the ward.
- We observed most wards, recovery areas and operating theatres were clean and tidy. All staff and the majority of patients we spoke with told us the cleanliness on the wards was good. Staff used green 'I am clean stickers' to show that equipment was clean. The majority of equipment we checked was clean. However, we saw that some items of equipment were dusty, despite being

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labelled as clean and ready for use. For example, we saw that the anaesthetic machine in theatre 3 had an 'I am clean' sticker, dated 10 February 2017 (three months previous), which had visible dust around the bottom. We also saw that several equipment trolleys in theatres had visible low-level dust.

- We observed a number of infection control issues relating to the operating theatre environment, including loose and exposed plaster on the theatre walls and damaged flooring. These issues were mainly in theatres 3, 4, 5, 6 and 7. We saw damaged, stained flooring and skirting coming away from the walls in theatres 6 and 7. In theatre 5, we saw damaged ceiling tiles with visible holes and gaps. In multiple theatre locations, we saw cracked or damaged walls, with plaster visible or peeling, and damaged doorframes. We also saw three stools with ripped covers. Numerous items of equipment we checked had some rust, including bins, a hand wash-holder, trolleys and a storage unit. This did not meet the Department of Health's standards set out within health building note (HBN) guidance HBN 00-09 'Infection control in the built environment'. We saw that theatre refurbishment was recorded on the service's risk register however only theatres 3 and 4 had been identified as non-compliant with required standards.
- Not all theatre areas had records of daily cleaning checks. For example, we reviewed six weeks of records for theatre 3 and found six dates when there was no recording of daily cleaning. In theatre 7, we found the daily cleaning record had only been completed once in the 10 days prior to our inspection. A theatre practitioner confirmed that staff should have completed the record daily.
- The trust provided evidence that all theatres areas had received a clinical 'deep clean' within the previous 12 months. Certificates showed that an external provider had carried out the deep cleaning for all theatre areas in July and August 2016. This was in line with the minimum NHS standard, but not with best practice recommendations as the per association for perioperative practice (AfPP) states theatre deep cleaning should take place every six months. We asked the trust to provide evidence of any deep clean audits carried out to review the quality of the cleaning but these were not provided.
- Hand washbasins and alcohol hand sanitising gel were easily accessible at ward and theatre entrances and the hand gel was available by each bed. Instructions for

their use were clearly displayed next to, and on, the soap/ alcohol dispensers. We saw there were posters at the entrance to each ward reminding staff to clean their hands before entering the ward. All nursing staff we observed adhered to the hand hygiene policy and cleaned their hands directly before and after any patient contact. We saw that staff wore appropriate personal protective equipment (PPE), including gloves and aprons, when required. Waste bags were clearly identified with all relevant information including date, theatre, and case number in line with association for perioperative practice (AfPP) recommendations for safe practice.

- We observed some staff did not adhere to the infection prevention standards and protocols. Across two wards, we observed seven doctors on the ward who were non-compliant with the hospital's 'bare below the elbow' (BBE) and hand hygiene policies. Doctors wore long sleeved clothing and watches or other jewellery and did not stop to clean their hands as they entered the ward. We did not see staff on the ward challenge this behaviour.
- We saw a number of theatre staff moving around the hospital, including non-clinical areas, in theatre scrubs and clogs without overcoats. The hospital's uniform policy stated that staff must wear an overcoat to reduce the risk of infection for patients having surgery. We were told that an order of overcoats had been requested but had not arrived.
- On Primrose ward, we saw a door to a side room where an infectious patient was being barrier nursed had been left standing open despite the sign on the door stating the door must be kept closed. Barrier nursing is necessary to prevent the spread of potential infection and involves a patient being nursed in a separate bay with extra precautions being taken by staff.
- We reviewed the trust's isolation and management of infectious diseases policy and found that it had not been reviewed since it had been approved in October 2013. The policy stated it was due for review in October 2016.
- A senior infection prevention and control (IPC) nurse said that the level of involvement of the IPC team on the wards had improved and that there were daily visits to each ward to review any patients with infections. We

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were told that each ward had an IPC link nurse who supported ward staff with IPC. However, not all nursing staff on the wards could tell us who the IPC lead or link nurse was.

- The IPC team carried out bi-annual IPC audits on wards. Audits reviewed the general condition and cleanliness of the environment and equipment as well as testing staff knowledge and understanding of infection control. Four wards had recently been audited in April and May 2017 and compliance varied between 51% (Poplar ward) and 89% (Sage ward). Some ward did not appear to have regular audits as Poplar ward was last audited in July 2016 where they had scored 87%. Primrose and Rowan wards had also not been audited for 12 months prior to this recent audit. Common areas for improvement were dirty floors, damage to walls and fixtures dirty and/or damaged equipment. On Poplar ward, the hand basins did not meet regulation standards due to limescale build up. The audit report also identified that many staff on the ward were either bank or agency and were unaware of infection control protocols. Action plans for areas for improvement escalated issues to estates or the cleaning contract provider where appropriate however many timeframes were recorded as 'ASAP' and it was not clear how actions were being monitored. Audits had not been carried out for theatres, pre-assessment or the eye treatment centre.
- Staff were required to complete a yellow transfer form which clearly identified any infection control issues for each patient. One ward manager told us that although the transfer form was currently just being trialled for patients transferred from the acute assessment unit (AAU) it had helped improve communication between teams. We saw evidence that the IPC team were monitoring compliance and had plans to audit the transfer process in July 2017.
- The surgical service had no reported cases of MRSA between April 2016 and March 2017. The trust policy stated that patients should be screened for MRSA within 24 hours of admission. MRSA screening rates on surgical wards varied between 30% and 100% for the period of April 2016 to March 2017.
- For the same period, there were three cases of Clostridium Difficile (C. Diff).
- The hospital's monthly infection prevention control audits, which included hand hygiene and catheter care, did not always take place on surgical wards. Information provided by the trust for April 2016 to March 2017

showed that all surgical wards were missing data for at least two months, with Plane Tree ward missing hand hygiene data for four out of 12 months and no data provided at all for Hope ward. The results showed that when audits did take place, most wards achieved the trust's target of 90%. However, Primrose ward scored below the trust's target in nine out of 10 catheter care audits (scoring 70% on seven occasions) and on five out of 10 hand hygiene audits (scoring 80%). Rowan ward also fell below the trust target on five out of 10 occasions for catheter care (scoring between 63% and 80%).

- Information about infections and IPC audit results were displayed on most wards for staff and visitors.

Environment and equipment

- Resuscitation equipment was available for emergency use on wards and in theatres. We saw that resuscitation trolleys were appropriately stocked and there was evidence that staff performed daily checks.
- All sharps bins we checked in wards and theatres were appropriately assembled, labelled and not overfilled.
- We found that the wards, although clean, were in need of refurbishment. We saw damaged walls, flooring, doors and noticeboards across a number of wards. Senior managers told us this was on the hospital's risk register and that there were plans for refurbishment however, we did not see evidence to support this.
- We found that some theatres were non-compliant with the department of health standards set out within HBN 26 'Facilities for surgical procedures in acute general hospitals.' For example, we saw that the flooring in theatre 7 was heavily stained with cracks in the surface and a large area opposite the scrub trough was coming away from the wall. In theatre 5, we saw damaged ceiling tiles with visible holes and gaps, outside the anaesthetic room. In both theatres, we saw damaged doorframes and walls with damaged or exposed plaster. We saw three stools, in three different theatre areas that had a damaged covering exposing internal foam.
- Staff told us that many items of theatre equipment was old and needed to be replaced. We saw that 17 of the 19 theatre-specific risks on the hospital's risk register related to old and in some cases obsolete, equipment that was at risk of failing potentially putting patient safety at risk.
- Lack of appropriate servicing and maintenance of theatre equipment had been on the hospital's risk

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register since 2014. Many items of equipment were no longer being maintained under an external service contract and there was no service plan in place to ensure all equipment was serviced within appropriate timescales. The hospital's medical engineering team taken over responsibility for equipment maintenance. Data provided by the trust showed that servicing targets were not being met and as at 1 June 2017, only 67% of theatre equipment had been serviced. Equipment not serviced included 31 'high-risk' items.

- The service had 15 anaesthetic machines that were eight years old and some were failing their daily safety checks which was resulting in delays. This risk had been added to the risk register in October 2016. To mitigate the risk to patient safety staff were required to complete daily safety checks of all anaesthetic machines. We checked between six weeks and three months of records for eight anaesthetic machines and found there was no record of staff completing these checks on numerous dates, on up to 22 occasions for two machines. We were told that this was because not all theatres were used at weekends. Although some of these dates were weekends, the logbooks did not record the theatre as closed. This did not meet national safety guidelines.
- Storerooms we checked had an adequate stock of sterile instruments and consumables. However, we found out-of-date equipment in theatre 5, including nine epidural syringes which expired in February 2017 and seven blunt drawing up needles which had expired in April 2017. We also saw three out-of-date spinal needles, two of which had expired in 2016.
- In the same theatre, we saw that some equipment including a freestanding O2 cylinder and a patslide were stored inappropriately on the floor, which was not best practice.
- Staff in theatres told us about problems with the instrument decontamination service, which had recently been outsourced to an external company used by the rest of the trust. Three theatre practitioners gave multiple examples of where instrument trays had arrived missing instruments or set out incorrectly. The theatre matron told us that this was a serious issue for the surgical service and that they met regularly with the decontamination lead to review the situation. Senior managers told us this was on the risk register and we saw that all staff were reminded to report any issues as incidents. Data provided by the trust between June 2016

and May 2017 showed that 11 incidents related to the instrument decontamination service. This was inconsistent with the scale of issue described by theatre staff and therefore it was unclear whether staff were always reporting their concerns as incidents. Although "disruption to the provision of sterile instrumentation and consumables" was on the hospital's risk register, there was no record of review since it was added in August 2015 and no documented controls in place to mitigate the risk to patients.

- We observed that theatre staff performed a visual and verbal instrument count, as per association for perioperative practice (AfPP) recommendations for safe practice. However, we saw there were some inconsistencies between teams and staff engagement and communication was better in some teams than others.
- On surgical wards, we found that handwashing sinks for staff did not comply with aseptic non-touch technique (ANTT) standards. The design of some sinks made it almost impossible for staff to turn the taps on without using their hands. This did not meet the Department of Health's standards set out within health building note guidance HBN 00-09 for 'Infection control in the built environment' which states, 'taps should be easy to turn on and off without contaminating the hands'. 'Swan-neck' taps are not recommended as they do not empty fully and can lead to bacterial growth.
- We found that the size and layout of bathrooms on the wards made it difficult for patients with walking aides to access and use the facilities. The bathrooms would not have been suitable for bariatric patients.
- We asked the hospital for the annual maintenance and revalidation checks of operating theatres ventilation. The trust provided us with the annual maintenance schedules which set out the dates maintenance checks for each theatre were carried out. However, it was not clear what the outcomes of these checks were as the trust said that records were not available. Although we did not have any concerns regarding the ventilation during the inspection, we were not provided with the evidence to assure us the ventilation was safe for patients undergoing surgical procedures. This issue was raised in our 2016 inspection report however; the trust did not appear to have taken any action to address this.

Medicines

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- We observed drugs management, administration and disposal was generally good across all clinical areas. Medicines were stored securely and appropriately across wards and theatres.
- All drugs fridges we checked were securely locked. There was evidence staff carried out and recorded daily temperature checks. All drugs we checked were in date.
- Controlled drugs (CDs) were securely stored in locked cupboards. Daily checks were double signed by two qualified nurses. We checked a sample of CDs and confirmed these tallied with amounts recorded in the CD register.
- In some theatres, we found that controlled drugs (CDs) were only checked once a day rather than twice. For example in theatre 4, we reviewed ten weeks of records and saw four occasions where the CDs had only been checked in the evening by staff.
- All nursing staff we spoke with were aware of policies on administration of controlled drugs as per the Nursing and Midwifery Council (NMC) standards.
- Staff told us that there were some issues with obtaining discharge medications and that this often resulted in patient's discharge being delayed. Staff said this was due to staffing problems within the pharmacy team. We did not see any evidence that discharge medications were audited to review reasons for any delays.
- We reviewed 39 prescription charts and found that all prescriptions, aside from one, had been appropriately signed and dated. For one patient, antibiotics had not been signed for on administration. However, this had been picked up by the pharmacist who had reported this as an incident. We found that all charts had been completed legibly, with any patient allergies documented.
- Each bay of beds had their own dispensing trolley, so the nurse in charge of each bay dispensed the drugs for those patients. The drug trolleys we saw were well organised, clean and tidy. They were kept securely in the locked treatment room when not in use. However, we saw there was no system in place to indicate to staff that a nurse was busy dispensing drugs. This meant that staff often were interrupted during a drugs round.
- During our previous inspection, we found that some treatment rooms were too warm. During this inspection, we found the treatment rooms appeared well ventilated and the room temperatures were within range but there was no evidence that the room temperature was being monitored.
- The trust pharmacy team carried out a quarterly 'safe and secure handling of medicines' and controlled drugs audits. The November 2016 report showed that a high occurrence of controlled drugs entries altered, obliterated, erased were found particularly on Primrose ward. Fridge temperatures were not always recorded and storage areas were not always secure. Rowan ward was the worst performer in this area. The report had commented that clinical areas had a low proportion of agency staff performed better than areas where temporary staff use was higher. The report was discussed at the trust's Quality & Patient Safety Group as well circulated to senior managers to share with ward staff. The governance pharmacist planned to attend safety huddles to highlight ward failings.

Records

- We found that patient records were not always stored securely in line with information governance standards. On four out of seven wards, we found the medical notes trolleys or cupboards were unlocked and therefore patients' records were not secured. On one ward, we saw that an access card was left in a computer. This could have potentially enabled an unauthorised person to access confidential information. We brought this to the ward manager's attention, who immediately addressed this.
- We reviewed 21 patient records across five surgical wards. We found the majority of records were clearly written and dated, with legible signatures. Most of the patient records were comprehensive, thorough and recorded evidence of input from nurses, doctors and other allied health professionals. Patients had their care needs risk assessed and appropriately recorded, with risk assessments completed including falls prevention, acute pain management and skin bundle. However, we found that four records (out of the 21 reviewed) did not contain evidence of a nutritional risk assessment.
- The hospital's nursing documentation audit for April 2017 showed that Poplar ward achieved 69% and Sage ward achieved 76% against the trust's 100% target. Other surgical wards were not audited. The audit report stated that wards achieving less than 80% would be required to complete an improvement plan but we did not see evidence of this. Areas of poor performance included: lack of documentation of evidence of patient or family involvement in care, and poor documentation of discharge planning.

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- The previous documentation audits for December 2016 showed that surgical wards achieved between 63% (Sage) and 88% (Sycamore), and for August 2016, between 60% (Rowan) and 89% (Sycamore and Poplar). The August 2016 audit stated that senior nurses would develop improvement plans to improve compliance. However, these improvement plans were not referred to in later audits.

Safeguarding

- Safeguarding adults level 1 and 2 training was completed online and repeated every three years. All nursing and medical staff were required to complete level 2 safeguarding children training, while senior staff were required to complete safeguarding children level 3 training. The trust's target was 90% completion for all staff.
- Safeguarding training data provided by the trust showed that overall compliance for all staff within the surgical service, with all required safeguarding training, was at 86%, which did not meet the trust target. Compliance with safeguarding adults level 1 met the target at 92% whilst level 2 adults training fell below at 75%. Similarly safeguarding children level 1 was at 95% with level 2 falling below at 85%. Only a small number of senior staff (12) were required to complete level 3 children's safeguarding training however less than half (5) had done so.
- Overall, surgical nursing staff completion rates were 90%, which met the trust's target. However, on individual wards training compliance varied. Sycamore and Plane Tree wards met or exceeded the target for all safeguarding modules however, Primrose and Sage wards did not meet the target for nursing staff compliance for either children's or adults safeguarding training level 1 or 2. The training module with the lowest compliance for these wards was safeguarding adults level 2 where on Primrose ward only 57% of staff had completed this. On Rowan ward only 67% of staff had completed safeguarding children level 2 and 60% had completed safeguarding adults level 2, although 93% of nursing staff on this ward had completed level 1 for both children and adults.
- Overall theatre staff were 96% compliant with all safeguarding training with only safeguarding adults level 2 at less than 90% for both additional clinical services staff (81%) and nursing staff (88%).

- Overall compliance for medical staff did not meet the trust target at 86%. Compliance varied between the different safeguarding training modules with the lowest compliance with safeguarding adults level 2 with 72% (85% had done level 1). Compliance varied between different specialities with only 43% of orthopaedic staff having completed it whilst 95% of junior doctors and 83% of anaesthetists had done so. Compliance with safeguarding children level 1 was better at 96%, however only 85% had completed level 2 and just 47% required to completed level 3 had done so.
- Staff we spoke with were familiar with the safeguarding arrangements and could give examples of safeguarding incidents which had been reported. However, some ward staff told us that they did not often hear about incidents and were not aware of incidents that had taken place in other parts of the hospital.

Mandatory training

- Overall compliance with mandatory training across all staff groups within the service fell just below the trust's target of 90% at 88%.
- Training was provided to staff through e-learning or face-to-face classroom training. Mandatory training covered a range of modules including safeguarding, medical gas safety, medicines management, nutritional care, information governance and dementia training. We found that staff compliance with training fell below the trust's target rate for most modules however, compliance rates varied between modules and staff groups.
- Although we saw good completion of some training including blood transfusion (96%) and consent (90%), overall compliance for most modules fell below the trust's 90% target. Clinical documentation, moving and handling and equality and diversity training were all just below the target at 89% followed by fire safety (88%), privacy and dignity (88%) and emergency planning (87%) and dementia training (87%).
- Mandatory training also included training on VTE, falls, pressure ulcer prevention and catheter acquired infections known as '4 Harms' training. Overall, 91% of nursing staff had completed this training. However, compliance varied between wards with 71% of nurses on Primrose ward and 80% on Poplar ward having done so.
- Training with the poorest compliance rates included medical gas safety training, where 75% of staff had

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completed this. Of nursing staff, 80% had completed medical gas safety training and 82% had completed medicines management training. However, performance between wards varied with only 40% of nurses on Rowan ward, 53% on Poplar ward and 55% on Plane Tree ward having completed both these modules.

- Infection prevention and control training had also only been completed by 75% of clinical staff. Again, although overall 79% of nurses had done this training, compliance on wards varied with only 40% nurses on Poplar ward, 47% on Rowan ward and 55% on Plane Tree ward having completed this.
- Nutritional care training had been completed by 91% of nursing staff however; some wards fell below target with 71% on Primrose ward and 73% on Poplar ward. Similarly, for information governance, training overall 92% nurses had completed this however; rates were lower on some wards Poplar and Primrose at 73% and 76%. Also only 79% medical staff had completed this training.
- Overall staff training rate on the early warning system used by staff to identify deteriorating patients was at 88% with 91% nursing staff had completed this. However, compliance varied between wards, with Sycamore at 95% and Plane Tree at 90% whilst Primrose and Poplar fell below target at 71% and 73%.
- Two junior members of staff on one ward said they did not get dedicated time to complete training and had to try to complete it during a shift, or in their own time. Most other staff said they felt supported by their managers and were given time to complete training.
- There was a local induction programme for newly appointed staff. New agency staff had to complete an induction, which included orientation and introduction to the environment. There was a local induction checklist for agency nurses that had to be completed before they started their shift. We saw written evidence of this.

Assessing and responding to patient risk

- The hospital used the national early warning score (NEWS) to identify deteriorating patients. This is a basic set of observations such as blood pressure, respiratory rate, oxygen saturation, temperature and pulse rate, which are then used to calculate a score indicating the severity of a patient's acute illness.

- The chart used to record the score had set parameters for each observation and clear instructions as to what action staff should take based on the patient's score. A NEWS score of five or above required staff to immediately escalate the patient to a doctor.
- We reviewed 21 patient records across five surgical wards and found that for the majority of patients the NEWS had been correctly calculated and any appropriate actions had been taken. However, on Sage ward, we found two patients whose score had been inaccurately calculated so that the scores were artificially higher than they should have been. Despite this, there was no record of any action taken by staff to escalate the patient, or to correct or explain the miscalculation. There was also no evidence that either patient had been reviewed by a doctor since admission to the ward, after their surgery over 12 hours previously. We brought this to the attention of the matron, who was unable to provide an explanation, but said that they would address the issue with staff on the ward.
- The hospital carried out a monthly audit of NEWS to measure staff compliance the trust's policy for identifying and escalating a deteriorating patient. The trust's target for compliance was 80%. Monthly data provided by the trust for November 2015 to December 2016 showed performance varied from 67% to 96% between months and wards. Rowan ward failed to meet the target eight out of thirteen months whilst Sage ward met the target in all but one month. From January 2017, the monthly NEWS audit was also carried out at night to measure staff compliance during the night shift. Data provided by the trust for between January and March 2017 showed that the majority of wards were now meeting the target during both day and night audits. However, the audit data identified that patients did not always have an individual monitoring plan and this did not appear to be improving. We did not see any action plan which set out how this was being addressed.
- Nurses carried out intentional rounding on the wards, visiting each patient hourly to check on them. We saw this documented in patient records and patients confirmed they were visited regularly by staff to ask if they needed anything.
- Sepsis teaching sessions had recently been delivered to staff to improve staff confidence in identifying and escalating patients with suspected sepsis. The sessions were available to all nursing staff and HCAs. However, attendance was low at only 17% (29 staff). Staff who

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attended gave positive feedback on the sessions. The trust told us that no sepsis audits had taken place within surgery at Whipps Cross University Hospital in the last 12 months. Therefore, it was not clear how the service monitored whether patients with suspected sepsis were provided with evidence-based care and treatment.

- Theatre staff took the appropriate safety checks before, during, and after surgery. These included the use of the World Health Organisation (WHO) surgical safety checklist. This checklist was developed to reduce errors and adverse events, and increase teamwork and communication in surgery. We saw that the four initial stages of 'team brief', 'sign in', 'time out' and 'sign out' were generally completed to high standard. We observed several procedures where these checks were thoroughly completed with all staff engaged appropriately in the process. We also saw some examples where the process felt rushed and staff did not seem fully engaged. We observed that surgeons did not always stay for the final 'debrief' check at the end of the theatre list.
- We observed that an appropriate modified WHO safety checklist was used by staff for ophthalmic procedures.
- Results from the monthly WHO safety checklist audit for February 2017 were 100% for both the main and eye theatres. These were based on between 40 to 80 audit checks in eye theatres and 94 to 100 in main theatres. For April 2017 eye theatres was 100% and main theatres was 100% except for the 'debrief' at 97% and the 'team brief' at 98%.
- The majority of surgical patients were pre-assessed by the nurses that ran the pre-assessment centre. These patients were assessed either on the phone, or in person. After the assessment, the notes were provided to the ward staff. We observed the forms that these nurses used to conduct a pre-assessment and found them to comply with the National Institute for Health and Care Excellence (NICE) guidelines
- We observed good standards of practice at induction of anaesthesia, with pre-induction checks, monitoring and anaesthetic agent induction completed in line with the national standards.
- We saw that (as we found at our previous inspection in July 2016), theatre recovery was being used inappropriately to look after critically ill patients overnight. A new high dependency unit (HDU) with eight beds had recently been opened and senior managers told us that this had reduced the number of HDU

patients being cared for in recovery. Data provided by the trust showed that between April 2016 and March 2017, 166 patients experienced an overnight stay in recovery. Of these, some patients were identified as requiring a HDU (15) or ITU bed (eight). This was a reduction from 52 patients reported by the trust as requiring either a HDU or ITU bed during the previous year. Staff told us that anaesthetist support was available in recovery at all times.

- Information provided by the trust showed that 22 out of 32 theatre practitioners had completed adult basic life support (BLS) training and 20 had completed intermediate life support training (ILS). Eight individuals had not completed either training course, although four of these were new starters awaiting training dates.
- All anaesthetic consultants had completed advanced life support training.

Nursing staffing

- The association for perioperative practice (AfPP) safe staffing guidelines were used to determine safe staffing levels in the perioperative environment. The AfPP guidelines recommend a minimum of two scrub practitioners, one circulating staff member, one anaesthetic assistant practitioner and one recovery practitioner for each operating list. We observed three operating lists and found them all to comply with AfPP standards
- During our previous inspection, we found the use of agency staff on some of the wards was as high as 50-70%. During this current inspection, we saw high vacancy levels and challenges to recruitment meant that some wards were still relying heavily on temporary staff. One ward manager told us that agency staff made up over 50% of their staffing rota on regular basis.
- Data provided by the trust for between May 2016 and March 2017 showed that monthly agency and bank staff use on general surgery wards varied between 27.6% and 38.5%. The most recent data provided for March 2017 showed the rate at 37%. Although this showed improvement from the previous 12-month period, (where agency/bank staff use was at 45.1%) these figures were still very high compared to the trust average (9.4%) and the national average (5.8%). On orthopaedic wards, the use of temporary staff varied between 16.6% and 33.7% for the same period. This also

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showed improvement as this had been 54.3% between April 2015 and March 2016 but again was still high compared to the trust average (9.4%) and the national average (5.8%).

- In theatres, the rate of temporary staff use was lower varying between 13.9% and 19.6%, with a rate of 18.8% for March 2017. However, this was an increase on the previous 12-months where the average agency/bank use in theatres was 12.4%. The trust told us that was partly due to additional theatre activity being undertaken at weekends in order to address access waiting list requirements and not due to increased vacancies in theatres.
- As at 31 March 2017, there were 56.23 whole time equivalent (WTE) nursing vacancies within the surgical services, this equated to a 19% vacancy rate. The trust's target vacancy rate was 5%. Nursing vacancy rates varied between specialities. General surgery had a nursing vacancy rate of 22.3% (14.36WTE nurses), ophthalmology 30% (8.9WTE), orthopaedics 17.23% (8.37WTE), pre-assessment 20.2% (5.91WTE) and theatres 15.5% (16.5WTE).
- Senior managers told us that measures had been put in place to support wards with high agency staff usage, including temporarily moving permanent staff over from other wards.
- We saw that the matron and associate director of nursing (ADoN) visited wards each morning to identify and address any staffing issues.
- Each ward had a supernumerary band 7 ward manager, or a band 6 junior ward manager to cover this role. Ward managers carried out weekly risk assessments to assess patient acuity and review staffing levels. Ward managers told us that all agency staff received an induction and orientation to the ward.
- Poplar ward was allocated as a short-stay ward with 29 beds. However, established staffing levels were only for 15 beds. Previously, 14 beds had been closed to accommodate pre-assessment for day case patients, but this had been relocated back to Hope ward and all 14 beds had re-opened. Staffing levels had not yet been re-established for this increased number of beds. The ADoN told us that there were plans to recruit more permanent staff. However; at the time of our inspection, the ward was heavily dependent on agency staff to fill shifts. The ward manager told us that although they had received support from senior managers, for example, being able to pre-book one agency nurse in advance, it

was still very challenging to ensure all shifts were filled. We also heard that some agency staff could be unreliable and sometimes cancel at short notice or just not arrive for their shifts.

- Data provided for the trust for May 2016 to May 2017 showed that there were a total of 675 unfilled nursing shifts on surgical wards, which totalled 5.3% of all requested shifts (12,623). In theatre areas, this was higher at 7.5% (307 unfilled of 4,073 requested shifts).
- Staff told us that the quality of the skills and abilities of agency staff who worked on surgical wards was variable. Staff said that dependency of some wards on agency staff was having a negative impact on the standard of care received by patients. For example, we were told that skin assessments were not always carried out appropriately by agency staff which put patients at increased risk of developing pressure ulcers. We saw that concerns about the impact of high numbers of agency staff on night shifts were recorded in governance meeting minutes we reviewed. This risk was acknowledged by senior managers we spoke with, however it was not recorded on the hospital's risk register.
- Morning and evening handover at shift change for all nursing staff was either in the staff room or at each patient's bedside. We observed two handover meetings and found that they were focused and relevant and that risks to patient safety were highlighted and reviewed. Staff discussed each patient in detail, and care plans, treatment and plans for discharge were reviewed. Staff demonstrated a good knowledge of their patients.
- Ward managers told us about a monthly forum held by the matron and ADoN where issues such as staffing, serious incidents and complaints were reviewed and discussed. Ward managers said they felt confident raising concerns and issues.

Surgical staffing

- During the day, the wards were covered by junior and middle grade doctors. They were supported by an on-call middle grade doctor and a consultant to cover and support the inpatient wards for their speciality. During the inspection, we saw that staffing levels and skill mix within theatres met AfPP recommendations for safe perioperative practice.
- On-site consultant cover was provided during the day, five days a week, as well as an on-call service out of hours and at weekends. For general surgery and

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orthopaedics/trauma, a 'consultant of the week' provided on call and out of hours surgical cover. The consultant of the week had their elective commitments cancelled during any on-call period. Other surgical specialities provided a 24/7 consultant rota supported by a middle-grade doctor. All acute and emergency surgical patients were reviewed within 24 hours of admission.

- Daily consultant led ward rounds of all emergency admissions and acute patients took place seven days a week.
- We spoke with four junior and middle grade doctors about surgical cover at night and they told us that on-call support arrangements had significantly improved since October 2016. We were told that the senior clinical leadership team had addressed the needs of the on-call team to ensure that safe care was now being provided to all patients out of hours and at weekends. New rotas had been introduced and on-call sub-speciality teams were now working closer together to support each other. We heard that communication had improved and on-call teams were more easily contactable.
- We were told that surgical staff did not attend the evening hospital-wide bed management meetings and instead held their own separate handovers.
- We attended the surgical evening handover for general surgery and found it to be efficient and thorough. We were told that each speciality had their own separate handover, although we did not see where these took place. Doctors we spoke with were unaware of the hospital-wide bed management meeting.
- The recovery area was staffed at night by one member of recovery staff, helped by theatre staff and the on-call team if needed. There was an on-call rota for anaesthetists in the event of a return to theatre and the on-call anaesthetist was responsible for providing out-of-hours cover for the recovery area.
- Vacancy rates varied between different surgical specialities but were particularly high for orthopaedics (30.4%/9.75WTE) and general surgery (28.3%/11.77WTE). However, this was much lower for anaesthetists at 2.7% (1.62WTE).
- We saw that staff had raised concerns regarding the lack of surgical staff at weekends. There was a concern that the inpatients were not receiving safe care at the

weekends due to the current level of staffing. This had been added to the hospital's risk register in March 2017 but it was not clear what controls were in place to address this risk.

Major incident awareness and training

- We saw the trust had a major incident plan that had been recently reviewed in April 2017. As well as the general hospital plan, the general surgery and urology services had their own business continuity plan that had been reviewed in May 2017. Theatres also had their own business continuity plan which set out actions required to respond to a major emergency to reduce where possible the impact on the service.
- Mandatory training was provided to all staff on fire safety and emergency planning; however, compliance for the 12 months prior to our inspection fell short of the trust's 90% target, with 88% and 87% of staff having completed the two training modules.

Are surgery services effective?

Requires improvement



We rated effective as **requires improvement** because:

- Patients did not have access to an enhanced recovery programme.
- We did not see evidence of how national audit results were being used to drive local improvement programmes. The trust did not provide us with any action plans to demonstrate how national audit results were responded to.
- Not all patients were screened for malnutrition as required by NICE guidelines. MUST compliance rates for surgical wards were still consistently below the trust target of 95%.
- The hospital's performance in the 2016 Hip Fracture Audit was mixed. For five measures, the hospital performed significantly worse than the national average and fell within the lowest 25% of all trusts. Performance against four of these five measures was also worse than the result for 2015. However, for three key measures performance was comparable or better than average.
- In the 2016 National Emergency Laparotomy Audit (NELA) the hospital submitted a very small sample size

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of only 12 patients that represented only 8% of eligible patients against the national standard of 80%. However, we saw that work was underway to improve data capture and submission to the NELA audit.

- Both non-elective and elective urology and elective ophthalmology had a higher than expected relative risk of readmission. This meant following surgery patients were at a slightly higher risk of being readmitted than in other hospitals in England.
- Staff told us that frequent issues with the IT systems often caused delays.
- The service did not meet NHS England's seven-day services priority standards for time to first consultant review. Vacancies in the occupational therapies and pharmacy teams impacted on service delivery and caused delays for patients.
- Not all staff received an annual appraisal, appraisal rates were varied between 56% and 77% for different groups of surgical staff.
- Poor communication between some teams and clinical areas created challenges to effective multidisciplinary team (MDT) working.
- Substantive nursing staff were concerned about agency staff competencies.

However:

- Clinical guidelines and policies were developed and reviewed in line with the National Institute for Health and Care Excellence (NICE), the Royal Colleges and other relevant bodies
- Patients' pain was assessed and well-managed and ward staff had access to support from a specialist pain team.
- In the 2016 NELA, the hospital performed within the top 20% of hospitals nationally, for three out of five measures. These included pre-operative documentation of risk of death, access to theatres within clinically appropriate time frames, and admission to critical care post-operatively. The hospital met or exceeded the national standard in each case
- Daily MDT board rounds took place on wards with input from range of allied health professionals.

Evidence-based care and treatment

- Patient records we reviewed showed patients' care and treatment was planned and delivered in line with evidence-based guidelines.

- Clinical guidelines and policies were developed and reviewed in line with the National Institute for Health and Care Excellence (NICE), the Royal Colleges and other relevant bodies. Policies and protocols were available on the hospital's intranet. Some wards also kept hard copies of protocols so that staff were able to access these in the event of IT downtime. Staff we spoke with knew how to access these policies and local procedures.
- All policies we reviewed had a document owner, a date of approval and a date for review. Most policies we looked at were within their review date. However, we saw the trust's isolation and management of infectious diseases policy had not been reviewed since it had been approved in October 2013. The policy stated it was due for review in October 2016.
- The hospital used the national early warning score (NEWS) to identify deteriorating patients. This was monitored in line with National Institute for Health and Care Excellence (NICE) guidance CG50 'Acutely ill-patients in Hospital.'
- Safety guidelines from the association of anaesthetists of Great Britain and Ireland (AAGBI) were kept within folders attached to each anaesthetic machine. We saw that staff followed these guidelines appropriately.
- During our previous inspection in July 2016, we were told that the service had introduced an enhanced recovery programme to improve patient outcomes. Enhanced recovery is an evidence-based approach that helps people recover more quickly after having major surgery. However, we were told by the clinical lead that implementation of the programme had been delayed due to funding. They said there were plans to recruit a clinical nurse specialist to lead the programme and that a business case for funding had been submitted and was awaiting approval.
- Staff followed the trust's policy for assessing and managing patients with suspected sepsis in line with NICE guideline NG51. Sepsis trolleys containing relevant equipment and documentation were available on some, but not all, wards. The trust told us that no sepsis audits had taken place within surgery at Whipps Cross University Hospital in the last 12 months. Therefore, it was not clear how the service monitored whether patients with suspected sepsis were provided with evidence-based care and treatment.

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- It was not clear whether surgical site infection (SSI) data was being collected. We were told that data was being submitted nationally for orthopaedic patients but that the results were not yet being used to make improvements.
- The hospital participated in a number of national audits including emergency laparotomy, hip fracture, bowel cancer and patient reported outcome measures (PROMs). During our previous inspection, the hospital did not provide us with any evidence that outcomes of national audits were being used to drive local quality improvement. During this inspection, the clinical lead told us that this had been improved and that action plans for national audits had been presented to the board. However, we were not provided with any specific examples of how these national audit results were being used to improve services for patients.
- The trust participated in the National Clinical Audit and Patient Outcomes Programme (NCAPOP). For 2016-2017, the service had contributed to a number of audits including the National Ophthalmology, Consenting Operative Orthopaedic Patients and National Prostate Cancer audits and we saw that action plans had been developed, after our inspection, in June 2017 to address areas for improvement.
- We saw that the results of surgical peri-operative audits including hygiene, instruments and swabs and scrubbing technique, were discussed at monthly theatre governance meetings. This was then fed back to staff via team meetings and briefing sessions.
- Staff on the wards told us about local audits for nutrition, documentation and infection control. On some wards, we saw that audit results were visibly displayed for staff. However, we heard that as ward meetings did not always take place, staff did not always have an opportunity to discuss these results.
- We saw the surgical service had a monthly audit plan for 2017 for infection control audits and pain audits. However, we did not see an overall audit for all local audits taking place on the wards. The trust told us it did not carry out local audits for sepsis, patient discharge or staff response to call bells.

Pain relief

- Staff used a recognised tool based on a numeric rating scale to assess patients' pain and the effectiveness of pain relief. This tool asked patients to score their pain

from zero to three, with zero meaning no pain and three severe pain. Staff told us if a patient's pain score went up then they were reviewed by a doctor and given pain-medication.

- A dedicated pain team visited wards daily and out of hours was managed by an on-call anaesthetist.
- We reviewed a sample of prescription records and saw that pain medication had been appropriately prescribed and administered.
- We saw that nursing staff carried out intentional rounding, regularly visiting each patient to check whether they were in pain and whether they needed anything.
- All patients we spoke with told us their pain was well managed and that staff regularly asked them about their pain levels.
- The pain team carried out an audit of 50 surgical patients in May 2017 and found that 86% of patients were either 'satisfied' or 'extremely satisfied' with their pain management. However, 44% of patients said they had not been asked about their pain and 24% had no formal pain assessment recorded. To address these areas for improvement, further quarterly audits were planned and there were plans for pain assessment to be covered with staff in the surgical nursing forum.

Nutrition and hydration

- Staff used a five-step malnutrition universal screening tool (MUST) to identify patients who were malnourished or at risk of malnutrition. This involved weighing the patient regularly to monitor any weight changes and then allocating a score based on risk.
- During our last inspection, we found not all patients were screened for malnutrition as required by NICE guidelines. The trust target of 95% for completion of MUST was not consistently being met.
- We reviewed 21 patient records across five surgical wards. We found we found that four records (out of the 21 reviewed) did not contain evidence of a nutritional risk assessment.
- Monthly MUST audit data from five surgical wards between May 2016 and May 2017 showed that overall compliance varied between 43% and 81% against the trust target of 95%. A new nursing documentation bundle had been introduced in September 2016 and overall compliance had shown a positive improvement trend between December 2016 and May 2017, improving from 43% to 76% over the six months. However only one

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ward (Sycamore) achieved the target compliance level (95%), scoring 98% for May 2017. Rowan and Primrose wards performed poorly, with compliance scores between 9% and 68% for the same period. Therefore, although overall compliance had shown improvement, the trust target was not being met and compliance varied significantly between wards.

- Royal College of Nursing best practice states where clinically appropriate, patients should be given the opportunity to choose whether to eat/drink at or away from their bed. Patients we spoke with told us that, where appropriate, they were given a choice of where they ate their meals and that staff provided sufficient support during meals.
- We saw that each ward had a system in place to identify whether a patient need additional assistance to eat and drink. Information about each patient's nutritional requirements was communicated to staff at handover.

Patient outcomes

- Between November 2015 and October 2016, most patients at Whipps Cross University Hospital had a lower than expected risk of readmission for both elective and non-elective admissions, when compared to the England average. However, both non-elective and elective urology and elective ophthalmology patients had a higher than expected relative risk of readmission. This meant that following surgery, these patients were at a slightly higher risk of being readmitted than in other hospitals in England.
- The trust told us there were 94 unplanned returns to theatre between May 2016 and May 2017; the majority (59) were following an emergency procedure.
- In the 2016 Hip Fracture Audit, the hospital's performance against the national average was mixed. For five measures, the hospital performed significantly worse than the national average and fell within the lowest 25% of all trusts. Performance against four of these five measures was also worse than the result for 2015. However, for three key measures performance was comparable or better than the national average.
 - The risk-adjusted 30-day mortality rate for the hospital was 7.3%, which was within the expected range.
 - The proportion of patients having surgery on the day of or day after admission was 79%, which did not meet the national standard of 85%. However, this showed an improvement from the 2015 figure of 69.7% and was better than the national average of 71.5%.
- The peri-operative medical assessment rate was 96.8%, which did not meet the national standard of 100%. However, this was better than the national average of 87.5% and showed a slight improvement on the 2015 figure of 96.2%.
- The proportion of patients not developing pressure ulcers was 91.5%, which was in the worst 25% of trusts. This was worse than the 2015 figure of 94.5% and the national average of 94.9%.
- The overall average length of patient stay was 23.6 days, which fell in the middle 50% of trusts. This was an improvement on the 2015 figure of 25.7 days, but was worse than the national average of 21.1 days.
- Patients admitted to orthopaedic ward within four hours was much worse than average at 2.7%, against a national average of 43.9%. This had declined from 3.7% in 2015.
- The measure relating to mobilising the patient out of bed after surgery was 59.1%, which was worse than the national average of 76.1% and the 2015 figure of 76.2%.
- The rate of return to original residence within 30 days had improved from 28.9% in 2015, to 32.8%. However, this was still much worse than the national average of 50.5%.
- The documentation of final discharge destination was 63.2%, which was worse than the national average of 82.2% and 2015 result of 65.9%.
- In the 2016 Bowel Cancer Audit, post-operative mortality and unplanned readmission rates for surgery at the trust were within expected ranges. However, 85% of patients undergoing a major resection (surgery to remove cancer) had a post-operative length of stay greater than five days. This was worse than the national average (68.8%) and the 2015 figure (75.7%). This information was only provided for the trust as a whole and was not available by hospital site.
- In the 2016 National Emergency Laparotomy Audit (NELA), the hospital performed within the top 20% of hospitals nationally, for three out of five measures. These included pre-operative documentation of risk of death, access to theatres within clinically appropriate time frames, and admission to critical care post-operatively. The hospital met or exceeded the

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national standard in each case. The risk-adjusted 30-day mortality was 11.2% and was within expected limits. However, the proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre was 50%. This did not meet the national standard of 80%. However, these results were based on a very small sample size of only 12 patients that represented only 8% of eligible patients (against the national standard of 80%). The clinical lead told us that work was underway to improve data capture and submission to the NELA. The trust provided a 'snapshot' report of hospital's status in relation to overall case ascertainment for the 2017 NELA. This showed that as of March 2017, data for 33 patients had been submitted to the audit, which represented approximately 75% of eligible cases and a significant improvement on the 2016 data set.

- The trust's Patient Reported Outcome Measures (PROMS) survey results for 2016/17 were generally in-line with national results. In the PROMS survey, patients are asked whether they feel better or worse after receiving the following operations: groin hernias, varicose veins and hip or knee replacements. The trust's performance on groin hernias was better than the England average for all three metrics; this was an improvement on the 2015 performance. Results for patients receiving all other procedures were mixed compared to the England average, with each procedure having one measure performing better than the average and two performing worse.
- The service's clinical lead told us that the results of these national audits had been presented to the board and that action plans had been developed. However, when we asked the trust to provide copies of these action plans we were told that they did not have any.

Competent staff

- Data provided by the trust for between April 2015 and March 2016 showed appraisal completion rates varied between surgical specialities. General surgery and urology reported 53% of all staff had received an appraisal whilst 71% of orthopaedic staff and 77% of peri-operative, pain and theatres staff had been appraised. This did not meet the trust target of 90%. However, all staff we spoke with told us they had received an appraisal in the previous 12 months.
- Although competency-based training was available to all staff, access to further education programmes were

limited due to lack of funding. Several members of staff told us that they were unable to progress their careers due to a lack of financial support available from the trust. One ward manager told us that this was the reason that many staff had left.

- Some staff said they felt well supported with regards to their development. For example, one scrub nurse told us that they had been supported by their mentor to complete an externally accredited, in-house theatre qualification. One health care assistant (HCA) told us how they had previously worked for the trust as a domestic assistant and had been encouraged and supported to train as a HCA. Student nurses we spoke with were very positive about the support and training they had received on their placements.
- At the time of the inspection, two surgical wards (Primrose and Rowan) had three patients requiring tracheostomy care. Ward managers said these two wards regularly received tracheostomy patients. One ward manager told us that there were plans to roll out a training programme for all staff led by a consultant anaesthetist. At the time of inspection, 76% of staff on Primrose and Rowan wards were trained in tracheostomy care. Staff we spoke with said they had received training and felt they had the right skills to keep patients safe.
- Agency nurse's skills and competency were discussed and checked by the ward manager during their induction on the first day of their shift. However, some nursing staff raised concerns about agency staff competencies. They gave us examples of where they had worked with agency staff that did not have the required skills to care for patients with complex needs. This often meant substantive staff had to take on more work. One ward manager told us that although agency staff may have the appropriate competencies they did not always display appropriate behaviours which often meant other staff had to pick up additional work to compensate for this.
- There was a monthly surgical nurse's forum dedicated to teaching and development. However, not all staff were able to attend due to issues with staffing levels.
- Junior doctors across different surgical specialities spoke positively about their training at the hospital and told us they felt well supported by consultants.
- We observed consultants providing structured and interactive teaching to junior doctors during procedures.

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In one case, the consultant sat directly behind the registrar throughout a procedure to provide immediate support if required. The consultant told us that all junior doctors were supported in this way.

Multidisciplinary working

- Medical and nursing staff undertook daily ward rounds. Rowan Ward, Poplar Ward and Primrose ward had a mixture of patients from different surgical specialities, as well as medical care patients. This meant that multiple ward rounds took place each day. One ward manager told us that nine different teams visited their ward on a daily basis and they did not always know when rounds would be taking place, which made effective communication difficult.
- Senior staff told us about plans to improve multidisciplinary team (MDT) working between nursing and medical staff by involving ward managers in each speciality's clinical governance meetings. However, at the time of our inspection, this was yet to take place.
- We saw positive examples of MDT working within the elective orthopaedic team, where the new standard operating procedure for Sage ward had made it easier for staff to manage the patient pathway. We saw that weekend plans for physiotherapy, nutrition and other required services were communicated efficiently.
- We saw that the daily MDT board rounds took place on wards were attended by the nurse in charge, discharge coordinator, social worker, rehabilitation support worker, physiotherapists and an occupational therapist. The team discussed patients, their discharge and care plans, as well as any support required from the MDT.
- We reviewed a sample of patient notes and saw evidence of regular MDT input from specialist nurses and allied health professionals.
- We observed good MDT working in operating theatres. Staff communicated effectively and there was good teamwork and collaboration. However, the theatre matron told that a lack of communication between clinical and administrative teams often led to theatres being underutilised. We were told the scheduling team and administrative team met weekly but without input from the clinical team, which meant that issues were not always picked up until the day of surgery. This often led to last minute cancellations and gaps in surgical lists.
- Nursing staff told us that most medical staff were approachable and they felt their opinions and contributions were valued and respected.
- Ward staff told us that communication and team working with recovery was poor. They gave examples of where patients had been sent up to the ward without any prior warning or where handovers were not appropriately completed. Recovery staff told us they felt under pressure to move patients out of recovery and that the lack of available ward beds made their job stressful.
- Some ward staff said they did not always feel supported by specialist nurses and sometimes felt they were critical of their work.
- Weekly surgical speciality MDT meetings took place for colorectal and urology services. A cross-site head and neck MDT was also held at another hospital within the trust. Doctors we spoke with said that IT issues made communication with oncologists on other sites difficult and therefore the MDT was often incomplete.
- We attended the hospital's bed management meetings and did not see any representation from surgical services. We saw that surgical staff held separate evening handover meetings and did not engage with the hospital-wide evening handover. Doctors we spoke with were unaware of the hospital-wide bed management meeting.

Seven-day services

- Service leaders told us surgical services were working towards seven-day working. However, this was not yet in place at the time of inspection.
- The service did not meet NHS England's seven-day services priority standards for time to first consultant review. This priority standard states that all emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of arrival at hospital. The trust told us that current rotas and working patterns meant they were unable to meet this standard but that all acute and emergency surgical patients were reviewed by a consultant within 24 hours of admission.

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- There were two emergency theatres, one operating 24 hours a day and the other nine hours a day, both seven days a week. After 10pm, the emergency theatre covered immediate life, limb or organ-saving interventions.
- Radiology services were provided 24 hours a day, seven days a week. On-call cover was provided 5pm to 9am during the week and at weekends.
- A physiotherapist service was provided 8am to 6pm seven days a week however at weekends, a priority service operated with reduced staffing. At weekends three physiotherapists and two rehabilitation support workers provided cover to surgical wards and critical care. Out-of-hours (6pm to 8am) there was an emergency on call service for urgent patients with respiratory compromise.
- Occupational therapist services were available 8am to 6pm, Monday to Friday only. We were told that that due to the large number of occupational therapist vacancies (35%) at weekends only one therapist covered the whole hospital site. This was recorded on the hospital's risk register as this issue was affecting patient discharges.
- Dietitian and speech and language therapy (SALT) services were not available out of hours (after 5pm) or at weekends. The trust told us they had introduced a competency based training programme for nursing staff for swallow assessment to reduce the time patients placed on nil by mouth had to wait for SALT assessment over the weekend. Training for this had started after our inspection had taken place.
- The hospital had a pharmacy dispensary and ward pharmacy services seven days of the week, with reduced level services at the weekends and in the evenings 5pm to 9pm. Another hospital within the trust had 24/7 pharmacy service and provided on call services when the pharmacy was closed. Ward staff told us that pharmacy services were over-stretched due to a high vacancy rate and that this often led to delayed discharges whilst patients waited for medicines to take home.

Access to information

- Staff told us that frequent issues with the IT systems often caused delays.
- During our inspection, we saw that two theatre lists were delayed in starting due to problems caused by IT.

Staff were unable to log on to the system to observe diagnostic results. Surgical staff informed us that site-specific surgeries could not commence without access to patients diagnostic and imaging results.

- We also saw that due to IT system failures staff on the wards were unable to log on to some computers. For example, on one ward only one computer was allowing staff to access the system.
- During one MDT meeting we attended, we heard how IT problems were leading to delayed discharges for some patients, as they were awaiting discharge medication being prescribed.
- One ward manager told us that the IT issues meant that staff physically had to leave the ward and collect patient results from different areas of the hospital. This placed further strain on staffing levels.
- Doctors told us that there were often delays in receiving results from the off-site pathology service. They told us that in certain cases, this had delayed treatment decisions for over three weeks.
- One ward manager told us that patients often arrived on the ward from other areas of the hospital without any supporting paperwork. A new handover template had been developed to address this problem. This was currently being trialled with the acute assessment unit (AAU).

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Information about the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) were displayed on the wards. All staff received basic MCA and DoLS awareness training, which was part of the adult safeguarding e-learning course
- We observed staff obtained and confirmed each patient's consent prior to a surgery or procedure. We saw consent was obtained from patients in line with the trust's policy. All of the patient records we checked had a completed consent form for any procedures, or surgeries undertaken. The forms contained full details of the operation/procedure and any risks associated with this.
- Patients living with dementia had their capacity assessed on admission. We did not see any records for patients living with dementia during this inspection. Staff told us if a patient did not have capacity to make a decision about their treatment, a best interests meeting would be held.

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- Data provided by the trust after the inspection showed that 87% of staff had completed training in consent procedures and 88% had completed dementia awareness training, as of 1 June 2017.

Are surgery services caring?

Good



We rated caring as **good** because:

- Most patients we spoke with told us their experiences of care were positive.
 - We saw that staff treated patients with compassion and demonstrated a genuinely kind and caring attitude.
 - We observed staff treated patients with respect and their dignity was maintained at all times.
 - Patients told us that staff introduced themselves and gave them the opportunity to ask questions.
 - The Friends and Family Test (FFT) response rate for the service was 28%, which was in line with the England average of 29% between February 2016 and January 2017. Individual ward response rates fluctuated between 16% and 44%. This was an improvement on the 2016 FFT results, where response rates for most surgical wards were very low (between 11% and 16%).
 - Some surgical specialities, including orthopaedics, ophthalmology and colorectal services, provided patients with access to additional support to help them cope with the emotional impact of their treatment.
- In theatres, and on wards, we observed staff treated patients with respect and their dignity was maintained at all times. We observed a number of situations when staff had drawn curtains to protect patients' dignity and privacy. Patients told us they felt their privacy was respected by staff. We were told that staff knocked before entering the bathroom. We observed that staff closed the curtains around each patient's bed before carrying out any personal care.
 - One patient said they felt staff were, "truly caring", "always smiling" and there was "a positive atmosphere between colleagues which makes it nice".
 - Another patient told us that, "staff listen to patient's requirements" and that they "never had to press the call bell as there are always people checking me." A further patient said staff always asked first thing in the morning, "am I ok? Do I need anything?" One morning, they had asked for a blanket as they were cold and had received it straight away.
 - We observed that staff were kind and caring in their interactions with patients. For example, in the morning, they greeted patients, introduced themselves, and informed them it was breakfast time.
 - We saw theatre staff reassuring a nervous patient by taking the time to provide a clear explanation of what was happening. We saw that staff treated the patient with compassion and demonstrated a genuinely kind and caring attitude.
 - We saw many examples of where patients and their relatives had sent 'thank you' messages to staff expressing their gratitude for the care and attention they had received whilst in hospital.
 - The Friends and Family Test (FFT) response rate for surgery at Whipps Cross University Hospital was 28%, which was in line with the England average of 29% between February 2016 and January 2017. Individual ward response rates fluctuated between 16% and 44%. This was an improvement on the 2016 FFT results, where response rates for most surgical wards were low (between 11% and 16%). Sage ward had the highest response rate at 44%. Poplar and Primrose wards had the lowest response rates at 17% and 16%. Ward managers said this was because staff often forgot to ask patients to complete the survey, as they were too busy. The percentage of patients that would recommend the hospital to family and friends was variable across the wards, and fluctuated between months with scores between 60% and 100% for individual wards. Sage ward

However:

- The percentage of patients that would recommend the hospital to family and friends was variable across the wards and fluctuated between months with scores between 60% and 100%.
- Some patients told us that they wanted clearer information about their care and treatment and communication between staff and patients could be better.

Compassionate care

- During the inspection, we spoke with 18 patients. Most patients told us their experiences of care were positive. We observed staff were kind and caring towards patients and spent time providing reassurance where needed. Patients spoke highly of staff and told us they were treated with kindness and compassion.

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consistently scored between 93% and 100% and Plane Tree ward (day case centre) also had consistently high scores with between 94% and 97%. Most wards scored 85% or above for the 12 months reviewed.

Understanding and involvement of patients and those close to them

- Patients told us that staff introduced themselves and gave them the opportunity to ask questions.
- We saw that where staff needed to move patients to make them more comfortable, they explained what they were doing and why and asked if the patient was ready.
- Most patients we spoke with felt they were kept informed about their care. However, some told us communication could have been better.
- Some patients told us that they were unsure about when they were due to be discharged and others felt they were not always kept informed about what was happening with their treatment. One patient on Rowan ward told us that their operation had been postponed twice and the reason given had been that they were “too busy.” They also said that after shift change new staff seemed “a bit confused about what is going on”, as one day they were told they would be going home and the next they were told they were staying. Another patient said, “It’s been confusing. I would like more definite information about what they are going to do”.
- We observed good communication between patients and staff during operations. Staff explained the process and checked patients were aware of what was happening.
- We heard that the urology service had recently introduced educational seminar sessions run by clinical nurse specialists. The focus was on teaching patients about their disease and diagnosis, managing side effects, what to expect and addressing patient expectations, future plans and treatments. This included a ‘well-being’ event for patients with prostate cancer, which was provided by a multidisciplinary team including psychologists.

Emotional support

- A team of clinical nurse specialists (CNSs) supported patient care on the wards. CNSs acted as a key point of contact for patients and relatives and provided a link between the hospital and community care. Patient’s holistic needs assessments were reviewed by CNSs and any concerns followed-up.

- Patients had access to peer support sessions provided through educational seminars in some departments. Patients attending these sessions were signposted to relevant support services.
- Orthopaedic patients attended a ‘joint school’ before having their hip or knee replacement. They were invited to bring a relative or friend to act as a ‘coach’ and support them. Patients met all the team members that would be involved in their care from the pre-assessment nurse, to the surgeon and physiotherapist. The sessions aimed to reduce anxiety by familiarising patients with what would happen at all stages of their care and treatment.
- Eye clinic liaison officers (ECLOs) provided ophthalmology patients with both emotional and practical support. ECLOs helped patients understand their diagnosis, deal with their sight loss and maintain their independence. They spent time with the patient to discuss the impact the condition may have on their life.
- Colorectal services provided emotional support to patients undergoing stoma-forming surgery by offering pre-operative counselling and ‘buddy’ system peer support. Patient support group meetings were held monthly in the local community to support patients post-procedure.
- The hospital was in the process of developing their pain management programme and had plans to introduce a specialist pain psychologist to support patients with complex pain needs. However, this was awaiting approval for funding.
- Patients and visitors of all faiths and beliefs had access to on-site chaplaincy services situated within the ‘retreat’. The retreat included a chapel, Muslim prayer room and quiet area, for prayer or reflection. Weekly services were held for Catholic mass, as well as Hindu and Muslim prayers. Access to pastoral, spiritual or religious support from the chaplaincy team was available 24 hours a day via an emergency phone number.

Are surgery services responsive?

Inadequate



We rated responsive as **Inadequate** because:

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- We saw limited evidence of improvements made to the service, since our last inspection in 2016, to make the service more responsive to patient needs.
- The overall 18-week referral to treatment time (RTT) performance for patients waiting for surgical specialties at the hospital was 69%. Performance was worse than expected but could not be accurately measured against the national average due to quality issues. There were significant data quality concerns that meant the trust could not provide assurance that referral to treatment times were being monitored effectively and the trust were not submitting national data.
- Between April 2016 and March 2017, the service's cancelled operations as a percentage of elective admissions was 1.6%. This was worse than the England average of 1%.
- Theatre cancellations were happening on the day of surgery due to lack of available beds and over-running and late starting theatre lists. Theatre utilisation rates had improved but were still below the trust's target. Theatre lists were frequently delayed due to IT and equipment issues and last-minute list changes. Data provided by the trust for the period November 2016 to April 2017 showed that 79% of lists did not start on time, with 39% of lists starting over 30 minutes later than planned.
- Bed shortages on wards meant recovery areas were regularly used to nurse patients overnight. Staff were concerned that patients' needs were not being appropriately met.
- The average length of stay in trauma and orthopaedics was longer than the England average for both elective and non-elective patients.
- Patients were not aware of their indicative discharge date and discharge-planning documentation was not always completed.
- Increasing numbers of patients were discharged out of hours (after 8pm) due to delays including waiting for medication.
- We did not observe that SAFER processes were embedded on the wards and it was unclear how this was being monitored by the service.
- Most complaints were not responded to within the trust target timescale and we saw limited evidence that learning from complaints was identified and shared with staff.

- Patients gave us mixed feedback about food. We heard that options were not always available and the quality of the food was variable.
- There was no hospital-wide electronic flagging system to identify patients living with dementia.
- The hospital environment was not dementia friendly and did not support patients' independence.
- Facilities for visitors and relatives were limited. We saw that some family members resorted to standing in the corridor outside the theatre recovery area.
- We did not see patient information leaflets on the wards were available in other languages.

However:

- The percentage of patients whose operations were cancelled and not rebooked within 28 days had significantly improved. The trust told us that only two patients had breached this standard at Whipps Cross Hospital between April 2016 and March 2017, which was better than the England average.
- Relatives and carers were encouraged to be involved in patient's day-to-day care via the 'enhanced care' programme.
- The trust was rolling out a pilot 'Forget-Me-Not' programme to provide additional support to patients living with dementia.
- Ward staff had access to support from a site-based specialist dementia and delirium team.
- Most patients told us staff responded promptly to call bells although this was not audited.
- Daily discharge meetings took place on each ward with input from social services, therapies and rehabilitation support.

Service planning and delivery to meet the needs of local people

- The hospital provided services to a large local population of elderly patients, a large proportion of which were living with dementia.
- However, we saw that the hospital environment was not designed to meet the needs of patients living with dementia. Staffing levels did not always allow for one-to-one care where it was needed.
- The director of operations told us the trust had recently carried out a demand and capacity review on each hospital site, which had found that there was not enough capacity on each site to accommodate the

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orthopaedics service. They said the trust was planning to increase pain and other support services for patients in community to reduce the number of patients who needed to be admitted.

- We saw that although action had been taken by the service to separate elective and non-elective care on orthopaedic wards, on other wards there was a mix of patients from different surgical specialities, as well as medical outliers.

Access and flow

- The trust suspended monthly mandatory 18-weeks referral to treatment (RTT) reporting from September 2014 onwards. This was due to significant data quality concerns relating to the accuracy, completeness and consistency of the RTT patient-tracking list (PTL).
- The overall RTT performance for patients waiting for surgical procedures at the hospital as at 14 June 2017 was 69% which was low compared with the national indicator for RTT performance for admitted pathways (90%). RTT performance varied between specialities with trauma and orthopaedics at 61%, general surgery at 62%, urology at 64% and ophthalmology 67%. ENT performed slightly better at 78%. Performance was worse than expected but could not be accurately measured against the national average due to quality issues.
- Between April 2016 and March 2017, the hospital reported 1,598 elective surgeries were cancelled on the day of surgery. These represented 11% of all elective cases booked (15,151). Of these last-minute cancellations, 245 were cancelled by the hospital for non-clinical reasons. The service's cancelled operations as a percentage of elective admissions was 1.6%. This was worse than the England average of 1%.
- Of these 1,598 cancelled procedures, 65% (1,032) were patient-initiated, with 466 of these recorded as patient 'did not attend' (DNA). There were 245 hospital-initiated cancellations for non-clinical reasons, which included: ran out of time (82), lack of staff (62), lack of beds (32), equipment issues (28) and administrative error (19). Other reasons recorded for cancellations included: patient unwell on the day (214), patient clinically unfit (156), patient cancelled (161) and operation not needed (146). The largest number of cancellations were in orthopaedics (297), followed by ophthalmology (247) and ENT (212).
- In the same period, there were 21 repeat cancellations, of which 12 were cancelled by the hospital for non-clinical reasons due to lack of staff, equipment issues, lack of ICU/HDU beds and lack of time.
- If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard, and the patient should be offered treatment at the time and hospital of their choice. The trust told us that at Whipps Cross Hospital only two patients had breached this standard between April 2016 and March 2017. This represented 0.8% of non-clinical last minute cancellations. This was much better than the England average of around 8%. The trust's performance against this standard had significantly improved since 2015 when almost 30% of patients whose operations were cancelled by the trust were not treated within 28 days.
- During the two-day inspection, we saw 12 patients had their operations cancelled on the day of surgery. Of these 12, two patients had their operations cancelled due to their operation no longer being required. However, as staff did not identify this in advance, no replacement patients had been organised. Other reasons for cancellations included: four patients who were clinically unwell or unfit for surgery, and three patients who did not attend. This had a negative impact on theatre utilisation as it meant that one theatre was only used for one hour, rather than the full day. The theatre matron told us this was due to lack of communication between the clinical and administrative teams. We were told the scheduling team and administrative team met weekly, but without input from the clinical team, which meant that issues were not always picked up until the day of surgery.
- Theatre utilisation rates for April 2017 across the 10 main theatres varied between 41.1% and 81.6% against the trust's target of 85%. This performance had improved from our last inspection where most theatres fell below 50% utilisation between February and April 2016. The hospital's quality improvement plan reported the hospital was on track to achieve its target by December 2017. However, data provided by the trust showed that utilisation had decreased for seven out of 10 theatres between February and April 2017.
- During the inspection, we saw two last-minute changes of theatre list. In one case, the anaesthetist changed the list order as the first patient was not ready. In the other

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case, it seemed unclear who had been responsible for the last-minute change to the list. The doctors suggested the list was changed by administrators, and the administration team suggested the doctors changed the order at late notice. In both cases, we saw that there was a delay to the list starting.

- Data provided by the trust showed that the service had recorded 77 'on the day' list changes between April 2016 and April 2017. This represented 2% of all theatre lists for the period. It was not clear how often the list was changed for a non-clinical reason, as this data was not provided. We were told that there were a number of reasons for list changes, including that the first patient on the list was not ready for theatre.
- However, data provided by the trust for the six months November 2016 to April 2017 recorded that there were 1,457 delayed theatre lists of which 23% of delays were due to the order of the list being changed. This meant that there were at least 335 list changes for the six-month period, significantly more than the 77 list changes recorded for the 12-month period. Therefore, it was not clear how accurately list changes were being recorded by the service.
- We discussed this with the clinical lead who said that last minute list changes for non-clinical reasons should not happen but they were aware that they occasionally did take place. They told us there were still some challenges getting all specialities to "lock down" theatre lists. We heard work was underway to reduce last-minute list changes and a daily meeting was held to review theatre lists with any last-minute changes for non-clinical reasons escalated to the director of operations.
- A theatre improvement group had recently been set up to review each surgical sub-speciality in turn to identify areas for improvement. However, we were told these meetings were usually only attended by nursing and operational staff and therefore lacked clinical input from surgeons. As this review had only recently started, we did not see examples any specific actions taken to improve list management.
- Theatre staff told us some on the day surgery cancellations were due to overrunning of surgical lists. Staff said that lists overran due to theatre lists starting late, which was a common occurrence. Data provided by the trust for the period November 2016 to April 2017 showed that 79% (1,457 of 1838) of lists did not start on time, with 38% of lists starting over 30 minutes later

than planned. The number of late running lists had increased by 82% when compared to data provided by the trust for the six months prior to the 2016 inspection (1,457 late lists against 805). Data provided by the trust showed that 34% of delays were due to the patient not being ready on the ward, 23% due to the order of the list being changed and 8% due to the surgeon not being available. Other reasons for theatre delays included equipment not available (5%), incomplete paperwork (5%) and radiographer not available (5%).

- Staff told us there were numerous reasons for theatre delays but that IT issues and problems with equipment caused regular problems. Staff told us that since the sterile services had been outsourced, there had been frequent issues with surgical instrument sets. Staff said that wrong sets, or delay in returning sets, led to changing list orders, delays and cancellations.
- As in our previous inspection, we found significant issues with patient flow between theatres, recovery and wards due to limited bed availability. Theatre staff said that the recovery areas were regularly used to look after patients due to a lack of ward beds. The senior leads for the service told us that all overnight stays in recovery were recorded and reviewed daily by the senior management team. We were told that there had been significant improvements due to the opening of the new high dependency unit (HDU). However, staff told us this was not the case. Staff told us the recovery area was used "most days" as an overnight ward, without the correct amenities for the patients. We found the recovery was not suitable for nursing patients for long periods as it did not offer privacy, toilets were not located nearby, there were issues with feeding patients and visitors were not allowed. The theatre matron told us that this was an on-going problem and that it had been escalated to the service's risk register. However, we saw that this risk had been on the hospital's risk register for four years since May 2013 and there was no record of when senior managers had last reviewed this or what controls were in place to mitigate the risks to patients.
- The hospital's standard operating procedure (SOP) for the use of theatre recovery overnight stated that it was not appropriate to keep patients who were ready for transfer to a ward, in recovery overnight. The SOP stated that recovery should only to be used for elective patients in the event of there being no available bed in ICU. It also stated that patients should be moved out of recovery by 10am. The SOP stated that it was applicable

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in exceptional circumstances only but had not been reviewed since December 2015, and therefore had not been updated since before our last inspection in July 2016.

- Between April 2016 and March 2017, 166 patients experienced an overnight stay in recovery. This compared to 129 patients for the previous 12 months. Of these, 121 were due to lack of an available ward bed, with 23 patients identified as requiring a HDU or ITU bed, which was unavailable. Of the 166 patients, only 27 patients were recorded as being transferred out of recovery before 10am the next day. A total of 39 patients did not have a transfer out time recorded. During our inspection, we saw that one patient stayed overnight and then until 5pm the next day. We attended the hospital's bed management meeting and observed that managers were unaware of this patient. We did not see that patients kept overnight in recovery were regularly reviewed at bed management meetings.
- Staff in the pre-assessment centre told us, that due to a shortage of beds, patients were mainly listed as day cases. They said there was an "administrative pressure" to list patients as day cases rather than inpatients. We were told that the admissions office was responsible for completing paper work that indicated whether a patient would require an overnight bed. This decision would affect the number of the number of available ward beds and often lead to patients being kept overnight in recovery. Recovery staff told us that they felt the reason day case patients often became inpatients was because their risks were not fully assessed at the pre-assessment stage. All day case patients were required to have a nominated person to escort them home and we were told this was not always arranged in advance.
- A pre-assessment nurse told us that some patients who were listed on the admission sheet as day cases actually required an overnight stay, or vice-versa. The theatre matron, recovery staff and anaesthetists told us that there were a number reasons for late notification of a patient who required an inpatient stay post-surgery. These included IT issues and an "unpredictable need to stay". Staff we spoke seemed unclear on who was responsible for the final decision as to whether a patient would need a bed on a ward following surgery.
- Between May 2016 and April 2017, the hospital recorded 618 'failed' day cases (5% of all booked day cases), where day case patients had been admitted as an inpatient following surgery, rather than going home on

the day as planned. The trust said that it was standard practice to list all patients undergoing minor procedures as day-cases and the main reasons for converting to overnight stay were requirements for extended recovery, social arrangements changing, or anaesthetic complications.

- Between February 2016 and January 2017, the average length of stay at the hospital for most surgeries was in line with the England average for both elective and non-elective admissions. However, average length of stay in trauma and orthopaedics was longer than the England average for both elective surgeries (4.7 days against England average of 3.4 days) and non-elective surgeries (11.8 days against an average of 9 days). This meant that, on average, elective patients stayed in hospital 38% longer and non-elective patients 31% longer than the England average.
- We were told that Poplar ward was the designated short-stay ward. However, the ward manager told us that they often had patients staying for several weeks. Senior managers had attempted to ring-fence beds for elective patients, but this had been unsuccessful and we were told that the majority of patients were admitted from A&E. During our inspection, there were 11 medical outliers on the ward and only two elective patients. The ward manager said that the number of elective admissions to the ward had decreased recently.
- Most patients we spoke with did not know when they were due to be discharged. For example, one patient told us they had been on the ward for four weeks but had been waiting at least two weeks for equipment, including a bed and hoist, to be fitted at home. Another patient said they found it "confusing" as they kept being told different information. Several patients told us that they were awaiting procedures or tests that had been delayed. The discharge coordinator told us that they had four patients on one ward who were ready to go home, but were awaiting social care packages.
- Several patients told us that their operations had been delayed or postponed and that they did not always get clear information about when they would be discharged home.
- We spoke with four patients on the pre-operative ward who had all been made aware of whether they would require an overnight stay. However, one patient had been told that he would be admitted for "up to seven days" without being given an estimated discharge date.

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- The hospital's nursing documentation audit for April 2017 showed that documentation of discharge planning was poor, with the patient's estimated discharge date recorded in only 36% of records checked. The discharge checklist had been completed in only 53% of records, against the trust's target of 100%. The results of the documentation audits for August and December 2016 showed that compliance with 'evidence of discharge planning' in patients' records had declined from 75% to 63%, and then further to 42% in April 2017. We did not see evidence of any action plan to address this declining performance.
- Between May 2016 and April 2017, 576 (7.3%) patients were discharged out of hours (between 8pm and 8am). Data provided by the trust showed that monthly figures for out-of-hours discharges had more than doubled from 5% in May 2016 to 10.7% in April 2017. Staff on the wards told us that patients were often discharged late due to waiting for medications due to staffing shortages in the pharmacy team. We asked the trust to provide reasons for delayed and out of hours discharges but they said they were unable to provide any further information and that no specific discharge audit was carried out.
- We attended the daily MDT board meeting on two wards and saw that each patient's discharge arrangements were discussed. The meetings were attended by the ward manager, discharge coordinator, physiotherapists, occupational therapists and rehab support and a social worker. Action points included referral to the district nursing team and homeless person's unit. We heard that discharge was delayed for some patients due to IT issues and patients waiting for medication to take away. The estimated discharge date was not recorded on the patient information board.
- Senior managers told us about the recent introduction of the NHS Improvement 'SAFER' patient flow bundle. SAFER is a practical tool designed to reduce patient delays and improve patient flow through the hospital. The tool brings together five elements of best practice including that patients should be reviewed by a senior clinician before midday, have an expected discharge date and where possible be discharged home from wards before midday. We did not observe that SAFER processes were embedded on the wards and it was unclear how this was being monitored by the service.
- Patients on Rowan, Primrose and Poplar wards told us it was often noisy at night which made it difficult to sleep. Mainly this was noise caused by other patients, but in some cases we were told staff talked loudly and bins were being opened and closed. One patient said they were offered a headset so they could listen to the radio, which they said helped block out ward noises.
- Patients gave us mixed feedback about food. Some patients said that the food often did not arrive warm enough and that the quality was variable. We saw the menu had a range of food choices, including options for Halal, Kosher and vegetarian diets. However, patients told us that sometimes options were not available. One patient who had been on the ward for a few weeks told that options were limited at weekends. Another patient told us how she had only been offered a hot chocolate for breakfast one weekend. A further patient said there was a lack of variety and described the food as "the same every day".
- Doctors assessed all patients over the age of 75 on admission and screened them for dementia or delirium. However, there was no hospital-wide electronic flagging system to make staff aware of the patient's diagnosis. Instead, a generic 'at risk' flag was placed on their electronic records.
- Staff across surgical wards had access to a site-based dementia and delirium team that consisted of dementia clinical nurse specialists, dementia nurses and dementia support workers. A dementia nurse attended the surgical board rounds once every week so that staff had the opportunity to discuss any patients they had with dementia and delirium.
- Some wards had activity boxes to support with therapeutic engagement, stimulation and activity. We were told that all wards would have an activity box by the end of July 2017.
- At the time of the inspection, the trust was rolling out a pilot 'Forget-Me-Not' programme to provide additional support to patients living with dementia. All patients admitted with dementia were to be offered a 'Forget-Me-Not' document to be completed as part of a personalised care plan. This document captured information about the patient's personal preferences to allow their care to be responsive to their needs. The trust's carers' policy allowed flexible visiting hours for carers of people living with dementia. Carers were encouraged to be as involved as much as possible in the patient's care.

Meeting people's individual needs

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- The trust's dementia strategy included a commitment to work towards developing a dementia friendly environment across all sites by encouraging closer working with dementia strategy groups. Senior leads told us about plans to refurbish surgical wards that would include making them dementia friendly. However, at the time of our inspection we found that most wards were not dementia friendly.
- Learning disability link nurses were available on wards to support staff in delivering care and treatment to patients with a learning disability.
- Most patients told us nursing staff responded promptly to call bells. However, the trust told us they did not carry out call bell audits to monitor response times.
- We saw posters explaining to the patients what to do when English was not their first language. This information was available in a variety of languages
- Theatre staff told us that although interpreters were available via a telephone service they tried to use their own staff first. When that was not possible, they often used the patient's relatives, which was not best practice as it could breach patient confidentiality.
- Visitors were not allowed in the theatre recovery area. One ward manager told us that after the elective assessment ward closed for the afternoon, relatives came up to the ward. They were often quite distressed, as they were unable to visit their loved one. There were limited facilities for relatives and we saw that some family members resorted to standing in the corridor outside the theatre recovery area.
- The trust told us they had introduced 'enhanced care' to the wards to provide additional support to patients who required it, to involve carers and family in the care of patients. The enhanced care document bundle provided a comprehensive pathway to help identify each patient's support needs. Ward managers carried out a risk assessment for each patient with additional support needs, such as dementia or confusion. This would then be submitted to the associate director of nursing for approval. We saw the tool was being used effectively and allowed ward managers to request additional nursing support if required. However, staff told us that staffing levels did not always allow one-to-one care to take place. We were provided with examples of where relatives had been actively involved in their loved one's care and been able to stay with them on the ward to provide support.

- The trust told us they planned to audit the use of the 'enhanced care' bundle in August 2017, once it had been in place for 12 months.

Learning from complaints and concerns

- Between June 2016 and May 2017, there were 61 formal complaints relating to surgical services. Of these, the majority of complaints were about surgical wards (47), including 16 complaints made to orthopaedic wards, nine to the day case ward, eight to Rowan ward and five each to Popular and Primrose wards.
- Most common reasons for complaints related to dissatisfaction with treatment (18), poor communication (12) and delays or cancellations (nine). Only three complaints were recorded due to poor staff attitude (compared to 11 during the previous 12 months).
- Ward managers told us they provided feedback to staff about complaints at monthly staff meetings. However, staff on some wards told us either these did not take place or they did not attend them which meant they did not always hear about complaints.
- The patient advice and liaison service (PALS) within the hospital told us that most surgical complaints were from orthopaedic patients regarding appointments. We were told that appointments were being cancelled but patients were not notified so they arrived on the day, only to be told there was no appointment for them.
- Staff on the day case ward said that patients often complained informally about waiting times and delays caused by long lists and changes in times to theatre lists.
- Staff told us they always tried to resolve complaints informally where possible and would then escalate complaints to a senior member of staff if necessary.
- The trust's target time-line for responding to complaints was 25 working days. The trust aimed to respond to 80% of complaints within this timescale. We saw that complaints and response times were monitored via monthly performance reports. We saw the performance report for the surgical service for April 2016 to February 2017 that showed that only 14.5% of complaints had been responded to within the 25-day target.

Are surgery services well-led?

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Inadequate



We rated well-led as **inadequate** because:

- We saw limited evidence of improvements to the service to make it safer for patients and more responsive to their needs. Many of the areas of concern highlighted during our last inspection still needed to be addressed by the service.
- We were told that significant work had now been done to improve the hospital's clinical governance structures; however, we did not see evidence that this had been embedded in surgical specialities.
- The risk register did not reflect all current risks to the service. Some risks had been on the register for several years and it was not clear when these had last been reviewed. The risk register did not show what controls were in place or actions taken to mitigate risks.
- Although ward meetings were scheduled monthly, staff told us they were haphazard and did not always happen.
- A number of staff in different areas told us about ongoing issues of bullying, favouritism or unfair treatment.
- Most staff we spoke with were not able to tell us what the trust values were.
- During our previous inspection, we identified that poor collaboration, communication and lack of understanding between different clinical areas within the service resulted in staff blaming each other for poor patient flow. Staff told us that this was still a problem and we saw little evidence of improvement.
- Staff on the wards said they felt senior leads were unaware of the pressures staff faced and felt they could be more visible and 'hands-on'. Some staff were unaware of the local management structure and were unable to tell us who the senior leads for the service were.
- In the NHS staff survey 2016, the staff response rate for the surgical and cancer division was 29.4%, which was significantly worse than the overall trust response rate of 47.3%. The service performed significantly worse than the trust average in questions related to staff engagement with senior managers.
- Some staff told us that they felt pressure to come to work when they were unwell.

- We asked the trust to provide evidence of how results of the national audits were being used to drive local quality improvement programmes however, we were not provided with any specific examples.
- High vacancy rates and dependency on temporary staff meant that some staff felt there was no sense of teamwork on the wards. Staff on some wards said they found working with agency staff stressful.
- Several staff told us they lacked confidence in the hospital's HR department and felt reluctant to raise concerns.

However:

- Staff across wards and theatres spoke highly of their direct line managers and said they felt supported by the matrons who were visible and approachable
- Most staff spoke highly of their team and colleagues. A junior member of staff said they felt their colleagues were "like an extended family."
- The service had developed an action plan in response to a report by a local consumer champion group.
- The friends and family test response rate for the service had improved to 28% and was now in line with the national average.
- The trust had held several 'listening into action' events to capture the views of staff.
- A nursing representative from each hospital area attended a daily safety huddle to enhance patient safety across the hospital.

Leadership of service

- The surgical service had a site based leadership team. A clinical director, associate director of nursing (ADoN) and divisional service managers provided leadership of the service. This senior leadership team provided the main point of leadership and management for patient-facing staff.
- The senior leadership team told us that action had been taken to address the issues of bullying and harassment, which were highlighted during the 2016 inspection. They provided examples of specific action that had been taken to address localised issues. A trust-based operational development team had carried out listening events with staff. A site-wide workforce plan was in the process of being developed, which would include actions on bullying and harassment.
- At the last inspection in 2016, staff told us about allegations of significant bullying and intimidation in

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theatres and staff being fearful without support from service leaders. Staff also told us about a longstanding issue relating to a doctor allegedly reported for bullying and intimidation. Staff told us that senior leaders had since taken action to address these issues of bullying in theatres.

- Senior leaders had provided staff with support, including counselling and opportunities for team building. One individual told us, “there is a difference now”, and another said, “I feel the team are moving on.” However, staff also said that they had not heard about the outcome of the investigation and that this uncertainty was stressful.
- One ward manager told us that they felt bullying issues had not been fully addressed. They said that often they felt pressured into admitting patients to the ward when they did not feel staffing levels were adequate to keep patients safe.
- Staff across wards and theatres spoke highly of their direct line managers and said they felt supported by the matrons, who were visible and approachable. However, some staff were unaware of the local management structure and were unable to tell us who the senior leads for the service were.
- Ward managers told us that the matron and/or the ADoN visited each ward every morning to identify any staffing issues and any patients who were ready to be discharged home. However, several staff on one ward said that they only saw senior leaders briefly usually when they visited the ward to deliver negative feedback. One nurse said staff often felt they were being “told off” by senior leaders and another said they felt they were treated like “school kids” and felt this was not supportive. Several staff on the wards said they felt senior leads were unaware of the pressures staff faced and felt they could be more visible and “hands-on”.

Vision and strategy for this service

- The trust’s values were based around six key themes of being respectful, equitable and welcoming to patients and colleagues, collaborating and engaging to drive forward improvements and individual accountability for delivering high standards.
- The vision for the trust was “to be a high performing group of NHS hospitals, renowned for excellence and innovation and providing safe and compassionate care to our patients in east London and beyond.”

- Although most staff were unable to tell us what the specific vision and values for the service were, the majority told us that delivering safe and compassionate care to patients was a priority for the trust.
- During our previous inspection in 2016, senior leaders for the service told us the service’s vision was to reconfigure the surgical wards making them fit for purpose, and reduce costs at the same time. The services had plans to make surgical wards into dedicated speciality led wards, which aimed to reduce length of stay and enhance patient care. Aside from in orthopaedics, we did not see evidence this had taken place.
- The surgical triumvirate had produced a business plan, which included the service’s top three priorities for 2017-2019. These were to address the high staff vacancy rate and other workforce issues, improve RTT performance and improve theatre utilisation. Key investment priorities included replacing theatre equipment, and utilising two empty theatres to make space for pain management services within the day case ward.
- The service had a specific service improvement plan to address the areas of concern identified by the last CQC inspection in July 2016. Actions included reviewing patient flow through the hospital, with plans including a new surgical assessment unit and rolling out the ‘SAFER’ bundle (a practical tool designed to reduce patient delays and improve patient flow through the hospital) across all surgical wards.

Governance, risk management and quality measurement

- The hospital’s clinical services were previously organised into clinical academic groups (CAGs). However, senior leads told us that there was now a new structure based on divisions rather than CAGs. Each division had a clear three-part leadership consisting of a clinical lead, service manager and ADoN.
- We were told that significant work had now been done to improve the hospital’s clinical governance structures, with the assistance of NHS improvement (NHSI). A new standard agenda for all clinical governance meetings had been developed and a clear reporting structure was now in place. Senior leads told us that each speciality was now having monthly clinical governance meetings, which fed directly into the monthly divisional meetings. However, we did not see evidence to support this.

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- We reviewed a sample of clinical governance meeting minutes provided by the trust and clinical governance meetings across surgical specialities and found they varied in quality and detail. There was a lack of consistency in the format and structure of the meetings and there was no set agenda across the specialities. Aside from in ophthalmology there was limited or no discussion of incidents, risks or audit results. It was therefore not clear how lessons learned and areas for improvement were being shared with staff.
- Managers acknowledged that there was still further work to be done, including improving the integration between nursing and clinical governance. Minutes of the surgical clinical governance meeting from July 2016 noted the meetings were not attended by senior sisters, and it was therefore it was “difficult to get specifics of ward issues”. At the time of our current inspection there was still limited input from nursing staff. The ADoN told us that he held weekly meetings with ward managers and there were plans in place for ward managers to take it in turns to attend each speciality’s clinical governance meetings.
- We reviewed a sample of monthly ward meeting minutes. Discussion of incidents, safeguarding, and patient feedback/complaints was inconsistent and did not always appear to take place. Discussion of audit results was limited (other than nutrition assessment and cleaning). We asked the trust to provide examples of ward meeting minutes for each surgical ward. However, we were only provided with minutes for two wards. Staff on some wards told us that meetings did not always take place.
- The clinical lead told us that all national audit results were submitted and presented to the board and that there were action plans to address each audit. We were told that oversight and ownership of audits had improved and that action was being taken to address areas for improvement. For example, the clinical lead told us that work was underway to improve data capture and submission to the National Emergency Laparotomy Audit (NELA) as the 2016 results were based on a very small sample size of only 12 patients.
- We asked the trust to provide evidence of how results of the national audits were being used to drive local quality improvement programmes. However, we were not provided with any specific examples. The trust did not provide us with any action plans to demonstrate how the outcomes of national audits were being responded to.
- A nursing representative from each hospital area attended a daily safety huddle. This was a meeting which aimed to enhance patient safety across the hospital. Safety huddles focused frontline teams around discussions and updated them on specific risks to patient safety and service delivery, including staffing and safeguarding issues. We attended a safety huddle and saw that the session was well-attended and focused on communicating key issues.
- The hospital’s risk register did not reflect all current risks to the service. Some risks had been on the register for several years and it was not clear when these had last been reviewed. The risk register did not show what controls were in place or actions taken to mitigate risks.
- There were approximately 30 risks on the hospital’s risk register relating directly to the surgical service. Not all risks seen during the inspection, and acknowledged by the service leads, were recorded on the risk register, for example agency staff use or issues with provision sterile instruments. The majority of risks related to risk of equipment failure in theatres and issues around servicing and maintenance. Three risks had been on the register since between 2012 and 2014. One of these related to the risk of suboptimal care of patients in the theatre recovery area due to lack of ward beds. This had been on the register for four years since May 2013.
- The hospital’s medical director (MD) told us that although the trust was not reporting RTT data nationally, performance was being monitored on a weekly basis. They said that at the time of our inspection the trust still had “massive data quality issues”. Therefore, we could not be assured that that the RTT data provided was accurate.
- The trust told us that they carried out monitoring to ensure that patients had not experienced harm because of their wait for treatment. The trust carried out a weekly review and investigation of actual clinical harm for all patients on the waiting list who breached the 31 and 62-day standards. Clinicians carried out a monthly review of 52-week breaches and any cases of moderate or severe harm were escalated as serious incidents. Data provided by the trust showed that between June 2016 and February 2017, there were 158 patients waiting for treatment for more than 52 weeks. However, no

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cases of moderate or severe harm had been identified by the trust. Updated data provided by the trust for June 2017 showed that the number of patients waiting more than 52 weeks had increased to 268 and for 288 patients their waiting time was 'unknown'. It was therefore not clear how risks to these patients were being identified and addressed.

- The service's failure to comply with the 18-week access standard was added to the risk register in February 2017 and was due for review in June 2017. The director of operations told us that the trust were on track to start re-reporting RTT in October 2017. We were told that "significant progress" had been made to improve RTT, however we did not see evidence of this within surgical specialities as overall performance remained low with only 69% of patients being admitted within 18 weeks of referral.

Culture within the service

- During our 2016 inspection, we spoke with a number of staff in different clinical areas who told us that they had experienced bullying or intimidation from colleagues or managers. Although most staff we spoke with during this current inspection spoke positively about the culture within the service, we found that staff on some wards were still unhappy with the work environment and gave us examples of favouritism or unfair treatment.
- During the previous inspection, we identified that poor collaboration, communication and lack of understanding between AAU, recovery and wards, which resulted in staff blaming each other for poor patient flow. Senior leads told us that substantive management posts had now been filled and that the reduction in interim managers had helped to improve collaboration between teams. However, staff told us that this was still a problem and we saw little evidence of improvement.
- Most staff spoke highly of their team, colleagues and managers. A junior member of staff said they felt their colleagues were "like an extended family." A nurse who had joined from overseas said that they had been "fully supported" by the whole team, including their mentor and the matron.
- In one department, we saw staff were actively celebrating 'international nurses week'. We saw that the consultant had provided lunch for the entire team and that team-building activities and games had been organised. We were told that all the team had

participated. The staff room noticeboard had been covered with positive messages, with staff sharing complimentary feedback about their colleagues. For example, one message said "always smiling and encouraging me. Works to the best of her ability." Staff said that the celebrations had been "really nice" and "the team are wonderful".

- Staff in the eye treatment centre had been invited to a 'Listening into action' (LiA) event to gather feedback and generate ideas of how to improve teamwork and morale within the team. Outcomes had included development of a 'staff promise' designed to encourage respectful interactions between colleagues. Suggestions for team away days and diversity training had also been taken forward.
- Most nursing staff spoke positively about doctors and said they had a good working relationship with them, where their opinion was valued and respected.
- Most staff said they felt able to raise concerns and challenge behaviours if appropriate. However, we saw that this did not always happen in practice. We saw that nurses did not always challenge doctors on breaches of the hospital's 'bare below the elbow' and hand hygiene policies.
- We heard that a number of staff had left the hospital in the previous six months due to the lack of opportunities for progression. Data provided by the trust for the 12 months to March 2017 showed that overall turnover for all nursing staff at the hospital was 12.9% but that for theatres this was higher at 13.1% and 19.9% for ophthalmology.
- Staff told us that there was low morale on some surgical wards. High vacancy rates and dependency on temporary staff meant that some staff felt there was no sense of teamwork on the wards. Staff on some wards said they found working with agency staff stressful, as they had to take responsibility for more patients, as well as other tasks which agency staff were unable to complete (for example, medication checks).
- Two members of staff from one ward said that workloads on the ward were not always assigned fairly and they felt that managers sometimes showed 'favouritism' towards certain members of the team, giving them lighter workloads and leaving other staff with more complex cases.
- Some staff told us that they felt pressure to come to work when they were unwell. They said they had been told they must contact a senior manager directly rather

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than their own ward manager, which they felt uncomfortable about. Staff told us that they were not supported if they were unable to attend work due to illness. One individual told us that they had been told they were making the ward “unsafe” by not coming in to work and felt they had been unfairly treated because of being absent from work due to illness. Data provided by the trust for April 2016 to March 2017 showed that sickness rates for nursing staff in general surgery (5.9%), theatres (4.6%) and ophthalmology (6.7%) were higher than the hospital average (4%) and the trust target (3%).

- The trust told us that the assistant director of workforce development conducted confidential drop-in sessions in March 2017. These were open for any member of the surgery team to seek confidential advice relating to any employment matter at work. This included how to handle behaviour that might be considered to be bullying and harassment. However, several staff told us they lacked confidence in the hospital’s HR department and felt reluctant to raise concerns. Staff said that when they had raised concerns no action was taken by HR or senior managers. One individual told us that they had raised concerns with HR about the way they had been spoken to by a senior manager but that the concerns were not kept confidential.
- In the NHS staff survey, the surgical service performed slightly worse than the trust average in questions about bullying from managers and colleagues. Seventy-eight percent of staff agreed with the statement that they had ‘Not experienced harassment, bullying or abuse from managers’ (vs 81% trust average) and 73% agreed with the statement that they had ‘Not experienced harassment, bullying or abuse from other colleagues’ (vs trust average of 76%).

Public engagement

- We saw that the service had taken action to address concerns raised by patients and their families. A local consumer champion group carried out an ‘enter and view’ visit to one surgical ward in February 2017. The team spoke to a number of patients about their experiences of being on the ward and produced a report on their findings. We saw that senior leads for the service had responded to this report with a detailed action plan and had put in place improvements to address concerns raised by patients. An example of this

was that patients had not been aware of how to raise a complaint. To address this, patient information leaflets providing information on complaints had been introduced on the ward.

- Patients’ views of surgical wards were also gathered through the NHS Friends and Family Test. The surgical service’s overall response rate was 28% between February 2016 and January 2017, which was in line with the national average (29%). Individual ward response rates fluctuated between 16% and 44%. This was an improvement on the 2016 results where response rates for most surgical wards were very low (between 11% and 16%).
- Between August 2016 and January 2017, the trust took part in the national inpatient survey. Questionnaires were sent to 1,250 recent inpatients with a 29% response rate. Areas where the trust performed worse than the national average included the quality of food and social considerations during discharge planning. We did not see any evidence that these issues were being addressed at the time of inspection.
- The urology department gathered feedback from patients who attended the educational seminar sessions to identify whether all relevant issues were being addressed.

Staff engagement

- The 2016 NHS staff survey results for the trust were based on a 90 question, on-line survey open to all staff employed by the trust. Staff were surveyed between mid-September and beginning of December 2016. The response rate for surgical and cancer services at Whipps Cross Hospital was 29.4%, which was significantly worse than the overall trust response rate of 47.3%. Although the majority of questions received responses in line with the average trust response, for 25% of questions asked, the service received responses which were significantly worse than the trust average. Questions were scored based on the percentage of staff providing a favourable response of either ‘agree’ or ‘strongly agree’. Questions where the service performed significantly worse than the trust average included: ‘I know who senior managers are’ (69% against 80%), ‘Communication between senior management and staff is effective’ (31% against 41%), ‘senior managers try to involve staff in important decisions’ (23% against 35%) and ‘senior managers act on staff feedback’ (24% against 33%).







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- Staff on some wards told us that ward meetings did not always take place regularly. The matron told us that ward meetings should take place monthly on each ward but that she was aware this was not happening on all wards. However, no alternative ways of communicating and engaging with staff had been introduced. One ward manager told us that most staff did not check their emails and therefore it was difficult to share information with everyone.
- We saw that on two wards, daily safety huddles took place, but these did not happen consistently across all wards.
- The trust held a series of 'Listening into action' (LiA) events which provided a forum for staff to engage in plans for service improvement. Recent LiA events included gathering staff views on implementing National Safety Standards for Invasive Procedures (NatSSIPs) and development of the hospital's 'enhanced recovery' programme.
- Surgical staff forums were held monthly. However, some staff told us they were unable to attend due to staffing issues.
- Orthopaedic patients attended a 'joint school' before having their hip or knee replacement. This was an opportunity for patients to discuss the process with nursing staff, physiotherapists, occupational therapists and members of the pain team. Patients also had an opportunity to talk to a patient who had previously undergone this surgery about what to expect. Patients and their family members or carers were encouraged to be active participants in their treatment pathway to encourage quicker and more effective recovery from surgery.
- Eye clinic liaison officers (ECLOs) provided ophthalmology patients with both emotional and practical support. ECLOs helped patients understand their diagnosis, deal with their sight loss and maintain their independence.
- The trust was continuing to implement the National Safety Standards for Invasive Procedures (NatSSIPs) and to develop the Local Safety Standards for Invasive Procedures (LocSSIPs). The NatSSIPs bring together national and local learning from the analysis of never events, serious incidents and near misses through a set of recommendations that help provide safer care for patients undergoing invasive procedures. We saw that staff had been encouraged to contribute to the development of local safety procedures.

Innovation, improvement and sustainability

- The urology service provided patients with access to educational seminar sessions run by clinical nurse specialists. The focus was on teaching patients about their disease and diagnosis, managing side effects, what to expect and addressing patient expectations, future plans and treatments.

End of life care

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

Information about the service

Whipps Cross University Hospital is a 586 bed district general hospital. This was a focused unannounced inspection that took place on 10 and 11 May 2017.

Between October 2015 and September 2016 there were 1,370 deaths at the hospital. This figure included deaths that occurred at the Margaret Centre, where palliative and end of life care are provided. The Margaret Centre (MC) had nine single rooms and one double room. It also contained offices for medical staff from the specialist palliative care team.

The hospital specialist palliative care team (SPCT) were a small team of clinical nurse specialists (CNS) who, along with consultant input, supported ward teams to deliver end of life care to patients. The team were involved with every hospital patient that was on the compassionate care plan for the dying patient (CCP) which currently amounted to 86% of expected hospital deaths. This had risen from 68% last year. Ward staff told us the team visited the wards on a daily basis.

Within the hospital there was a mortuary, bereavement service, chapel and chaplaincy service. These also fell within the scope of this inspection.

During our inspection, we spoke with six patients and their relatives including two groups of relatives. We were privileged to have been granted permission by the family to sit in on one family meeting.

We spoke with over 30 members of staff, which included porters, ward nurses, physiotherapists, psychotherapists,

palliative care consultants, medical consultants, clinical team leaders, managers, bereavement officer, chaplain, mortuary staff, clinical nurse specialists and facilities managers.

We observed care and treatment within the wards and visited a number of different areas within the hospital including post surgery wards, older people's care wards, the Margaret Centre, critical care wards and the mortuary. We also visited the bereavement office, porters office, chaplaincy and chapel.

We reviewed 12 care records and 14 Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms. We also reviewed a number of documents that were provided to us following our visit that related to end of life and palliative care including audits, policies, minutes of meetings and progress on work streams.

End of life care

Summary of findings

We rated End of Life Care as requiring improvement because:

- Although ward staff felt well supported by the specialist palliative care team (SPCT) it was a widely held belief among senior staff at the Margaret Centre and SPCT that a barrier to promoting a positive culture of end of life and palliative care being everyone's responsibility and lay with the education of ward staff.
- Despite issues regarding equipment being identified through audit and reported as acted on in March 2017, we found there was a lack of working equipment available within the mortuary. Twenty fridge spaces were available in the mortuary and deceased patients were frequently transferred to other premises. There were no bariatric fridge spaces and the audit stated that fridges were quite old. It recommended this issue for the trust risk register. Out of hours mortuary viewings were arranged and managed by the porters. However, the porters had not been trained in any mortuary duties.
- More clinical nurse specialists and consultants had been recruited as part of investing in end of life and palliative care which was a positive step. However, not all posts had been recruited to and staffing levels remained on the risk register. Consultant levels had increased and were due to increase further. However, they were still below the national guidance ['Commissioning Guidance for Specialist Palliative Care: Helping to deliver commissioning objectives' (Dec 2012.)] which recommends a minimum requirement of one whole time equivalent consultant in palliative medicine per 250 hospital beds. Association for Palliative Medicine of Great Britain and Ireland recommendations and the National Council for Palliative Care guidelines of a minimum of one consultant per 250 beds. The hospital had 586 beds.
- Provisions for relatives who were at the hospital with their loved ones for long periods of time were not consistent and differed from ward to ward. Some

were provided with tea and coffee, others with tea, coffee and sandwiches. For relatives staying overnight, some wards could only provide chairs while others had fold down beds.

- The availability of single rooms was at a premium in the hospital, which made dignified care for people at the end of their lives harder; this compounded the issue of patients being sent to the Margaret Centre, where care was provided in single rooms.
- The discharge team told us they tried to meet a target of 48 hours for rapid discharge. However, although they monitored this on a day to day basis they did not measure this in any other way, such as over time or through any sort of audit and did not understand their effectiveness against this target or its effect on patient care.
- Staff from both the SPCT and Margaret Centre we spoke with were not aware of a nominated non-executive director for end of life care, or of any representation at board level.
- There was a culture for end of life care at the hospital to be seen as the responsibility of the SPCT. There was also a culture of patients being admitted to the Margaret Centre to die rather than being cared for at home or on the wards.
- The mortuary was managed by an outsourced third party on behalf of the trust. There were systems in place that were not effective and others that the trust had no oversight of.

However:

- There were mechanisms in place for learning from incidents to take place through a multi professional, cross divisional hospital group who led on all matters that related to end of life and palliative care.
- The SPCT took working to resolve issues for patients receiving end of life care as something they took responsibility for within the hospital. They described being open, apologetic to people when things went wrong and resolving matters for patients.
- Ward staff, the SPCT and staff at the MC were all able to describe the trust's safeguarding referral process.

End of life care

They also knew when it was appropriate to seek help and advice as well as escalate potential safeguarding issues. We came across one current example of this in practice.

- A programme of refurbishment was taking place at the Margaret Centre. Updates had already taken place to the premises to improve infection control and protect peoples' privacy and dignity.
- The compassionate care plan for the dying patient (CCP) was in use throughout the hospital. Staff we spoke with on hospital wards and at the Margaret Centre told us that the end of life care was hugely helped by having the CCP in place.
- Patient deterioration, symptom management, continuing assessment and ongoing monitoring for each patient where appropriately discussed and reviewed in daily handover meetings at both the SPCT and MC.
- We found plenty of examples where end of life care was being delivered to national guidelines and in compliance with National Institute for Health and Care Excellence (NICE).
- DNACPR forms were in place and fully completed, including discussions with the family where appropriate. There was only one DNACPR form in use now.
- The Margaret Centre and the SPCT staff worked on relationships with services within the hospital to promote better end of life care. Ward staff we spoke with thought both the SPCT and the MC staff were helpful.
- Patients and relatives were positive about the care they had received.
- Family meetings were held soon after referral to the SPCT. Family involvement was discussed in handover meetings of the SPCT and the Margaret Centre.
- There was a good meeting structure that enabled accountability and direction for end of life care. The deteriorating patient improvement group met on a monthly basis and was the principle governance

meeting for the hospital that was concerned with end of life care. This group was now developing in to the end of life care group, which was to be led by the director of nursing at the hospital.

End of life care

Are end of life care services safe?

Requires improvement



We rated safe as requiring improvement because:

- Previous inspections had reported on low staffing levels for CNSs in the SPCT and consultant posts in SPCT as well as the MC. More CNSs and consultants had been recruited as part of investing in end of life and palliative care which was a positive step. Despite the positive increase in funding and staffing for the MC and SPCT, staffing remained an issue on how the teams could deliver care. We were told that staffing levels remained on the risk register.
- The SPCT were involved in all patients in hospital who were on the CCP, which currently amounted to 86% of expected deaths at the hospital. Ward staff told us they saw the SPCT visit wards on a daily basis. However, the CNSs were still unable to carry out education of ward staff as they had wished, record patient outcome measures or work outside of normal hours. The current staffing was one full time post short, which was being recruited to.
- Consultant levels had increased and were due to increase further. However, they were still below the national guidance ['Commissioning Guidance for Specialist Palliative Care: Helping to deliver commissioning objectives' (Dec 2012.)] which recommends a minimum requirement of 1 whole time equivalent consultant in palliative medicine per 250 hospital beds. The hospital has 586 beds.
- It was reported that the specialist palliative care team (SPCT) had not received incident reports back from the hospital since October 2016 due to a reported lack of administrative support. In addition to this, the lead consultant at the Margaret Centre (MC) was not receiving incident reports specifically for the MC also due to the lack of administrative support.
- We found examples where patients on the SPCT case list were on nightingale style wards or in dorms of four. The shortage of single rooms at the hospital impacted on the dignity of palliative and dying patients and contributed to the culture that existed within the hospital, whereby ward staff perceived dying patients to be the responsibility of the Margaret Centre, where single rooms were more likely to be available.
- A mortuary audit was carried out by the hospital and took place in March 2017. Although it rated the mortuary compliant for good general cleanliness it remarked that the floor was clean but stained in places, it also remarked that although fridge doors were clean they were stained.
- The mortuary audit also looked at whether there was enough fridge space and marked this as 'non compliant'. There were 20 spaces, and deceased patients were frequently transferred to other premises. There were no bariatric fridge spaces and the audit stated that fridges were quite old. It commented that this should be considered for entry onto the trust risk register.
- Despite issues being identified through audit and reported as acted on in March 2017, we found there was a lack of working equipment available within the mortuary. The patient slide (PAT slide) used for moving patients was missing and the concealment trolley used to remove a deceased patient from the ward to the mortuary was broken. This piece of equipment was essential and was reported to have been broken and out of use for a month. There was no replacement available and no temporary trolley was provided. The mortuary had to use a normal hospital bed with a covering instead.
- Out of hours mortuary viewings were arranged and managed by the porters. However, the porters had not been trained in any mortuary duties.
- The mortuary audit that took place in March 2017 rated hand washing facilities as 'compliant' and adequate. However, only one of the two sinks within the mortuary had hand wash available and paper towels to dry the hands.
- The mortuary was visibly clean. However, the hospital was unable to show us mortuary cleaning schedules.
- In the second viewing room (in the accident and emergency department), the skirting around the bottom of the walls was coming away and looked dirty and unsightly.

However

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- Incidents and learning were discussed in the deteriorating patient group. The deteriorating patient group was the multi professional, cross divisional hospital group who led on all matters that related to end of life and palliative care.
 - With regard to the duty of candour, the culture of candour was identified by the SPCT as one of their functions and something they took responsibility for within the hospital. They described being open, apologetic to people when things went wrong and working to resolve issues for patients receiving end of life care and their relatives.
 - Ward staff, the SPCT and staff at the MC were all able to describe the trust's safeguarding referral process. They also knew when it was appropriate to seek help and advice as well as escalate potential safeguarding issues. We came across one current example of this in practice.
 - A programme of refurbishment was taking place at the Margaret Centre. Updates had already taken place to the premises to improve infection control and protect peoples' privacy and dignity.
 - We found examples where patients had anticipatory prescribing taking place.
 - The compassionate care plan (CCP) was in use throughout the hospital for palliative care and end of life care. Between July 2016 and February 2017 the number of expected deaths of patients at the hospital who were also on the CCP had risen from 68% to 86%. We found it in use in a variety of settings including post surgery, gastro, elderly care and ITU. It contained a list of priorities for patient care of which there were 20. It included ensuring that patients were appropriately monitored and reviewed and that symptoms were managed and documented.
 - We observed the daily handover meetings at both the SPCT and MC, and accompanied SPCT team members to hospital wards. Patient deterioration, symptom management, continuing assessment and ongoing monitoring for each patient where appropriately discussed and reviewed.
- Incident reporting, learning and improvement**
- There had been no never events or serious incidents attributable to end of life care. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
 - From June 2016 to May 2017 there were a total of 184 incidents that were associated with patients receiving end of life care. There was consistent reporting throughout the year. Most of these were categorised as delays in care, continence management, medication, patient falls and skin trauma. Incidents and learning were discussed in the deteriorating patient group. The deteriorating patient group was the multi professional, cross divisional hospital group who led on all matters that related to end of life and palliative care. This group was currently being reconfigured but was set to retain this function.
 - The specialist palliative care team (SPCT) members told us they were aware that the number of incidents that related to end of life and palliative care patients reported by the hospital averaged around 15 a month and most of these related to tissue viability; either from people admitted from home or on the hospital wards. We were also told that other recent incidents that could be recalled related to drug use and handling of a body after death.
 - Minutes from the deteriorating patient improvement group for January, February and March 2017 showed learning from incidents and root cause analysis feedback was discussed. For instance, one learning related to the intubation of a patient with a do not attempt cardiopulmonary resuscitation (DNACPR) in place. Another learning related to patient deterioration and end of life care. March's minutes showed that of the 16 incident reviews completed last month, 10 related to pressure ulcers (two were acquired and six inherited). The group were to look further at which were avoidable and unavoidable.
 - The online reporting system had recently been updated, and now contained a drop down box for identification of incidents that related to end of life care (EoLC) and palliative care. However, this was a recent addition which was complicated by two issues. Firstly, it relied upon ward staff to identify patients as palliative or dying. Secondly palliative care was in the process of moving directorates within the trust and aligned to a

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different governance structure. This meant that the incident reporting system needed updating again as the system reported within directorates. Action was being taken on this.

- Due to hospital administrative issues the system was not working as well as it should. It was reported that the specialist palliative care team (SPCT) had not received incident reports back from the hospital since October 2016 due to a reported lack of administrative support. In addition to this, the lead consultant at the Margaret Centre (MC) was not receiving incident reports specifically for the MC also due to the lack of administrative support.
- There were six mortuary incidents reported between June 2016 and January 2017. In September 2016 there were two incidents where bodies, stored at the hospital, were found to be damaged, and a third of poor treatment while removing a body from a ward. As a result of these, representatives from the hospital met with managers of the sub contracted undertaker's service. All incidents that were reported and logged also demonstrated learning.
- The mortuary manager (from the outsourced company) did not have access to the trust's electronic incident reporting system. Should an incident have occurred, the mortuary manager reported this to the trust's overall mortuary manager to upload onto the electronic incident reporting system. The mortuary manager was not supplied with feedback following reporting an incident.
- With regard to the duty of candour, the culture of candour was identified by the SPCT as one of their functions and something they took responsibility for within the hospital. They described being open, apologetic to people when things went wrong and working to resolve issues for patients receiving end of life care and their relatives.
- There were variable responses from staff when we asked about the duty of candour. The SPCT told us they had received no specific training in the duty of candour but that it was covered in conflict resolution training. On Primrose ward we were told they apologised when things went wrong and that there was regular training on the last Tuesday of the month.

- Training data supplied by the trust showed that nursing staff working in palliative medicine (including the Margaret Centre) were 100% up to date with their safeguarding training. This was itemised as safeguarding adults, level 1 and level 2, and safeguarding children, level 1 and level 2.
- Ward staff, the SPCT and staff at the MC were all able to describe the trust's safeguarding referral process. They also knew when it was appropriate to seek help and advice as well as escalate potential safeguarding issues.
- We came across one current example where the SPCT were engaged in a multi-agency safeguarding approach to facilitate discharge. It involved the local authority safeguarding team, police and social workers to support the patient's choice and protect them from a family member.

Environment and equipment

- The MC had nine single rooms and one double room as well as offices for medical staff and the SPCT. Reorganisation had taken place with the help of charitable donations. There was a comfortable and relaxed day room with a kitchen leading off for relatives and patients to use. Updates had taken place to the premises to protect peoples' privacy and dignity. Previously, in order to access offices, staff needed to walk down the ward corridor where patient rooms were located. Due to the size of patient bedrooms, doors were often kept open, which meant that dying and palliative patients were inappropriately observed by staff and other visitors. There was now a second entrance via swipe card entry to the offices, which had been brought back in to use and enabled access without walking through the ward area. However, at the time of our unannounced visit, the MC was in the process of being redecorated so it was out of use at the time.
- We were provided with details of improvement works made to the Margaret Centre. This included becoming infection control compliant through replacement of the clinical hand wash basins installed throughout the building. 11 existing clinical hand wash basins were replaced. All were located in patient side rooms and one

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in the treatment room, with another in the sluice room. The sluice sink was replaced with an HTM 64 compliant stainless steel combined sluice slop hopper unit, completed after replacement flooring was laid.

- Refurbishment also included replacement of the electrical system including circuit breakers, sockets, light fitting replacements and fire alarm system. There were also replacement electrical white goods such as fridges and freezers, pipework insulation, redecoration and replacement blinds, flooring and signage.
- The majority of wards at the hospital were built in the open 'nightingale' style. Some had side rooms which were in dorms of two and four. Others had none. The elderly care wards were part of an ongoing programme of refurbishment, which had meant more single rooms were becoming available. However, the number of single rooms available did not currently meet the needs of the hospital.
- There were 34 T34 syringe drivers at the hospital in total. 19 were used on the wards and 15 were solely for the use of the MC. They could also be used in the hospital if the need arose. The medical devices team took responsibility for maintaining and loaning out syringe drivers. The use of syringe drivers, their storage and maintenance appeared safe and effective.
- The syringe drivers were stored in a central library and were regularly checked and maintained by the medical devices team. This was evidenced by an electronic logging system. Syringe drivers were kept within locked boxes and all wards had a key to open them to enable access. A spare key was available from the medical devices team and site manager if needed. The medical devices team picked up all devices from the wards twice a day. The MC's syringe drivers were also maintained by the medical devices team.
- Out of hours, the syringe drivers were accessed by the site manager and documentation of where each syringe driver was located, was documented in the log. They used a ticket library system of tracking. Electronic logging of syringe drivers' maintenance was also seen.
- The community part of the SPCT told us they accessed items such as commodes, urinal bottles and bath chairs through the community team's occupational therapist (OT) who also assessed and organised delivery. Beds and hoists were obtained through the district nursing service which was managed by another trust.
- We were told the MC now had their own bladder scanner. They also had their own syringe drivers but the numbers were dwindling. An air tube system was in use to send samples for testing to the pathology laboratory.
- Within the mortuary, there was a main viewing room and a body storage facility with 20 spaces. There were no bariatric mortuary facilities available.
- A mortuary audit took place in March 2017. It looked at whether there was enough fridge space and marked this as 'non compliant'. Patients were frequently transferred to another of the sub contracted undertaker service's premises. There were no bariatric fridge spaces for which deceased patients were also moved. It also remarked that fridges were quite old and commented that this should be considered for entry on to the trust risk register.
- Other items marked 'non compliant' included no evidence seen of the hoist having been serviced; the sub contracted undertaker's service was asked to service the hoist 'as soon as possible'. The condition of the concealment trolley was commented on, which was found to not work properly, prompting porters to borrow another from another department. This was reported as promptly serviced and evidence was seen of this being repaired by an engineer.
- We found there was very little equipment available within the mortuary. The patient slide (PAT slide) used for moving patients was missing and the concealment trolley used to remove a deceased patient from the ward to the mortuary was broken. This piece of equipment was essential and was reported to have been broken and out of use for a month. There was no replacement available and no temporary trolley was provided. The mortuary had to use a normal hospital bed with a covering instead. There was a variety of personal protective equipment (PPE) for use within the mortuary. This included gloves of various sizes and aprons.
- A mortuary audit took place in March 2017. It rated the mortuary 'compliant', and no action needed, in a number of areas. This included being secure from

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intruders, good recording of fridge temperatures, good general cleanliness, clean fridge doors, body trays were clean, there was an audible working alarm fridge unit that went through to security to alert staff to a fridge failure/temperature fault. However, although it reported that the floor was clean it also stated it was stained in places, it also remarked that although fridge doors were clean, they were stained.

- We saw evidence that the body storage fridges had their temperatures checked and logged twice a day. The fridges were linked to the trusts security system. In the event that the fridge temperatures were incorrect, an alarm was sent to the security department. This generated a call to the third party and the facilities manager for the trust site.
- The audit reported there was a standard operating procedure (SOP) on receiving patients to the mortuary, an SOP on what to do if a body was received without any identification bands and a check on whether patient information had been entered correctly onto the register. All these items were marked as compliant.
- The viewing room was a small room with a pre waiting area attached. The waiting area contained chairs, information leaflets and tissues. The main viewing room was carpeted and dimly lit. It contained a viewing trolley and the walls were neutral in colour. There was no availability of religious symbols.
- Vigils were accommodated by the trust. These were usually carried out on the wards in a side room, or within the accident and emergency viewing room rather than in the mortuary area. Out of hours viewings were arranged and managed by the porters. However, the porters had not been trained in any mortuary duties.
- There was a second viewing room, located within the accident and emergency department. This room was larger than the one based within the mortuary. It was also dimly lit, had neutral walls and a wipe clean laminated wooden flooring. There were two black wipe clean couches within the room, a small unit containing essential supplies and a picture of an outdoor scene on the wall. The room was quiet and of ambient temperature. There were two leaflet holders on the wall, however these did not contain any leaflets.
- The hospital did not have a concealment trolley for transporting deceased babies or infants from the wards.

There was no internal route between the maternity department and the mortuary and the terrain and distance meant that it was not appropriate to push a trolley. Instead, an infant carrier was used.

- The chapel/multi faith and quiet area was called The Retreat. A concern we noted with The Retreat was that the parquet wood flooring was loose and constituted a trip hazard. This was brought to the attention of the estates manager during the inspection. We were told that this would be dealt with.

Cleanliness, infection control and hygiene

- At the MC we observed a handover meeting where the team discussed taking Carbapenem resistant organisms (CRO) swabs for infection control purposes, and a patient being barrier nursed. The SPCT went through their list of current patients and discussed patient deterioration, continuing assessment and ongoing monitoring. We observed a variety of different aspects of care discussed that were appropriate to individual patients and infectiousness was included in this.
- The trust infection control policy included procedures to follow in the event of a death of a patient with an infectious condition. This included involvement of the mortuary staff, mortuary procedure, post mortems and procedure regarding visits to the mortuary.
- The mortuary audit that took place in March 2017 rated the following as 'compliant' in all areas: PPE, waste bins / clinical waste bin, the floor in a good state of repair, adequate lighting, if there were boxes of tissues available, cleanliness of the waiting area, adequate cleaning equipment and disinfectants and adequate hand washing facilities.
- The mortuary audit that took place in March 2017 rated hand washing facilities as 'compliant' and adequate. However, only one of the two sinks within the mortuary had hand wash available and paper towels to dry the hands.
- The mortuary was visibly clean. However, the hospital was unable to show us mortuary cleaning schedules.
- In the second viewing room within the accident and emergency department, the skirting around the bottom of the walls was coming away and looked dirty and unsightly.

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Medicines

- The expectation on the SPCT, including consultants, was that the team saw patients and gave advice on symptom control. We came across numerous examples where the compassionate care plan (CCP) was in place for patients and symptom management was taking place. For example, on Nightingale ward, it had been commenced for one patient two days ago. The patient was being re assessed by the SPCT that afternoon.
 - We observed the daily handover meetings at both the SPCT and Margaret Centre and accompanied SPCT team members to hospital wards. Symptom management, continuing assessment and ongoing monitoring for each patient were appropriately discussed and reviewed. Patients on the CCP also had anticipatory medicines prescribing taking place. For instance, we found anticipatory medications were being given to one patient for secretions and agitation.
 - There was information available for ward staff on the intranet via a link that included clinical guidelines for symptom management in palliative care. This was dated March 2017. One clinical nurse specialist (CNS) from the SPCT we observed, carried a paper copy around for ward staff and reference. The compassionate care plan also contained a list of priorities for nursing care that included ensuring patients were appropriately monitored and reviewed, and that symptoms were managed and documented.
 - On 'Blackthorne on Syringa' ward, we found that controlled drugs (CDs) were stored within a treatment area that was keypad secured. The CD cupboard was locked securely. The CD book and register of drugs showed that CDs were checked daily. However, the drug cupboard in the treatment area had no locking mechanism. This was highlighted to the nurse in charge of the ward at the time. On a return visit later on the same afternoon the locked door to the treatment room observed as left open, with the drug cupboard open and unsupervised. We also observed that the keypad code to the door to the treatment room was written in pen on the door itself. Matron immediately contacted maintenance to rectify this issue.
- care. We found it in use in a variety of settings including post surgery, gastro, elderly care and ITU. It contained a list of priorities for nursing care, of which there were 20. It included ensuring that patients were appropriately monitored and reviewed and that symptoms were managed and documented. The CCP was used alongside other plans such as SSKIN (a five step model for pressure ulcer prevention) bundles. The SPCT staff told us they were in the process of trying to get the CCP included in the hospital's standardised documentation bundle. This would enable end of life and palliative care to be seen as more mainstream within the hospital and promote a culture of being everyone's responsibility.
- The lead anaesthetist and EoLC lead told us they had set up an audit of use of the CCP. Data was collected when the death certificate was completed and CCP uptake rates were measured. Between July 2016 and February 2017 it showed the number of expected deaths of patients who had been on the CCP had risen from 68% to 86%.
 - A new clinical records system had recently come in to use at the hospital and had been used by the SPCT since April 2017. It had built in mechanisms to record patients' preferred place of care and preferred place of death (PPC and PPD). We were told that the SPCT were involved in approximately 90% of end of life care patients and routinely documented PPC/PPD on their first visit if possible. A CQUIN regarding this took place in March 2017 and showed it had only been documented in around 50% of cases. However, the audit involved trawling back through case notes in paper files in order to locate where it was documented, which made it a problematic exercise. As a result of this, the new online records system contained a section for a 'first assessment for palliative care'. We viewed this new addition to the records system and found it included spiritual, physical and psychological needs and stated patients' PPC and PPD. Such information would now be easy to access and extrapolate. Any repeat audit would show performance on this.
 - Additions to the on line system were introduced in March 2017, and had been in use since April 2017, so less than a month before this inspection and therefore,

Records

- The compassionate care plan (CCP) was in use throughout the hospital for palliative care and end of life

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too early to observe improvement. There was also now space to write an overall summary and actions for the SPCT to follow up as well as notes for ward teams to read for better continuity of care.

Mandatory training

- Training data supplied by the trust showed there were a total of 31 items of training that nursing staff working in palliative medicine (including the Margaret Centre) were required to train in. Out of 31 required training topics, 27 met the trust's 90% target. Staff were 100% up to date in 12 training subjects that included safeguarding adults, levels 1 and 2, and safeguarding children, levels 1 and 2, the four harms, (itemised as separate pieces of training); catheter acquired infections, pressure ulcer prevention, slips, trips and falls, and venous thromboembolism (VTE). Training that did not meet the target included infection prevention and control and health and safety, both showed that 10 of 14 staff had attended.
- Staff categorised as 'additional clinical services' working in palliative medicine within the hospital were required to complete 26 training topics. It showed there were four staff required to complete all 26 subjects. In all cases three had completed their training. It also showed a total of 14 training topics to be completed by estates and ancillary staff, which totalled one staff member, who was 100% up to date with their training.
- The SPCT team leader was able to identify from mandatory training records how up to date each individual team member was. Records also showed a red/amber/green (RAG) rating system was in use; this was used to show how up to date each team member was for each training topic.
- Records showed that staff were expected to complete training in a number of topics that included dementia awareness, information governance, privacy and dignity, pressure ulcer prevention and nutritional care. While records showed that team members were up to date, one was not up to date with most of their training which was being addressed by the team leader.
- The bereavement officer's training log showed they were up to date with all mandatory training. Topics included conflict resolution, dementia awareness, security and moving and handling. The chaplaincy training log was also up to date with training that included safeguarding children and adults levels 1 and 2.

Assessing and responding to patient risk

- We observed the handover meetings of both the SPCT and the MC. The SPCT handover meetings occurred each morning. A list was generated daily that included new referrals which were allocated to team members. Patient numbers on the SPCT case list varied from around 25 to 40. We observed them go through their list of patients and discuss patient deterioration, continuing assessment and ongoing monitoring of individual patients. They included: infectiousness, deterioration, anxiety with breathing, patient transfer from ITU to MC, syringe driver monitoring, medications for pain, nauseousness, pain relief as well as eating and drinking.
- At the MC we observed a handover meeting that included medical and nursing staff. The headings on the handover sheet stated room, name, reason for admission, do not attempt cardiopulmonary resuscitation (DNACPR) status, next of kin, clinical information including the CCP and tasks. The team went through each patient and identified any risk factors and developments in care or patient deterioration. The ward manager had developed a nursing handover sheet that contained drop down boxes to enable better monitoring and identify actions agreed. This was recorded daily and stored in easily accessible records.
- The results from the National Care of the Dying Audit 2016 for Barts Health NHS Trust showed 85% of patients across the trust were recognised by the multi-disciplinary team as dying; the England average was 83%. Results of the National Care of the Dying Audit undertaken during 2016 showed 80% of patients across the trust were recognised as at end of life, which was just above the national average 79%.
- The community SPCT told us that the core of their work was home visits and advisory work such as with district nursing services. They would assess the deteriorating patient and access the MC for symptom control and respite. Monthly meetings were held with the district nursing service to discuss patients who may be end of life. Telephone contact with palliative care consultants was maintained for ongoing support around symptom control and medication reviews.
- The compassionate care plan (CCP) contained a list of priorities for nursing care of which there were 20. The SPCT told us that ward staff should be meeting these

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priorities anyway. However, it helped to raise the profile of patients receiving end of life care and palliative patients within the hospital. It included ensuring that patients were appropriately monitored and reviewed and that symptoms were managed and documented.

- We accompanied SPCT team members to hospital wards. On Cedar ward we saw that a comprehensive assessment of the patient's symptoms had been completed by the SPCT that included pain, nausea and constipation. Regular PRN (when necessary) medications were discussed with the patient and with the family present, and a plan of symptom management put in place.
- On Nightingale ward we saw that the CCP was in place for a patient. The nursing continuation bundle showed that pressure area care was documented as being checked every three to four hours. Mouth care checks were taking place. Bowel and bladder checks took place appropriately. It identified the deteriorating patient as not for escalation to CCU/ITU, which had been documented in the patient notes.

Staffing levels and caseloads

- Previous inspections had reported on low staffing levels for CNSs in the SPCT and consultant posts in both the SPCT and MC.
- As a result of the profile of end of life care and its priority within the trust being raised, funding had been made available for additional CNS and consultant posts. We were told that a business case was made for extra funding for staffing. Phase one of this case was to source funding and recruit CNSs and consultants in to the SPCT. Phase two would look at chaplaincy support, administration, social work and psychological support. Phase one was just coming to an end and phase two had not yet commenced.
- The SPCT caseload varied from between 25 to 40 patients at any one time. The team were involved in all patients on the CCP which amounted to 86% of expected deaths. Ward staff told us they saw the team visit wards on a daily basis.
- Within the SPCT, the Band 8a CNS team leader post had previously been shared 50/50 with another acute

hospital within the trust. A new 8a post had just been recruited to at the other acute hospital which meant they were very soon to become full time SPCT team leader.

- In addition to this, there had been an increase in Band 7 CNS staffing. There were currently 1.6 whole time equivalent (WTE) band 7 CNS posts. Two more had been newly funded and were being recruited to. One was due to start in July 2017. In the meantime, a seconded CNS was covering some of the workload. The second CNS post was being re-advertised.
- The Margaret Centre (MC) had recruited a ward manager in the last year, who took on coordinating duties and day to day charge of the service.
- A full time palliative care consultant covered community and SPCT hospital work 50/50. This work was compressed in to four days.
- There was a full time consultant who covered the MC duties and was available to review hospital and community patients if this consultant was not around. They were supported by a registrar and FY1. Another consultant was due to be appointed soon and we were told there was an applicant. It was intended for them to do seven sessions in the MC and three on education. However, we were also told a further three sessions would be available to the hospital when this post had been recruited to.
- Officially both consultant posts were split 40/60 to cover MC and SPCT work, but in reality one covered SPCT and the other the MC. These roles were interchangeable when this was called for. Either way, it meant there were eight consultant sessions in total shared between the hospital and community.
- However, despite the positive increase in funding and staffing for the MC and SPCT, staffing remained an issue on how the teams could deliver care. We were told that staffing levels remained on the risk register.
- Consultant levels were below the national guidance ['Commissioning Guidance for Specialist Palliative Care: Helping to deliver commissioning objectives' (Dec 2012.)] which recommends a minimum requirement of 1 whole time equivalent consultant in palliative medicine per 250 hospital beds. The hospital has 586 beds.

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- In addition to this, the MC also had 0.5 of a WTE social work post, 0.6 of an occupational therapist post and psychological services. Both the SPCT and community SPCT told us they could access this very limited resource. For instance, the psychological service was provided by the trust and took 25% MC referrals. The rest were community referrals. All MC referrals were accepted.
- The psychological support service had 21 hours of admin support a year. Both the Margaret Centre and the SPCT were currently lacking admin support. The SPCT teams were currently completing their own admin as the post which was for two days a week was currently vacant. We were told this post was being recruited to.
- The community part of the SPCT were a well established team that covered the borough of Waltham Forest, with CNSs assigned to areas within the borough.
- We spoke to the chaplaincy at the trust. We were informed that there was one chaplain working for the hospital. He had approximately 20 volunteers of different faiths assisting throughout the week. Faith leaders from other communities were available to attend the hospital if required with a call out time of one hour. There were always three chaplains on call at any one time. If the ward required a chaplain, they would contact the hospital switchboard who would put them through to an on call faith leader.

Are end of life care services effective?

Requires improvement



We rated effective as requiring improvement because:

- A new clinical records system contained mechanisms for better patient outcome data to be collected. However, patient outcome measures were not currently being carried out. The outcome measures had been on the new system since March 2017, which the SPCT had used it for a matter of weeks prior to our unannounced inspection and were not yet in use.
- We were told that promoting a positive culture of end of life and palliative care being everyone's responsibility, lay with the education of ward staff. We were also told that if ward teams in the hospital did not feel every patient had to come to the Margaret Centre to die and

the SPCT received referrals sooner, it would be a better scenario all round. The SPCT were currently short of staff to be able to effectively deliver ward training and the trust's education facilitator post for end of life care was currently vacant.

- There was a limited multidisciplinary input to the Margaret Centre and SPCT; social work, occupational therapy and psychological services were a very limited resource within the teams. The Margaret Centre had 0.5 of a whole time equivalent (WTE) social work post, 0.6 of an occupational therapist post and psychological services. The SPCT and community SPCT told us they could both access this resource but it was a very limited resource, especially when shared among three teams. This was due to be addressed in 'phase 2' of the business case for extra funding for staffing.

However

- We found plenty of examples where end of life care was being delivered to national guidelines and in compliance with National Institute for Health and Care Excellence (NICE).
- We found DNACPR forms were in place and fully completed, including discussions with the family where appropriate. There was only one DNACPR form in use now.
- The expectation on the SPCT was that the team saw patients for symptom management and were involved with their CCP. We shadowed members of the SPCT, who monitored a number of patients' care. Pain was appropriately managed. Nutrition and hydration was being effectively managed.
- The Margaret Centre and the SPCT staff worked on relationships with services within the hospital to promote better end of life care. Ward staff we spoke with thought both the SPCT and the MC staff were helpful. The teams worked alongside a variety of specialties on different wards, including stroke, resuscitation, acute admission, care of the elderly and ITU.

Evidence-based care and treatment

- We found plenty of examples where end of life care was being delivered to national guidelines and in compliance with National Institute for Health and Care Excellence (NICE).
- For instance, on Cedar ward we observed comprehensive assessments of patient symptoms,

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completed by the SPCT that included pain, nausea and constipation. Regular PRN (when necessary) medications were being discussed and plans of symptom management put in place. Care was discussed with patients and with the families present. All prescribed medications were appropriate and dose appropriate. (NICE guidance (NG)140 (2013/2017).

- We observed a conversation with a patient and their family, conducted with sensitivity and dignity. Curtains were drawn around the patient's bed for privacy and there were no interruptions. Everyone was seated. The conversation took place at the patient's pace and was not rushed. Further conversations were going to take place with the family later that day. This was consented to by the patient (NG31- care of dying adults in the last days of life December 2015. CG 140 Palliative care for adults 'strong opioids for patient relief' May 2013 updated Aug 2016. QS 13 End of life care for adults Nov 2011 updated March 2017). Discussions around nutrition and fluids took place with patients and families (NG31-p11, 2015).
- We observed DNACPR forms were in place and fully completed, including discussions with their family where appropriate. Staff told us there was only one DNACPR form in use now (Resus council UK).
- We found that the replacement for the Liverpool Care Pathway (LCP); the compassionate care plan (CCP) was in place throughout the hospital (QS13 Nov 2011 updated March 17). We also found examples where identifying the deteriorating patient had been documented in notes and in the DNAR form. For instance, not for escalation to critical care/intensive care (5 Priorities for care (leadership alliance) one chance to get it right June 2014).
- Anticipatory medicines prescribing was taking place (NICE CG 140 (2013 updated 2016)).
- Syringe drivers were in use; the storage and maintenance appeared safe and effective. They were kept within locked boxes and all wards had a key to open boxes to enable access. Spare keys were available from the medical devices department or site manager if needed (2011 end of Life Care for adults QS 13, updated March 17 P63).

Pain relief

- We were told that the expectation on the SPCT was that the team saw people for symptom management and were involved with patients on the CCP. On a post surgery and gastroenterology ward, we shadowed a member of the SPCT, who monitored a number of patients' care. All assessments and reviews included pain management. One patient was being discharged home on the day of the inspection (preferred place of care). Part of the ongoing monitoring included understanding how patient anxiety was exacerbating pain and vice versa. The patient had been offered complementary therapy as well as psychological therapy.
- We found one example where a patient was on a lot of opioids; due to their pain they had stopped mobilising as much. Pain was being managed with a plan to discharge. Another patient told us that the hospital was managing their pain well. They told us they needed something and had slow acting morphine every four hours. They told us that a nurse had been allocated to help them manage their pain and medication. We understood this to mean a CNS from the SPCT.
- On Nightingale ward, we found one patient on the CCP, who had a 'standard of care for acute pain management' document commenced the day before our inspection. Their pain score was documented, sedation score documented and nausea score documented. Interventions for these were also documented and PRN (when necessary) pain relief had been given appropriately.

Nutrition and hydration

- We found that patients' nutrition and hydration was being regularly assessed. Nutrition and hydration needs were included in patient care plans. For instance, we reviewed patients where the CCP was in place. On Nightingale ward we observed a patient's records where they had been commenced on the CCP two days ago. This included pragmatic feeding and fluids. The family were involved in this decision, which was assessed by the dietitian as requiring thickened fluids. A swallowing assessment had also been carried out.
- The nursing continuation bundle showed that pressure area care for end of life patients was documented as, for example, three to four hourly checks. Fluid intake, mouth care, bowel and bladder checks took place appropriately.

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- On Cedar ward, a comprehensive assessment of a patient's symptoms was completed by the SPCT that included nutrition and hydration. This was discussed with the patient with the family present. We observed discussions around nutrition and fluids took place, with the patient and their family. The family had concerns that the patient had no appetite and was just drinking small amounts. The SPCT reinforced that patients in their condition invariably had poor appetite which the family understood. Regarding nausea, which impacted on diet, a prescription was put in place. It was discussed that this also may be related to constipation for which a prescription was also given.

Patient outcomes

- Barts Health NHS Trust contributed to the National Care of the Dying Audit (NCDA) March 2016. The trust was below the England average on three out of the five clinical indicators and only achieved one out of the five organisational key performance indicators (KPI). However, this data was collected nearly two years ago and may not be the best indication of progress made by the trust.
- A new clinical records system had been in place for less than a month prior to our inspection. The system contained mechanisms for better patient outcome data to be collected. There were two new outcome measures that had been on the new system since March 2017. Outcome measures were not yet in use and the team told us they were looking to start this soon. We were told barriers to this were finding the time.
- The two measures in place on the new system but not yet used were: 1. Outcome scales for measuring palliative care (known as IPOS) was also available on the new system, which would make outcomes and the ability to understand how they were making a difference easier to understand. For instance, with pain, shortness of breath, weakness, nauseousness, poor appetite, sore or dry mouth, drowsiness. The idea was that this outcome process was completed every three days but sensitivity would be considered beforehand. 2. The Australia-modified karnofsky Performance scale(AkPs)was a measure of the patient's overall performance status or ability to perform their activities of daily living. The AkPS score was now to be completed on each SPCT patient visit or when there was a change.

- Patients' preferred place of care and preferred place of death (PPC/D) were also now recorded on the new system. Audits showed that this had previously not been well documented when recorded in paper files (around 50%). However, the audit had involved trawling back through case notes in paper files, which made locating whether PPC/D had been documented problematic. As a result there was now a section to state patients' PPC/D in the online records system.

Competent staff

- The Margaret Centre (MC) and the SPCT staff worked on building positive relationships with services within the hospital to promote better end of life care. Ward staff we spoke with thought both the SPCT and the MC staff were helpful. Although they engaged well with ward staff and supported teams to deliver end of life care, we were told that promoting a positive culture of end of life and palliative care being everyone's responsibility, lay with the education of ward staff. We were also told that if ward teams in the hospital did not feel every patient had to come to the Margaret Centre to die and the SPCT received referrals sooner, it would be a better scenario all round. The SPCT were currently short of staff to be able to effectively deliver ward training and the trust's education facilitator post for end of life care was currently vacant.
- There were meant to be two link nurses for each ward. However, current systems and turnover of staff meant that this had not proved effective. The SPCT did their own link nurse training, which stopped when the trust wide end of life education facilitator left. This post was currently vacant. It was reported that there was a new starter in this role commencing in June 2017; a month after our visit.
- The SPCT reported that they had tried running education sessions for hospital staff as a drop in, which had not proved to be an efficient way of delivering training due to poor turnout. It was widely felt that this was due to the wards being pressurised which accounted for the low attendance by ward staff.
- We asked if providing training at nurse handovers had been considered. We were told that the shift structure meant there were no split shifts at the hospital now, which meant training would be outside of normal SPCT

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working hours. A barrier to this training was given as staffing and budget; at present we were told there was not enough staff to cover the training programme they would want to run.

- We were provided with a statement dated 5 June 2017, showing that 42% of ward staff had received syringe driver training. Ward staff were also supported by either the site manager, MC or SPCT when setting up syringe drivers. The SPCT staff took informal opportunities to train staff on single end of life care issues, or syringe driver training. We were told that the SPCT were trying to do training on an ad hoc daily basis with ward staff.
- We were provided with details of a specialist palliative care study day that took place once in May and once in November 2016. It was presented by members of the MC and SPCT and covered aspects of care such as spirituality, nausea, vomiting and constipation, pain and terminal agitation. May's session showed that out of 26 attendees, 14 were from a mix of hospital wards.
- We were told by some medical staff that there was a training need for some consultants in older people's care and the CCP. They had known of patients coming off of the CCP due to concerns that it was like the Liverpool Care Pathway and so were reluctant to use it.
- Other competency issues that affected end of life care included basic nursing skills. We spoke with one family who told us that that generally the care had been very good for their dying relative but described some poor technique and rough treatment from one nurse when draining fluid from the lungs via a nasal tube. This had been taken up with their ward manager.
- There was information for staff available on the intranet via a link that included clinical guidelines for symptom management in palliative care. This was dated March 2017. Staff were aware of intranet access to CCP and policy.
- Elsewhere we found resource folders on wards that contained clinical guidelines for symptom control, SPCT patient information leaflets, SPCT contact details, introduction to the CCP, the daily CCP plan and initial assessment and the Margaret Centre out of hours policy.

- We were told that the contract for porter services had been outsourced in December 2016. No formal training other than a basic induction had been given and mandatory training was not provided.
- Spiritual dimensions to death and dying, was given by the chaplain during hospital induction sessions, in which an hour was dedicated to the chaplaincy. Support was available for staff after traumatic events, for example an unexpected death. The Chaplain was able to provide group and one to one support in these instances. The chaplain had not been given an appraisal within the past three years at the trust. However, he had regular one to one meetings with his line manager.

Multidisciplinary working and coordinated care pathways

- The SPCT team worked alongside a variety of specialties on different wards, including stroke, resuscitation, acute admission, care of the elderly and ITU. Ward staff in these settings told us they had good links with the SPCT and felt they worked well with them. For instance, ITU told us they liaised well with the SPCT, where they reviewed patients who were palliative or end of life. An oncology lung CNS told us they worked alongside the CNSs from the SPCT where there was a shared need. SPCT team members also attended ward multidisciplinary team meetings when needed.
- There was a limited multidisciplinary input to the Margaret Centre and SPCT; social work, occupational therapy and psychological services were a very limited resource within the teams. The Margaret Centre had 0.5 of a whole time equivalent (WTE) social work post, 0.6 of an occupational therapist post and psychological services. The SPCT and community SPCT told us they could both access this resource but it was a very limited resource, especially when shared among three teams.
- The psychological support service had two full time psychotherapists, one family therapist three hours a week and 60 part time volunteers. The annual report for 2015/16 stated they had 550 referrals for the year. The team had concerns about advertising their service as it was currently bursting at the seams and could not cope.
- The community SPCT worked alongside district nursing services. Monthly meetings were held with the district nursing service to discuss patients who may be end of life. Telephone contact with palliative care consultants

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was maintained for ongoing support around symptom control and medication. There were joint hospital and community SPCT discussions of patients; the team leaders shared an office and staff were based in the same building.

- We found examples where patients receiving end of life care were well engaged with multidisciplinary services. We observed hospital therapies teams of physiotherapy and occupational therapy carrying out assessments of end of life patients, and reviewing daily plans for intervention. We found patients were offered complementary therapy and psychology.

Access to information

- The new online records system contained a section to record a first assessment for palliative care. This included spiritual, physical and psychological dimensions of care as well as stating patients' PPC/D, which was recorded on the first visit if possible. The new online system also allowed space to write an overall summary and actions for the SPCT and notes for the ward team, to see what had been discussed.
- This addition to the online system was introduced in March 2017, and had been in use by the SPCT for less than a month before our unannounced visit. Although too early to properly assess, this potentially improved the continuity of care for end of life patients through better ward access to SPCT documentation.

Consent

- We reviewed 14 DNACPR forms and found them all correctly and appropriately completed. We found a consistent approach to DNACPR. We found one form in use. We were told that the deteriorating patient group had worked at improving completion of DNACPR forms with tasks taken away by individuals to action.
- They were all located in patient files in a variety of wards and settings that included Nightingale ward, 'Blackthorne on Syringa' ward, B3 ward, Faraday ward, ITU and the Margaret Centre. In all cases we found that the forms were dated, located at the front of the patient notes with the patient's name and ID details completed. They were signed by the professional completing the form, countersigned with designation stated and the rationale for the DNACPR being completed. Patient discussion had also been documented. If this was not documented, reasons were stated for this; six of the 14

stated capacity assessments concluded no capacity to discuss. Out of the 14 forms, 12 stated that discussion with the family had taken place and two stated no discussion had taken place, one of those stated 'N/A'.

Are end of life care services caring?

Good



We rates caring as good because:

- Patients and relatives were positive about the care they had received. We spoke with a family group of one patient receiving end of life care who told us this was their eighth or ninth day in hospital and the third setting they had experienced. They told us care was delivered with compassion, that staff were generally caring and carried out their work with patient dignity and respect in mind.
- Family meetings were held soon after referral to the SPCT. Family involvement was discussed in handover meetings of the SPCT and the Margaret Centre. We observed family involvement at meetings and came across records of discussions with families, both documented in the CCP and in case notes.
- We came across examples where the SPCT had supported patients emotionally.

However

- The psychological support service was very stretched and overloaded with referrals for the number of staff they had.

Compassionate care

- We spoke with a group of relatives of one patient who told us their loved one's condition had deteriorated to the point of them being in the last days of their life. They told us that this was their eighth or ninth day in hospital and the third setting within the hospital they had experienced. They told us they had experienced care that was compassionate and had been given by staff who were caring and carried out their work with patient dignity and respect in mind.
- A palliative care patient on Cedar ward told us that they found the staff to be caring. They told us they were a lovely team and that they knew them all by name. "I

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came to the ward last week. I've observed good care and I've experienced good care, compassionate care and kind staff". "The staff talk to me by name and explain what they are doing beforehand".

- We spoke with two relatives of a patient at the Margaret Centre, who told us their loved one had experienced kind staff and were also being cared for appropriately. They felt they had received good nursing care and could not fault the care.
- One patient on ITU told us that the consultant was very nice, and that staff said goodnight to them when they went home.
- On B3 ward, we observed that staff were responsive to call bells and spoke in a positive caring manner to patients.
- We observed care being carried out in a compassionate and caring way on a (although not ideal) nightingale style dementia/ care of the elderly ward ('Blackthorne on Syringa' ward'). Patients were spoken to appropriately and curtains were drawn around the bed when it was appropriate to do so, to preserve dignity and privacy. Patients appeared clean and dressed in clean garments. Water jugs and beakers were present and filled. Dietary requirements such as vegetarian were catered for and clearly displayed for each patient.
- We were provided with a copy of a survey completed by relatives following bereavement dated February 2017. It used a sensitive approach to gathering information and divided responses into the categories of care, staff, beliefs, at the time of death, return of personal items, viewing and bereavement officer. Under each of these headings were a collection of 'feeling words' that ranged from 'informed, warm, involved', to 'unmet needs' and 'not sensitive'. People were also invited to include their own. Responses were recorded in two categories. First based on the feeling words and second on peoples own words. Analysis showed how well the hospital did in terms of being sensitive and not meeting people's needs. Individual comments were also itemised. Results showed some positive care but were overall mixed. How this information was used to improve care was not stated.

Understanding and involvement of patients and those close to them

- We observed family involvement at meetings about individual patient care and came across records of discussions with families, both documented in the CCP and in case notes.
- We observed that family involvement was discussed in handover meetings of the SPCT and the Margaret Centre. A CNS from the SPCT told us that family meetings were held soon after referral to the SPCT. For instance, on Cedar ward, where one patient had a family meeting arranged for the day following our unannounced inspection. This was to involve them in care and ascertain the patient's PPC. It was explained that often cross borough funding could be required when a patient was being discharged to their loved ones' home which may be outside of their own borough. We were told that patients came from numerous boroughs with Redbridge, Newham and Waltham Forest being the main ones. All of this was included as part of the family meeting.
- We observed a conversation between a member of the SPCT, a patient and their family. It was conducted with sensitivity and dignity. The curtains were drawn around the patient's bed for privacy and there were no interruptions. Everyone was seated. The conversation took place at the patient's pace and was not rushed. The family were able to express issues they had around aspects of care. The SPCT CNS sensitively explained aspects of care for people with their condition. Further conversations were going to take place with the family later that day, which was consented to by the patient.

Emotional support

- On Cedar ward, a post-surgery and gastroenterology ward, we discussed some of the cases the SPCT were involved in with one of the CNSs, who was visiting the ward. We came across examples where the team supported patients emotionally. One patient had been told by the ward that they had a short time to live. The CNS saw their role as picking up the emotional side of what had been said to them.
- Another patient had experienced recent family conflict. The patient had been offered complementary therapy as well as psychological support. The patient had not taken up the psychological support as they wanted the continuity of SPCT's emotional support.

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- There was a psychological support service. 20 to 25% were Margaret Centre referrals and we were told that hospital patients could be referred by the SPCT. The rest were Waltham Forest community referrals, as the service was commissioned by them. All MC referrals were accepted and first considered at the MC's MDT meeting.
- We spoke with the psychological support service, who had two full time psychotherapists, one family therapist three hours a week and 60 part time volunteers. The annual report for 2015/16 stated they had 550 referrals for the year. The team had concerns about advertising their service as it was currently bursting at the seams and could not cope.
- There was a CNS forum run by psychological services.
- Although the SPCT routinely documented patients' preferred place of care and preferred place of death (PPC/D) an audit showed this was not well documented. As a result, the online records system now included a section to record a first assessment for palliative care that stated patients' PPC/D. As this was a new audit process, it was too early to judge outcomes of effectiveness from these changes.
- With regards to out of hours cover, we were told that within the SPCT there just was not enough staff at present to provide a service in the evenings or at weekends. Even with future extra numbers in post it would still not be enough to cover seven days.
- There were no religious texts readily available except for the Muslim faith at the time of the inspection.

Are end of life care services responsive?

Requires improvement



We rated responsive as requiring improvement because:

- Provisions for relatives who were at the hospital with their loved ones for long periods of time were not consistent and differed from ward to ward. Some were provided with no tea and coffee, others with tea, coffee and sandwiches. For relatives staying overnight, some wards could only provide chairs while others had fold down beds.
- There was a car parking concessionary rate for families. However, nurses we spoke with on some wards were not aware of the parking concession.
- The availability of single rooms was at a premium which made dignified care for people at the end of their lives harder; this compounded the issue of patients being sent to the Margaret Centre, where care was provided in single rooms.
- We came across an example where a registrar did not incorporate a patient's dementia or communication issues in to their care plan.
- The discharge team told us they tried to meet a target of 48 hours for rapid discharge. However, although they monitored this on a day to day basis they did not measure this in any other way, such as over time or through any sort of audit and did not understand their effectiveness against this target or its effect on patient care.
- All patients on the SPCT's case list, including new referrals, were discussed in a daily morning handover where individual needs were addressed. Ward staff with patients on the CCP told us that the SPCT normally came to the ward daily.
- To ensure the smooth running of the office and to make sure the death certificates were ready for collection on time, the bereavement officer went above and beyond her role.
- The chaplain attempted to visit every ward within the hospital each week. They also utilised the volunteers to assist with this task.

However

- The CCP identified the individual care needs of patients at the end of life. 86% of patients with expected deaths were on the CCP. The expectation of the service provided by the SPCT was that the team saw all patients who were on the CCP. Staff we spoke with on hospital wards and at the Margaret Centre told us that the end of life care was hugely helped by having the CCP in place.
- We observed staff making the best of working in the 'nightingale' style wards. Although not ideal, we observed good that met people's needs care being carried out.
- All patients on the SPCT's case list, including new referrals, were discussed in a daily morning handover where individual needs were addressed. Ward staff with patients on the CCP told us that the SPCT normally came to the ward daily.
- To ensure the smooth running of the office and to make sure the death certificates were ready for collection on time, the bereavement officer went above and beyond her role.
- The chaplain attempted to visit every ward within the hospital each week. They also utilised the volunteers to assist with this task.

Planning and delivering services that meet people's needs

- The hospital was located in the borough of Waltham Forest but the catchment area covered numerous boroughs and taking many patients from Redbridge and

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Newham. Cross borough funding was sometimes required where a patient may be discharged somewhere other than their own home, such as to a relatives' home for care. This could mean a different GP and cross funding for a bed or equipment. The discharge team liaised with families and tried to link with CCGs for funding. We were told that if the family said they could support their relative, they were keen to facilitate patient choice. The community SPCT only worked in the borough of Waltham Forest, as this was who they were commissioned by.

- Provisions for relatives who were at the hospital with their loved ones for long periods of time differed from ward to ward. For instance, relatives we spoke with on Nightingale ward told us that although staff had been helpful they had not been able to provide them with any more than tea and coffee. They had chairs to sit on but mattresses or other provision for staying overnight was not available. ITU provided relatives with tea, coffee and sandwiches. There were also books for relatives and visitors. On Primrose ward there was access to fold down beds for relatives to stay overnight. At the Margaret Centre handover we learned there was a relative was staying with a patient.
- A CNS from the SPCT showed us information they carried with them as routine. This included information on palliative care for carers, complementary therapy for carers and details of special car parking rates for carers of palliative and end of life patients. There was a special rate of £2.50 a day for families and carers of patients who were at the end of life. Relatives we spoke with knew about this concession. However, nurses we spoke with on some wards such as ITU and Nightingale wards were not aware of the parking concession.
- The availability of single rooms was at a premium which made facilitating patient choice for people at the end of their lives harder. We observed staff making the best of working in the 'nightingale' style wards. Although not ideal, we observed good care that met people's needs being carried out.
- The SPCT saw part of their role as advocating for palliative patients and those in the last days of their lives to be moved to single rooms. We came across examples where this had happened and also where patients had been moved to a side ward of four.
- We spoke with the Macmillan cancer charity, who had a shopfront on the main hospital corridor. They told us they were proactive in seeking out the SPCT for advice and referred on people who had relatives with end of life and palliative care needs. There were two welfare benefit advisors on site twice weekly for 'ds 1500' benefit advice. This was a form, completed by a GP, consultant, hospital doctor or specialist nurse, that enabled someone who was terminally ill to claim Disability Living Allowance or Attendance Allowance under 'special rules'.
- The Chapel/multi faith and quiet area was called The Retreat. This was open to all faiths at all times. There were specific faith services for Roman Catholics, Sai Baba followers, the Muslim faith and Christians on various days throughout the week.
- We visited The Retreat and found that the area was the old hospital chapel. It had been split into three separate areas using mobile partitioning boards. One third of the chapel area was dedicated to the Muslim faith. This contained prayer mats, a separate men's and women's prayer area, religious pictures and symbols, as well as Qurans. There was also a washing/cleansing area in a room just next door to the Muslim prayer area.
- The middle section of the chapel was dedicated to the Christian faith. It contained an altar, religious symbols, a working organ, pictures and a seating area.
- The third section was denoted as the quiet area. This was a seated area containing neutral pictures on the wall.
- There were no religious texts readily available except for the Muslim faith at the time of the inspection. We asked the chaplain about the availability of religious texts. We were informed that there were usually bibles and religious magazines available within the chapel for the Christian faith. We were also told that should someone require a religious text, they should contact the chaplaincy who would be happy to provide this. Religious texts were kept within the chaplain's office or temporary storage facility. We found that this could be an issue to patients or relatives that may have wished to have access to these religious texts outside of working hours.
- We looked for head coverings for both men and women of different religious backgrounds but did not find these

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within the prayer area. We asked the Chaplain about this. We were informed that the majority of those who use these items would supply them for themselves, however he believed that there were some publically available.

- At the time of the inspection, there were no leaflets regarding the Chaplaincy, however we were informed that each ward had a poster with their details visible. We were told that there was a draft leaflet, however this was waiting for approval. We did not see this on the inspection.
- We spoke with the bereavement officer during the inspection. The bereavement officer dealt with the Coroner's Office, undertakers, GPs, relatives, families, released death certificates and cremation letters amongst other duties. To ensure the smooth running of the office and to make sure the death certificates were ready for collection on time, the bereavement officer went above and beyond her role. She had contact numbers of all the consultants and ensured that the relevant doctor was in the correct place at the right time for the certificates to be signed ready for the family to collect; this was usually the first working day after death. Out of hours, this responsibility fell to the site manager.
- We were shown leaflets that were available to relatives and friends at the time of a death. This included leaflets on those who had lost a baby or child.
- There was a chaplaincy policy (this included the religious and spiritual policy), however we were informed that this had just been re-written and was in a draft format.

Meeting people's individual needs

- The compassionate care plan (CCP) identified the individual care needs of patients at the end of life. The expectation of the service provided by the SPCT was that the team saw people who were on the CCP and for symptom control.
- Staff we spoke with on hospital wards and at the Margaret Centre told us that end of life care was hugely helped by having the CCP in place. It was felt it had helped to focus on care and there was more individualised care with the CCP. The CCP was in addition to other tools designed to meet patients' care needs that were part of the standardised care bundle.

- All patients on the SPCT's case list, including new referrals, were discussed in a daily morning handover where individual needs were addressed. Ward staff with patients on the CCP told us that the SPCT normally came to the ward daily. Ward staff called them when there were changes to someone's care or when there was a deteriorating patient.
- We came across many examples where care was being provided and meeting people's individual needs. For instance, for one patient on the CCP, we found it covered communication, privacy and dignity, agitation, pain, nausea, vomiting, respiratory and secretions. Anticipatory medications were given for specific conditions. It also covered comfort and safety, hydration, oral hygiene, bowel movement and personal hygiene. The patient appeared well cared for and their family told us that generally their individual needs were being met.
- However, they also told us a ward registrar was not aware of their loved one's dementia or communication issues. The plan had been to withdraw everything and make the patient as comfortable as possible. However, this plan seemed to change without any family consultation. The medical team's rationale for low sedation was so the patient could communicate with the family. However, the severe dementia had meant that such communication with the family had not occurred for years.
- On Cedar ward we found a comprehensive assessment of the patient's symptoms and needs had been completed by the SPCT. It included pain, nausea and constipation. Regular PRN (when necessary) medications had been discussed with the patient and a plan of symptom management put in place. This was discussed with the patient with the family present.
- We observed discussions around nutrition and fluids took place with the patient and their family. The family had concerns that the patient had no appetite and was just drinking small amounts. SPCT reinforced that patients with advanced cancer invariably had poor appetite which the family understood. Regarding nausea, which impacted on diet, a prescription was put in place.

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- We observed the work of the SPCT on Cedar ward. We witnessed discussions with the medical team regarding a new referral and the reasons for referral. The discussion focussed on making a fast track referral.
- Patients' spiritual needs were being met through its documentation on the CCP, which specifically addressed aspects of this. We also found that spiritual needs were considered in both handover meetings at the Margaret Centre and SPCT. SPCT staff we spoke with were able to tell us where this fitted in to individual packages of care. The SPCT were aware of who was involved in this respect. For instance, we came across examples where patients were involved with their local church and liaising with church groups had taken place.
- We were told that a family meeting was held soon after referral to the SPCT to ascertain patients' preferred place of care (PPC). One patient had a family meeting taking place the following day. We were told that so far, from a palliative care perspective, they were concerned with sustaining symptom control in the community. There was dietitian input. The aim was to go home and be active in the church community again.
- The community SPCT told us that part of care planning included preferred place of care (PPC). We were given examples of patients who were able to go and see the MC to see if they liked it first before deciding on it being their PPC.
- The chaplain attempted to visit every ward within the hospital each week. They also utilised the volunteers to assist with this task. End of life care patients were referred in a variety of ways to the chaplaincy; through various MDT meetings that they attended and through self referral and via staff that worked with the patients. This included anyone from the domestic staff through to the nurses and other medical staff and via relatives.
- The volunteers were available to the patients and their relatives. They were led by the patient as to their needs, by way of support and assistance that they provided. Volunteers assisted many patients and would make sure that when they changed wards, they were aware of the move, and would visit the patient on their new ward. One of the volunteers was training to become a deacon at the time of the inspection and had conducted funerals for past patients.

- The chaplain was able to organise marriages for end of life care patients at the hospital. The department was able to arrange this at very short notice if needed.

Access and flow

- There was a complex discharge team within the hospital. They told us that funding was negotiated by them. Patients came from numerous boroughs and so this could be a complex task. Redbridge, Newham and Waltham Forest were the main boroughs. The discharge team were involved in MDT meetings and worked alongside the social worker from the Margaret Centre, to facilitate fast track and other discharge.
- The discharge team told us they tried their best to facilitate patients' preferred place of care and preferred place of death (PPC/D). In terms of last hours of life, if equipment was not essential and the family said they could support discharge, they told us they were keen to facilitate patient choice and just looked to mitigate risks. They told us they tried to meet a target of 48 hours for rapid discharge. However, although they monitored this on a day to day basis they did not measure this in any other way, such as over time or through any sort of audit. The team did no data collection in relation to this or its effect on patient care.
- A log of fast track discharges showed the date they were ratified but not the length of time discharge had taken. It showed there were a total of 34 between October 2016 and May 2017, funded by five different responsible local CCGs.
- The SPCT also took a major role in discharge planning. The team told us that ward staff could do the fast track application but it was more likely to be completed by the SPCT; it tended to be the older population that the team saw in relation to this. We came across this work in practice. The SPCT had a family meeting taking place on a ward the day after our visit regarding discharge and planning. The OT was also involved in the planning. The aim was for the patient to go home as per their wish. The team were also facilitating palliative chemotherapy input.
- On Cedar ward we observed the SPCT discussing rapid discharge home and guidelines and referral to the MC prior to going home. Regarding PPC, it was established that the patient wanted to go home and the family would like a bed in the MC prior to discharge. A referral to the MC was discussed with the SPCT who said that at this time it would be inappropriate as their symptoms

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could hopefully be controlled now they were on the ward along with SPCT support. Both the patient and the family seemed content with this and the management plan of symptoms.

- The community SPCT told us they could be dealing with fast track discharges and could easily gather information from the hospital SPCT. Documentation could be completed within an hour and get a funding decision within the day. A single point of access was used out of hours to refer on to rapid response or the district nursing service when required.
- We were told that the SPCT routinely documented patients' preferred place of care and preferred place of death (PPC/D) on their first visit if possible. A CQUIN regarding this took place in March 2017 which showed this was not well documented in most cases. However, this audit had involved trawling back through case notes in paper files to locate where it had been documented. Patients' PPC/D had not been easy to identify. As a result, the newly implemented online records system now included a section to record a first assessment for palliative care that stated patients' PPC/D. It was too early to ascertain its effectiveness in knowing the hospital's success in achieving PPC/D.
- We spoke with trust senior managers with responsibility for palliative and end of life care regarding the role of the SPCT in rapid discharge. We were told they were flexible, often taking on roles that would support any function needed to expedite the discharge. They worked in partnership with the complex discharge team and ward staff, helped with completion of paperwork particularly regarding prognosis, worked with the ward team and junior doctors around medication and authorisation forms, worked with the patient and their family/loved ones to plan and facilitate the discharge.
- We asked trust senior managers whether success rates in achieving patients' preferred place of death were measured. We were told they were not. However, with the electronic patient record system now in place it will be measured, initially for patients known to the SPCT, with a longer term aim of extending across those services supporting people with generic end of life care needs. Methodology to capture the length of time rapid discharge had taken had recently been implemented at another of the trust's hospitals. This was discussed at the last trust wide end of life steering group (July 2017) as part of governance reporting, and had an implementation date at Whipps Cross of January 2018.
- The community SPCT told us they could be dealing with fast track discharges and could easily gather information from the hospital SPCT. Documentation could be completed within an hour and get a funding decision within the day. A single point of access was used out of hours to refer on to rapid response or the district nursing service when required.
- The community SPCT dealt with admissions to the Margaret Centre from the community. Patients were able to come in for symptom control, terminal care and respite. The community SPCT were able to contact the shift coordinator for a bed and for handover. We were told that the MC acted as a hub and referrals were made via either a community GP or the community SPCT. The average stay for this patient group was 7 to 12 days. There was one respite bed that was heavily used by the COPD service and cardiac service. Non-malignant use of beds was 50%.
- We observed the handover at the Margaret Centre. There were discussions regarding patient states and the team looked at trying to discharge patients where this was their wish. Discussions for individual patients included consideration of a variety of aspects regarding enabling such discharge. It included ensuring equipment such as a pressure relieving mattress was in place. We also heard about transfer to a nursing home for one patient. Involvement of the community SPCT was discussed in cases.
- There was a waiting list at the hospital of patients waiting to come in to the Margaret Centre. We were told that patients who came in to the Margaret Centre via the community for symptom management, tended to be discharged whereas patients that came in from the hospital tended to be patients at the end of life and had a short length of stay. There were increasing pressures to come in via the hospital route. A third of hospital deaths occurred at the MC a year, out of a total of 1370 within the hospital as a whole. This high proportion was influenced by the hospital's expectation of the MC, that dying patients in the hospital should be referrals. The MC felt that one contributory factor was that the SPCT needed earlier referrals from the wards. The lack of side rooms within the hospital further added to the pressures placed on the MC.
- Resource folders on wards for end of life care contained the Margaret Centre's out of hours policy, which stated

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patients must have a CCP started and a DNACPR, and will stay under a hospital team until 9am on Monday; this was to be agreed by a palliative care consultant and the drug chart must have anticipatory prescribing.

- There was a Christian chaplaincy on call rota that covered 8- 4pm and 4- 8am slots. This was shared between six chaplains. For all other faiths there was no on call rota. The switchboard had phone numbers for Roman Catholic, Muslim and Jewish chaplains.
- There were eight consultants that participated on the on call rota. This was mainly for telephone advice and included other palliative care consultants from the trust, as well as a local hospice. Access was through the trust or hospice switchboard. Ward staff were aware of how to access this. On Nightingale ward a member of staff told us there was an on site registrar and an on call number for a palliative care consultant out of hours. They told us they had never used it but knew it was there.

Learning from complaints and concerns

- Complaints were reviewed at the deteriorating patient group. This function was moving to the end of life care group, which had their inaugural meeting the day after this unannounced inspection. Complaints data was not provided by the trust.
- A major role of the SPCT was to liaise with families and work to resolve any issues they may have. The SPCT told us they worked to resolve issues with patients and their families in practical ways.
- We spoke with the Macmillan cancer charity who had a shopfront on the main hospital corridor. They told us they signposted people with concerns or complaints to PALS and to the SPCT for local resolution.
- During the inspection we visited the PALS office to understand the nature of patient complaints and issues. We found that there were not really any complaints regarding end of life care. We were told that this was a very rare occurrence. At the time of the inspection we were made aware of an end of life incident that was current. The complaint was due to a communication issue within the ward. The PALS team explained what had occurred and how they were working to resolve the problem.

Are end of life care services well-led?

Requires improvement



We rated well led as requires improvement because:

- There were senior leaders driving the development of end of life and palliative care within the trust. However, staff from both the SPCT and Margaret Centre we spoke with were not aware of a nominated non-executive director for end of life care, or of any representation at board level.
- There was a culture for end of life care at the hospital to be seen as the responsibility of the SPCT. There was also a culture of patients being admitted to the hospital to die, or to the Margaret Centre to die rather than being cared for at home or on the wards. There was a culture for end of life care in the hospital to be seen as the responsibility of the SPCT. We were told that getting the CCP included within the standardised care bundle would help to change this, but it remained a work in progress, as did a meaningful education programme for ward staff. Providing training for ward staff in end of life care had not properly got off the ground due to SPCT staffing, the developing nature of hospital services and staff movement. Establishing a link nurse system also remained work in progress for the same reason.
- The mortuary was managed by an outsourced third party on behalf of the trust. There were systems in place that were not universally recognised and could lead to confusion if the mortuary manager was not present for any reason.

However

- Senior staff within palliative and end of life care told us that the legacy of the trust merger, that was now five years ago, was beginning to be overcome. End of life care had not been seen as a priority but it was now felt that there was a new attitude to care within the trust with more of a vision for end of life and palliative care services for the hospital.
- There was a good meeting structure that enabled accountability and direction for end of life care. The SPCT quality improvement group met weekly and current pieces of work included looking at the MDT structure in order to streamline the process, including referral processes and delayed discharge.

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- The deteriorating patient improvement group met on a monthly basis and was the principle governance meeting for the hospital that was concerned with end of life care. Actions were taken away by individuals. Minutes showed work taking place around development of the group, sepsis, incidents, DNACPR and CCP audit. This group was now developing in to the end of life care group, which was to be led by the director of nursing at the hospital.
- The SPCT team leader post was currently 0.5 of a whole time equivalent. Extra funding meant that this was soon to be full time. At the Margaret Centre, a nurse manager had been appointed to take day to day control of the ward. There was medical leadership provided by a consultant.

Leadership of service

- There was clear leadership within both the Margaret Centre and the SPCT. At the Margaret Centre, a nurse manager had been appointed to take day to day control of the ward. There was medical leadership provided by a consultant. The SPCT band 8a team leader post was currently shared 50/50 with Newham University Hospital (NUH), another of the trust's acute hospitals. A full time team SPCT leader post had just been created and appointed to at NUH. This meant that the team leader post at Whipps Cross, was soon to also become full time.
- We were told that the trust's lead consultant for palliative care had been key to promoting palliative care and end of life care. Along with two trust directors within the cancer and surgery directorate, they were the voice and driving force for promoting palliative care and end of life care. We were told "a lot of pushing for extra funding came from these people. They champion end of life care". However, there was no visibility of the board lead for end of life and palliative care. Staff from both the SPCT and Margaret Centre we spoke with were not aware of a nominated non-executive director for end of life care, or of any representation at board level.
- For the last year, the lead anaesthetist had taken the lead for end of life care at the hospital. They had also chaired the deteriorating patient group. They told us the hospital had wanted someone who knew the hospital and had leadership experience to lead this, as well as promote 'buy in' from hospital staff in to end of life care.

This group was now developing in to the end of life care group, which was to be led by the director of nursing at the hospital. The inaugural meeting for the group was the day following this unannounced inspection.

- On the wards, we spoke with a new in post matron for elderly care. They had a clear vision of supporting their nursing staff to develop good care models and of leadership. Staff we spoke with on the wards told us they provided a visible leadership and spoke positively about her, even though she was new.
- The bereavement office was managed by the site manager and a line manager based at the Royal London Hospital, another of the trust's acute hospitals. The bereavement officer felt supported by management within their role. Appraisals were carried out once a year and the line manager had started to visit the different trust sites to meet with bereavement officers on approximately a weekly basis.

Culture within the service

- We were told that there was a culture of both patients being admitted to the hospital to die, and of patients being admitted to the Margaret Centre to also die rather than being cared for at home or on the wards. Patients that came in to the Margaret Centre from the hospital tended to be patients at the end of life and had a short length of stay. There were a total of 1370 deaths per year at the hospital as a whole, with a third of those at the MC.
- There was a culture for end of life care in the hospital to be seen as the responsibility of the SPCT. We were told that getting the CCP included within the standardised care bundle would help to change this, but it remained a work in progress, as did a meaningful education programme for ward staff. Providing training for ward staff in end of life care had not properly got off the ground due to staffing within the SPCT and the developing nature of hospital services and staff movement. Establishing a link nurse system also remained work in progress for the same reason.
- There was an elderly and frail demographic of patients within the hospital's catchment area, with patients supported by a lot of stand-alone GPs. This sat alongside a culture of coming in to the hospital to die. We were also told that a recent Listening into Action open group took place on symptom control. There was

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a mix of attendees but a lack of elderly care consultant representation. Of ten elderly care consultants seven were locums. It was felt that this needed a change of culture and 'buy in' to better understand the palliative and end of life care needs of patients.

Vision and strategy for this service

- Senior staff within palliative and end of life care told us that the hospital had suffered because the SPCT staff had been depleted by cuts after the trust merger. This was now five years ago and the legacy of this was only now beginning to be overcome. End of life care had not been seen as a priority but it was felt that there was now a new attitude to care within the trust and more of a vision for end of life and palliative care services for the hospital.
- The inaugural meeting of the EoLC board was happening the day after our unannounced inspection, taking the place of the deteriorating patient group. We were told this first meeting will include agreeing terms of reference and standing items. It would also agree on the inclusion of relative/patient representatives, local GP input, another GP from another CCG and involvement of other consultants from gynaecology and elderly care.
- We were told that within the trust, St Bartholomew's Hospital and the Royal London Hospital had a good staffing structure to be able to deliver end of life care, and the trust were now in support of looking to bring in this model to the trust's other two acute sites; Whipps Cross University Hospital as well as Newham University Hospital. A business case had been made for extra funding for staffing. Phase one of this business case was to source funding and recruit clinical nurse specialists (CNSs) and consultants in to the SPCT. Phase one was just coming to an end and phase two had not yet commenced, but would look at chaplaincy support, administration, social work and psychological support.

Governance, risk management and quality measurement

- The deteriorating patient improvement group met on a monthly basis and was chaired by the anaesthetist and resus lead within the hospital. This was the principle governance meeting for the hospital that was concerned

with end of life care. It was attended by the lead SPCT consultant, all staff members of the SPCT, doctors from the MC, lead consultant for sepsis, the matron from children's services and care of the elderly.

- The purpose of the group was to highlight practice with actions taken away by individuals to improve care. We were told funding was asked for where unmet need was identified. For instance, the need for another blood machine was identified as one of the two was not working. This meant people had to go to ITU to borrow the one that worked. Now there was one located within the surgical block. The group looked at incidents as a group which were related to end of life and palliative care. They looked at issues around the planning of DNACPR or advance care planning due to conversations with the family.
- Minutes from the deteriorating patient improvement group for January, February and March 2017 showed improvement work taking place. This included development of the group, sepsis, incidents, DNACPR, and CCP audit. Discussions also took place around aspects of end of life care. Monthly root cause analysis feedback and DNACPR audits for the month were discussed. Minutes showed learning from incidents.
- Attendance of the group showed reasonably good attendance from different leads and specialties but also showed a number of apologies from leads and departments.
- Out of deteriorating patient improvement group had grown the end of life care group. This group was to be led by the director of nursing at the hospital. The inaugural meeting for the group was the day following this unannounced inspection. We were sent the minutes of the first meeting of the end of life care group. Core objectives were stated to: promote compassionate care as stated in One Chance to Get It Right 2014, provide appropriate education and training, raise awareness and importance of end of life care within the hospital, promote the continuity of care across settings and promote best practice in line with national guidance. The group will be chaired by the director of nursing or the lead anaesthetist and attended by a broad range of people concerned with end of life care from around the hospital. The group was to meet monthly and the

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standing agenda items were updates from the trust steering group for end of life care, updates from quality improvement including DNACPR and CCP audits, and updates on staffing and education.

- Palliative and end of life care currently came under the cancer and surgery directorate and was soon to be moving to the medical directorate.
- There were a number of other meetings that took place. The SPCT carried out daily morning handover meetings and a joint community and hospital multidisciplinary team meeting for the SPCT took place weekly. It was attended by CNSs, the social worker, chaplaincy, psychology, medical staff and occupational therapist. Other multidisciplinary team (MDT) meetings were attended by the SPCT where appropriate, such as for specialties. These took place weekly such as lung MDT and gastroenterology MDT while the COPD MDT took place monthly.
- Weekly senior management meetings took place for one hour and were attended by the SPCT team leaders for both inpatient and community teams, consultants, the complementary therapy lead and the Margaret Centre ward manager. A finance meeting took place monthly. Head of department meetings took place every six weeks, and a trust wide palliative care steering group that rotated which hospital site it met at, also took place every six weeks.
- The SPCT aimed to attend the hospital huddle three times a week although other work pressures meant this was not always achievable. The morbidity and mortality group meeting for the Margaret Centre took place on a monthly basis. The SPCT also attended this when appropriate to do so. The hospital mortality meetings were not routinely attended by either the Margaret Centre or SPCT teams. We were told they would discuss their own complex deaths. They did not attend hospital bed meetings although the hospital had wanted them to. The reason stated for this was down to the limited staff resources of the SPCT.
- The chaplain was very involved within hospital groups. They attended the palliative care multi-disciplinary team meeting (MDT) in the Margaret Centre weekly, the deteriorating patient improvement group, the

bereavement committee meeting which occurred once a month, the hospital huddle was attended twice a week and the pregnancy loss group meeting that also took place once a month.

- The mortuary was managed by an outsourced third party on behalf of the trust. There were systems in place that were not universally recognised and could lead to confusion if the mortuary manager was not present for any reason. For instance, there was a system of identification based on numbers on a whiteboard that correlated with individual items of human tissue stored in a freezer. The system lacked transparency, which meant that anyone other than the mortuary manager from the outsourced third party would not be able to understand it. This included porters and site managers who both covered out of hours duties.
- There were 20 fridge spaces available in the mortuary. There were no bariatric fridge spaces available. Deceased patients were frequently transferred to other premises that were owned and managed by the outsourced third party providing mortuary services. The trust had no oversight regarding this movement of deceased patients.
- The bereavement officer was invited to attend end of life care meetings but was usually too busy to do so. The role was very demanding which meant that someone had to be available to relatives during working hours.

Public and staff engagement






- We were provided with a copy of a survey completed by relatives following bereavement dated February 2017. It used a sensitive approach to gathering information and divided responses into the categories of care, staff, beliefs, at the time of death, return of personal items, viewing and bereavement officer. Under each of these headings were a collection of 'feeling words' that ranged from 'informed, warm, involved', to 'unmet needs' and 'not sensitive'. People were also invited to include their own. Responses were recorded in two categories. First based on the feeling words and second on peoples own words. Analysis showed how well the hospital did in terms of being sensitive and not meeting people's needs. Individual comments were also itemised. Results showed some positive care but were overall mixed. How this information was used to improve care was not stated.

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- We were also provided with 'Have Your Say'. This was an event that took place in September 2016. The aim of the event was to enable relatives or friends of patients to share their experiences which could then be used to identify what went well and what improvements could be made. 168 invitations were sent out to bereaved relatives of patients who had accessed the Margaret Centre or the SPCT between April and December 2015. Eleven invitees accepted the invitation and six invitees attended. Four invitees described their ethnic origin as White British, one as of Pakistani origin and one declined to complete the ethnic monitoring form. The document contained constructive and positive comments. How this information was used to improve care was not stated.
- The trust carried out surveys for patient and staff satisfaction, although these did not specifically identify end of life care results.
- The SPCT quality improvement group met weekly after the MDT. Current pieces of work included looking at the MDT structure in order to streamline the process, including referral processes such as verbal referrals, ward referrals and on line referrals. Delayed discharge due to blockers such as funding and equipment were also being looked at.
- The community SPCT told us they were involved in the hospice at home service, which had been approved for funding and were now looking at how it can all work in practice.
- The SPCT team leader was part of the London end of life care clinical leadership group and recently became a member of its board. Meetings took place every six months. There were work streams around best practice and change and they were involved in the inequality of what different CCGs offered end of life patients.

Innovation, improvement and sustainability

Outpatients and diagnostic imaging

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

Information about the service

Whipps Cross University Hospital is one of four acute hospitals in Barts Health NHS Trust. It provides a range of outpatient and diagnostic imaging services. The outpatient services include: urology, ear nose and throat (ENT), audiology, cardiology, colorectal surgery, and cancer care. There were 505,945 first and follow up outpatient appointments between December 2015 and November 2016.

The diagnostic imaging services include X-Ray, Magnetic Resonance Imaging (MRI) computerised tomography (CT) and ultrasound scans. There were 198,301 reporting activities across all modalities between December 2015 and December 2016.

CQC carried out an announced inspection of the outpatients & diagnostic imaging services in July 2016, when an overall rating of inadequate was awarded. Ratings for the five key questions included safe – requires improvement; effective – inspected but not rated; caring – good; responsive – inadequate and well-led – inadequate.

We carried out an unannounced inspection at Whipps Cross University Hospital on 10 and 11 May 2017, during which we visited the outpatient department and radiology and diagnostic imaging services. We observed several clinics, including plastic surgery, haematology, endocrinology, phlebectomy, gynaecology, dermatology and orthopaedics. We also visited several areas of diagnostic imaging services. These included fluoroscopy, CT and MRI, GP, in-patient and ED x-ray dental and chest x-ray.

We observed x-ray and imaging activity, staff interaction with patients, and made checks on the environment and equipment. We spoke with 35 patients and their relatives. We also spoke with 80 staff including medical consultants and other medical staff, managers, nurses, healthcare assistants, allied healthcare professionals and administrative staff. We observed care and treatment, and following our inspection, we reviewed performance information submitted by the hospital.

Outpatients and diagnostic imaging

Summary of findings

We rated this service as requires improvement because:

- Incidents were not always reported or actioned in line with trust policy. The trust had identified capability issues with staff using the incident reporting system, however we were told this training was not included in induction training.
- Risk registers did not reflect all areas of concern, for example; concerns about transfers of patients between the emergency department and imaging department or lack of accessible resuscitation equipment
- The environment of the in-patient diagnostic imaging area was poorly maintained.
- There were on-going capacity issues in certain clinics to meet patient demand
- Staff did not have the available information to ensure non-medical referrers were compliant with the Ionising Radiation (Medical Exposure) regulations (IR (ME) R).
- Safety equipment was not always maintained or replaced to ensure the safety of patients or staff. In particular lead aprons, which provided radiation protection.
- Radiation doses received by medical staff was routinely higher than that recommended by the radiation protection advisor when measured against staff who performed similar procedures using x-ray equipment with modern dose limiting technology for the patients and operators.
- There was limited oversight of the extent or depth of potential patient harm as a result of a recent information technology systems failure.
- Governance systems were not always embedded in practice to provide a robust and systematic approach to improving the quality of services.
- Staff told us management was more visible.
- There was an improved staff culture, some of which staff attributed to a greater willingness amongst managers and the human resources department to tackle bullying issues.

However:

- Most patients were positive about the care they received and were treated with dignity and respect.

- Guidelines such as those published by National Institute for Health and Care Excellence (NICE) were in place and followed.
- Booking centre staff consulted with patients to ensure the appointment slot was convenient for them and accommodated their needs.
- Staff spoke positively of the newly appointed leadership team, and described an improved culture and better communication between staff and managers.
- Most patients and relatives we spoke with were positive about how they had been treated and we observed consistently good interactions.
- Staff had appropriate safeguarding awareness and understood their safeguarding responsibilities in and protected people from abuse.
- Medicines were generally stored safely and there was robust management of medicines administration records and prescription stationery.
- There were improved radiography staffing levels as a result of a recent recruitment campaign.
- Systems were in place to maximise patient record availability for clinics which meant staff had the information they needed before providing care and treatment.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Requires improvement



We rated safe as requires improvement because:

- Managers told us there was inconsistency in levels of understanding of what constituted an incident. Staff we spoke with told us they did not always record incidents on the electronic incident reporting system.
- There were no functioning panic alarms in the outpatients department since June 2016 and this was added to the hospital risk register in January 2017.
- Nurses were concerned about the safety of patients as they were transferred between CT and accident and emergency.
- At our inspection in July 2016, we found that maintenance records were not available to confirm that lead aprons were screened and safe for use. At this inspection (2017) 17 out of 179 records confirmed the lead aprons were screened and safe for use.
- We found that staff did not have the available information to ensure non-medical referrers were compliant with the Ionising Radiation (Medical Exposure) regulations (IR (ME) R) around non-medical referrers.
- There were information technology systems failures which led to the loss of patient images, appointment bookings and pharmacy stock control, and had the potential to impact on patient safety.
- There were frequent breakdowns of magnetic resonance imaging (MRI) machines and computerised tomography (CT) scanners which meant patient appointments were cancelled. The trust did not report on whether delays caused any potential harm to patients.

However:

- There were arrangements in place for safe and effective medicines management including monitoring of prescription stationery.
- There were safeguarding policies in place and clear procedures to follow if staff had concerns. Staff were aware of their roles and responsibilities and knew how to raise and escalate concerns in relation to abuse or neglect of adults and children at risk.

- We saw the WHO checklist was regularly completed. This included a sign-in, where there was a requirement to check the patient's risk factors for renal failure and for the procedural site to be marked.
- Infection prevention and control processes were in place to make sure infection risks were reduced.
- There was improved patient record availability at clinics. Records were safely and securely stored.
- There was evidence of improved radiography staffing levels with 45 whole time equivalent staff in post out of a total staffing complement of 48.

Incidents

- The trust reported no never events from February 2016 to March 2017. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- From February 2016 to March 2017 there were two serious incidents (SIs) reported in outpatients and diagnostic imaging which met the reporting criteria set by NHS England. One was a radiation incident (including exposure when scanning). The other was a diagnostic incident (including failure to act on test results).
- We looked at minutes of the monthly imaging service group performance review from June 2016 to April 2017. We saw there was a total of 29 radiation incidents reported between March 2016 and March 2017.
- The outpatients and diagnostic imaging department used the trust's electronic reporting system to record incidents. At our inspection in July 2016, we found that incidents were not always reported in line with trust policy. During this inspection, managers and staff we spoke with told us they felt there was still a significant amount of under-reporting of incidents. One manager told us that staff still had a mixed understanding of what an incident was and therefore lacked clarity about what should be reported. They told us there was a gap in the provision of trust wide training on incident reporting. However, they also told us they reminded staff during daily huddles to report incidents.
- We looked at the radiation incident log from January 2017 to June 2017. There was a total of 17 radiation incidents recorded. However, there was no incident

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recorded in relation to the failure of the radiology information system (RIS) or picture archiving and communication system (PACS) which were not in operation at the time of this inspection.

- On the day of our inspection, the information technology which enabled staff to view clinic schedules and access patient notes was not working. This impacted on patient flow, for example, over 50% of patients in the GP and outpatient x-ray department told us they had been waiting over an hour and up to two hours for an x-ray. Staff in the general surgery clinic told us the systems failure meant they could not access the clinic patient list, and therefore they could not be assured that all of the patient records were available to staff. We spoke with the same staff later in the day who confirmed that all of the patient notes were available.
- Staff told us there had been several occasions in recent months when there were a number of other systems failures, including information technology (IT) and the electronic reporting system.
- For example, the IT system and electronic incident reporting system were unavailable for five days in the month preceding our inspection. All staff that we spoke with could tell us about this incident but most told us they had not recorded it as an incident.
- One manager told us staff were expected to record incidents in writing which would then be reviewed on a daily basis by that manager.
- We saw a copy of the May outpatient services and health records newsletter. In it, there was a reminder to staff that where patients turned up for a clinic which had been cancelled, this must be reported as an incident. Clinic managers told us that on the day before our inspection five patients arrived for a clinic which was cancelled, however the patients had not received this information. Staff told us that this was not recorded as an incident.
- The June (2016) risk management committee minutes identified 'capability issues with staff using the trust's electronic reporting system without sufficient understanding of risk assessment and governance awareness'.
- We saw the breakdown of the magnetic resonance imaging (MRI) machines and computerised tomography (CT) scanners in the diagnostic imaging service was identified as a risk on the risk register. This meant patient appointments were cancelled and the trust did not have effective systems in place to check whether delays caused any potential harm to patients.
- We found that staff had mixed views about the benefits of reporting incidents. Some told us they were often too busy to report on the electronic reporting system. They said that clinics frequently over-ran but they prioritised patient care over taking time out to report the late running of the clinic as an incident. Others told us that when they did report incidents, they did not always receive feedback about any learning points or follow-up action.
- Managers told us they encouraged staff to report all incidents, regardless of harm or fault. We spoke with the newly appointed outpatient department general manager. They told us that a priority was to resolve the under-reporting of incidents. In order to capture data about late running clinics, which traditionally had not been reported, a member of staff had been nominated to monitor the flow of each clinic daily to. Any delays would be reported as an incident on the electronic incident reporting system and attributed to individual clinics.
- We spoke with the site lead pharmacist who told us medicines errors or omissions would be recorded as an incident on the trust's electronic incident reporting system. In addition, pharmacy staff maintained a reporting system to help identify the number and type of incidents, staff group and any emerging themes. We were told that learning from reported incidents was shared with staff in a quarterly medicines incident report. Since our previous inspection pharmacists attended the multi-professional daily site safety huddle where any incidents would be discussed and learning points shared.
- The duty of candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Staff were able to explain to us what DoC meant and told us they believed it was essential to be transparent with patients in the event of an incident in relation to their treatment. A nurse told us they were aware of DoC applied where there was a radiation error some time ago.

Outpatients and diagnostic imaging

Cleanliness, infection control and hygiene

- Most clinical areas appeared clean. There were systems to monitor cleanliness. We saw up to date cleaning instructions, schedules and checklists in place with the exception of the fluoroscopy area and the imaging interventional suite where schedules could not be found.
- We noted that cleaning checklists for the nurse's preparation room in the Fluoroscopy department within the imaging department had not been completed for three weeks prior to this inspection. This meant staff were unable to confirm when the area had last been cleaned. We brought this to the attention of staff who told us they would ensure the areas were attended to.
- We found used patient gowns were on the floor in another area of the department.
- We saw that floors in the in-patient radiology area were scuffed and appeared unclean. There were bags of trolley covers and used adult and children's gowns lying on the floor. There was a torn mattress on a patient trolley which was an infection hazard. Shelves and window sills were dusty and we saw used paper towels on the floor and in the sink of the dirty utility room.
- Staff told us their mandatory training included infection prevention and control training which we saw was included on trust data.
- Spillage kits and cleaning products were available to staff. We observed 'I am clean' stickers on equipment that identified it had been cleaned.
- The National Institute for Health and Care Excellence quality standard 61 requires that people receive healthcare from health care workers who decontaminate their hands immediately before and after every episode of direct contact or care. We saw that staff consistently used hand sanitisers, were bare below the elbow and washed their hands in accordance with national and local policy. We also saw visitors to the departments including other staff and patient's relatives and friends using hand sanitisers.
- We saw a query about the accuracy of outpatient department hand hygiene audits. Minutes of the April meeting of the outpatients service performance review noted that hygiene compliance was always 100% and requested validation of this. This was subsequently actioned; auditing staff were changed and the number of staff audited per month was increased. Due diligence process was confirmed.

- The main reception area in outpatients appeared clean with hard flooring and wipe clean furniture. However, we noted that the floor of one of the patient toilets in the main reception area was persistently wet, and presented a slip hazard. We spoke with a contract cleaner who told us this was due to the hand basin being too small and therefore water splashed out. They could not confirm whether this problem had been raised as an incident or was drawn to the attention of a manager.
- There were systems in place for the segregation and correct disposal of waste materials such as x-ray solutions and sharp items. Containers for the safe disposal of sharp instruments were available in each clinical area. These were dated and were not overfilled.

Environment and equipment

- During our inspection in July 2016, staff told us it could take a long time to resolve maintenance of equipment and the environment. We were told similar things during this inspection. For example, the temperature control system in outpatients x-ray had been out of order for almost one year and was on the risk register for most of that time. The manager we spoke with told us they had no indication from finance as to when this situation might be resolved.
- Clinical waste management practices were safe. There was a colour-coded system for disposal of waste, and clear segregation of clean and dirty equipment.
- We saw sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. Staff dated and signed sharps containers when brought into use.
- At our inspection in July 2016 we also reported that the breakdown of the CT scanners and MRI were identified on the risk register. During this inspection, we found there had been no investment in new machines since the last inspection, as a result of which, there continued to be machinery breakdowns. For example, we saw that over five working days between 24th and 30th May, the CT suite experienced a total of 12 hours downtime. The trust's five year imaging strategy summary identified a backlog in the replacement programme of machinery across all modalities as a threat to the completion of the strategy within the five years.
- The trust introduced technology to support service delivery in radiology and diagnostics. This included a radiology information system (RIS), designed to support

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operational workflow and business analysis. The system stored patient data and contributed to the electronic patient record. In conjunction with this, a picture archiving and communication system (PACS) was used. This provided short and long-term storage, retrieval, management, distribution and presentation of medical images. It allowed the service to capture, store, and view and share all types of images internally and externally.

- At the time of our inspection, we were told that both these systems had been out of operation for the previous two weeks, and were not expected to be restored for another week. We were told by a manager that the business continuity plan followed was written in 2014 and therefore did not reflect the updated IT and how to respond to systems failure. Guidance was subsequently introduced which included diverting or reducing the amount of GP referrals and there was a daily 'imaging downtime' cross site conference call. We have reported on this systems failure in more detail in the 'assessing and responding to patient risk' part of this report.
- We reviewed the trust business continuity plan for Whipps Cross University Hospital outpatient services which had an issue date of August 2016. It covered recovery procedures for clinical and non-clinical services within the remit of Outpatient Services, which included central appointments, outpatient nursing & phlebotomy and outpatient reception. Whilst we were informed the business continuity plan also covered diagnostic imaging there was no reference made to this service in the plan.
- The business continuity plan made reference to 'loss of ICT and telecoms to outpatient services' which made no reference to specific systems such as RIS, PACS or the electronic incident reporting system. It did not offer guidance to staff about how they might respond to breakdowns of these systems.
- Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R 2000) state that correctly selecting and using personal protective equipment available for the reduction of radiation exposure is the principle radiation protective tool for interventional workers and should be used at all times.
- The regulations also state that lead aprons should be checked annually for safety. The purpose of lead aprons is to reduce exposure to x-rays used in radiography,

fluoroscopy and computed tomography. Any damage such as cracks or splits in the apron would allow x-rays through and therefore cause potential radiation harm to the member of staff.

- We looked at the most recent radiation safety survey from June 2016. In this it was noted that there were no available records for lead apron checks. The recommendation was that a rolling programme of checks should be established and recorded.
- Records we looked at during this inspection showed that 17 out of a total of 179 lead aprons in use across the diagnostics imaging department had been audited and deemed safe on 17th February 2017. There was no evidence to assure us that the remaining 162 aprons had been screened and passed as safe.
- There was no readily accessible resuscitation equipment or emergency medicines for children or young people in the fluoroscopy clinic, despite there being regular attendance of children and young people in the clinics. One nurse told us it took five minutes to travel to the nearest children's ward where there was paediatric resuscitation equipment. Alternatively, they would ring the hospital emergency resuscitation number and say 'paediatric'. Staff we spoke with about this situation told us they had concerns but did not think it was on the risk register. Managers we spoke with subsequently confirmed that this was not identified as a risk on the risk register.
- We saw evidence that the resuscitation trolley in outpatient areas A and B had a full check on each clinic day. It was fully stocked and ready for use and all contents were in date.
- We were told that panic alarms had not worked in the outpatients department for almost one year. The head of outpatients told us this had been raised as a major problem in June 2016, though it was not added to the risk register until January 2017. We were told there was recent confirmation that work would begin in July 2017.
- We asked how the risk to patients and staff was mitigated in the absence of panic alarms and were told that the security guards on site were requested to respond promptly to a call for assistance. However, we were also told that it could take a security guard five minutes to reach outpatients in order to lend assistance. Staff were encouraged to avoid lone working where possible.
- We saw from minutes of meetings of the outpatient service performance review that panic alarms were

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discussed each month from December 2016 to April 2017. Minutes recorded that further clarification was required before progress on fitting a new panic button system could be agreed.

- We found the environment in the diagnostic imaging department was poorly maintained. For example, there was loose plaster on walls in an area where children were treated. Staff we spoke with did not know whether this environmental hazard had been risk assessed or was added to the electronic reporting system. The floor covering in the patient toilets was torn and there was loose plaster around the toilets. The corridors in the diagnostic imaging department were narrow and lined with shelves. These shelves had boxes and empty sharps bins stacked high on them, which presented a hazard to people who passed by.
- We checked areas A and B surgical outpatients and found that the specimen fridge had fluctuating temperatures above the recommended range of between three and five degrees. A nurse told us this was reported to maintenance but was unable to tell us whether it had been recorded as an incident or whether the pathology laboratory had been made aware of this issue.
- We found empty oxygen cylinders lying on the floor in an area of the outpatient reception area which meant they were not stored in accordance with local or national requirements. We drew this to the attention of a manager who arranged for the cylinders to be removed.

Medicines

- There were systems in place to ensure the safe supply and administration of medicines that were based on Royal Pharmaceutical standards and the National Institute for Health and Healthcare Excellence NICE NG5 Medicines optimisation: the safe and effective use of medicines. These were detailed in an up to date trust medicines management policy.
- The stock control of medicines was maintained electronically using the trust electronic information system. Labelling of medicines dispensed to patients was also generated electronically. Staff told us the trust electronic information system had failed from 24 April for five days. This meant that there was no electronic record of the medicines stock controls during that

period. We were told manual documentation and manual generation of dispensing labels was put in place until the electronic system was recovered though we did not evidence this during this inspection.

- We visited the fluoroscopy clinic at the beginning of the day, before clinic started. We saw an unattended clinical trolley in an unlocked room with contrast agents used for x-rays, and local anaesthetic medicines sitting on top. We drew this to the attention of a nurse who immediately attended to the trolley and its contents.
- All medicines were supplied on the written instruction of a doctor, either by individual prescription or by patient group direction (PGD). PGDs provide a legal framework which allows some registered health professionals to supply and administer specified medicines, such as painkillers, and contrast imaging dyes to a predefined group of patients without them having to see a doctor.
- Legal requirements for using PGDs are that they need to be signed by each individual member of the multidisciplinary group (doctor and pharmacist), the clinical governance lead on behalf of the NHS organisation authorising the PGD, and the individual health professionals working under the direction. We saw three PGDs used in the imaging department which all complied with the requirements.
- All nurses and doctors were provided with medicines management training as part of their induction training. This covered management of oxygen and other gases, controlled drugs (CDs) and intravenous fluids. In addition, targeted training of controlled drugs took place in response to training needs identified as part of the controlled drugs audits. In all of the areas we visited we saw that the medicines storage cupboards were kept stocked; all medicines were in date and checked regularly for expired stock.
- Intravenous fluids were kept in a locked cupboard in the fluoroscopy area. However, this cupboard did not have a temperature gauge and a nurse told us the room in which this cupboard was stored had fluctuating temperatures which could impact on the efficacy of the fluids.
- There were arrangements in place to ensure safe storage of prescription stationery.
- We were told if any prescription stationery was unaccounted for this would be escalated to the matron,

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pharmacy and logged on the electronic reporting system. Police would be notified if the prescription was not located. Staff could not recall any occasion when prescription stationery was unaccounted for.

- The stock of emergency medicines such as medicines used in resuscitation and to manage anaphylaxis was decided by the resuscitation team in discussion with the nurse or clinical manager in charge of each ward or department. Stock lists were kept with the emergency medicines so that checks were made to ensure they were complete.
- Emergency medicines and emergency equipment was available on resuscitation trolleys. These were recorded as being checked daily. Emergency drugs were checked and in date. We saw a grab bag containing children and young people emergency medicines in outpatients; however there were no such medicines available in the imaging department.
- Medication administration training was provided by the trust and competency frameworks were in place to ensure staff were compliant with trust policy.
- Pharmacists told us they carried out quarterly controlled drugs audits, safe and secure storage of medicines audits, and timeliness of supply of medicines in all clinical areas. Outcomes of the audits were reported to the pharmacy governance committee. The pharmacy governance committee would escalate any significant issues to the pharmacy governance board, and the clinical support services quality and safety committee.
- Out of hours staff at Whipps Cross Hospital were able to access advice from other pharmacists at the Royal London Hospital 24 hours seven days a week.
- There were no ward based pharmacists or technicians. Pharmacy staff could not attend departments at scheduled times.

Records

- At our inspection in July 2016, we found a lack of availability of notes for clinics and temporary files made up which did not include all of the patient's notes.
- We found this situation to be much improved during this inspection where the majority of patient notes were available for the clinics we observed. Staff spoke positively about a new system in place where notes were delivered the night before morning clinics. This meant staff could check the patient list to identify any missing records and make an urgent request for them.
- In the absence of a patient's notes, a temporary file up was created and copied information such as GP referral, consultants' letters and patient details into it from electronically held information. Staff we spoke with told us there was a significant reduction in the amount of temporary records made up. However, this was not accessible when the IT system broke down, which happened frequently, including on the day of our inspection.
- We spoke with the health records site manager who told us departmental audits demonstrated that patient records were available for clinics of the large majority the time. Data submitted following this inspection showed that between December 2016 and April 2017, up to 16,000 patient records were required per month across all clinics. Data showed that patient records were available to clinics 99% of the time, with a total of 69 temporary records (0.4%) made up during this same time period.
- New procedures had been initiated to achieve this improvement. This was made possible due to a significant increase in staff levels which enabled allocation of specific roles to staff such as: the accurate filing of records, merging loose sheets with the patient record, and responding to information requests from other healthcare professionals.
- We spoke with managers who described some challenges to the efficient running of the patient records service, which included poor record tracking. They told us problems with missing patient records arose if all staff did not use the electronic patient record tracking system. We were told that not all clinic staff scanned the patient notes barcode which then made it almost impossible to identify where the patient record was last located.
- We were assured that all records are tracked as they leave the records department. It is then dependent on clinics to scan the patient record bar code to ensure that the record continues to be tracked. We were told that this has improved and was discussed at the daily morning meeting of outpatient managers.
- Staff told us how outpatient clinic managers and staff from the records department worked together to ensure that all patient records were available prior to the start of each clinic. Any records which were not found after a comprehensive search would be recorded on the electronic incident reporting system.

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- We saw the standard operating procedure for booking of short notice appointments and the provision of case notes. This defined the time frame within which requests for patient records should be requested. Another challenge which the records department had to manage was the late request for records from extra clinics or late addition of patients onto clinic lists.

Safeguarding

- Data submitted reflected the trust wide safeguarding training levels for adults and children. Overall compliance of diagnostic imaging staff was 93% for safeguarding children level 2 and 86% for safeguarding adults level 2. Compliance levels for outpatient staff were 93% for safeguarding children level 2 and 79% for safeguarding adults level 2. These were all lower than the trust compliance target of 95%.
- Managers we spoke with were aware of these compliance rates and we saw they were reported on in each newsletter update. We were told staff who had not completed their training would be requested via e-mail to do so and saw that plans and dates were in place for further training programmes.
- We commented in the last CQC inspection in July 2016 how the radiation safety survey in June 2016 identified areas that needed attention. This included ensuring that personal protective equipment (PPE) checks were completed; this is equipment that protects the user against health or safety risks at work, for example lead aprons. We found that little or no action had been taken on this since the time of our last inspection.
- During our inspection we observed clinics attended by children and young people including fluoroscopy, radiology and fracture clinic. The trust informed CQC subsequent to this inspection that there was no data kept on the numbers of children and young people attending adult clinics.
- The statement of purpose related to children treated in adult clinics stated that in all instances where a paediatric patient attends and is seen in an adult area, the outpatient nursing team should raise an incident detailing the reasons, mitigating actions and outcome. Senior managers told us children and young people routinely attended adult clinics and said this was identified on the risk register. They also said staff were encouraged to record attendances on the electronic incident reporting system. Staff told us they seldom did this since it was a routine occurrence and they did not think recording attendance would amend the situation.
- We subsequently saw that paediatric clinics held in adult clinic areas was entered as a risk on the hospital risk register in February 2016 and was noted to present a safeguarding concern.
- We saw the trust radiation safety policy was recently updated in March 2017.
- We saw radiation guidelines, local rules and national diagnostic reference levels (DRLs) were available for staff to access on the intranet. There was an assigned radiology protection adviser for each clinical area. The trust had a radiation protection supervisor to lead on the development, implementation, monitoring and review of the policy and procedures to comply with Ionising Radiation (Medical Exposure) Regulations.
- The Ionising Radiation (Medical Exposure) Regulation (IRMER 2000) required doses arising from medical exposures to be kept as low as reasonably practicable. To comply with this legislation patient dose data had been collected and analysed for examinations. For example, an audit of mammography patient doses carried out across 11 trust sites in November 2016 found all units delivered acceptable patient doses and were suitable for continued clinical use.
- Staff in radiography used the WHO 'Surgical Safety Checklist: for Radiological Interventions'. This included a sign-in, where there was a requirement to check the patient's risk factors for renal failure and for the procedural site to be marked. We looked at the most recent audits which showed that there was consistent and full compliance with the WHO checklist.
- We saw information displayed in outpatient clinics which gave advice about how to report any safeguarding concerns. There was a separate poster which highlighted the need for awareness about female genital mutilation. We also saw safeguarding information for staff was accessible in folders in each clinic. This included contact lists and guidance on how to make a referral.
- There was good awareness of safeguarding and nurses we spoke with were familiar with the trust's safeguarding processes and who to contact for further advice.
- Children deemed to be at risk were flagged on the electronic patient system. Staff in the bookings centre

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told us they were level 2 safeguarding adults and children trained which helped them to recognise potential irregularities. For example, a booking clerk told us of a recent situation where there was no confirmation of an appointment for a child flagged on the system. They followed this up with the child's carer and confirmed the child's attendance at the appointment.

- On the day of our inspection, we saw an e-mail from a staff member which notified a booking clerk about a child who did not attend the clinic. The booking clerk explained to us that in these circumstances, they always rang the child's parent or carer to establish a reason for non-attendance and to rebook the appointment. If the appointment was refused, they alerted the original referrer to inform them of this.
- Elderly patients were also flagged on the system. If there was a non-attendance of an elderly patient, the referrer was notified.

Mandatory training

- In our inspection report in July 2016 the trust board report stated staff training performance was below the targets for statutory and mandatory training requirements. The exceptions to this were Level 1 safeguarding training, information governance, infection control Level 1 and safeguarding children.
- Data submitted by the trust showed that staff across all of the diagnostics and imaging department were between 95% and 100% compliant with mandatory training as at May 2017. This included infection control levels 1 and 2, dementia awareness, privacy and dignity and equality and diversity training.
- Data for staff in outpatients showed there was 95% compliance with mandatory training in the same areas as at May 2017.
- We looked at monthly outpatient services and health records newsletters between January and May 2017 and saw an update on compliance levels with statutory and mandatory training was regularly included. Staff were required to monitor and maintain their compliance with mandatory training and to discuss and act upon any outstanding training needs with their managers. Staff told us this acted as a reminder to keep their training records updated.

Assessing and responding to patient risk

- Nurses raised concerns about the transfer of patients between CT and accident and emergency in the event of an emergency. They told us this was via a very long corridor, which we saw was the case, and that the patient was usually accompanied by a health care assistant. We were told that in the event of a cardiac arrest, there was no means of summoning immediate assistance other than relying on another staff member passing by for assistance. They did not know whether there was a risk assessment for this or whether it was on the risk register. The trust subsequently confirmed that there was no risk assessment for this transfer and we noted that it was not on the risk register.
- The trust subsequently told CQC there was no risk assessment for the transfer of patients between Accident and Emergency and CT. Instead, the service should review incidents logged on the electronic incident recording system and discuss any concerns with staff.
- The NHS e-Referral Service (e-RS) combines electronic booking with a choice of place, date and time for first hospital or clinic appointments. Patients can choose their initial hospital or clinic appointment and book it in the GP surgery at the point of referral, or by phone or online. When no clinic appointment was available for patients to book in e-RS the referral could be forwarded or deferred to the patient's chosen provider to enable an appointment to be booked. When a referral was forwarded or deferred, it appeared on that provider's appointment slot issues (ASI) worklist.
- Trust policy on ensuring patients who were unable to have an appointment booked due to capacity stated appointment slot issues (ASIs) should be resolved within a maximum of seven working days for urgent patients and 15 working days for routine patients.
- During our inspection in July 2016, we found there were issues with the systems to triage new referrals and send appointments to patients. During this inspection, we found there were systems in place to improve efficiency. Administrative staff told us they ensured that the standard operating procedure for the booking centre was adhered to as far as possible. They said patients were booked with an appointment as soon as a referral was made. These details were sent to the consultant, who must then triage the referral information and return

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the vetting form to the booking centre within five working days. If the booking form was not returned within the five days, the consultant was contacted for a response.

- The trust radiology information system (RIS) and picture archiving and communication system (PACS) systems were out of operation from two weeks prior to our inspection and were not expected to be on line for a further week.
- The diagnostic imaging system downtime and recovery plan 2016 suggests urgent examination images can be exported to either CD or DVD and sent with patients where possible.
- However, three senior managers independently told us that the likely effect of this systems failure was the potential loss of thousands of images and MRI data as the system may have auto-purged a substantial amount before a local solution was initiated. A manager told us the priority had been to recover high dose radiation imaging over plain x-ray images. They were unable to give us any assurances that there was full knowledge of the overall quantity of images and data lost. Minutes of the weekly clinical support services senior team meeting updates 2 May noted there was no available data on the potential risks to patients.
- This same manager told us checks for lost images had begun and were told that this was a long process. All GP and in-patient x-ray and MRI requests were printed off and manually cross referenced against completed reports. Where there were no reports, it was assumed that those images or MRI scans had yet to be identified or were presumed lost.
- Another member of staff told us they also relied on GPs contacting the department to ask for their patient's results. This would then help to identify that this patient's results needed to be searched for or the patient would be recalled.
- This situation had potential to have a significant impact on patient safety. For example, a delayed diagnosis of a serious identified health problem would mean a delay in treatment.
- Following this inspection, the trust provided assurance to CQC that a restore from back up took place.
- The site imaging lead told us how GP reporting time on x-rays had slipped to three weeks, where the trust target was one week. Another manager told us systems failure

of PACS and RIS had affected the reporting of plain x-ray films, which had not been reported on at all for duration of the outage, despite there being a trust target of one week.

- We witnessed a patient who attended a clinic for MRI results and was told by a nurse their results could not be accessed due to a systems failure and consequently had their appointment rescheduled. The nurse later told us they hoped that in the meantime, the patient's results would materialise, otherwise the appointment would have to be deferred. During our inspection in July 2016, we saw there were few notices displayed around the imaging or outpatients department that requested patients who might be pregnant to inform a member of staff before they were exposed to any radiation. We found this to be still the case and saw just two of these notices throughout the whole department during this inspection.

Nursing staffing

- There are no nationally recommended methodologies for identifying nurse staffing levels or skill mix within an outpatient setting; the hospital has created its own method of assessing staffing levels.
- The outpatient clinics were staffed by registered nurses and health care assistants who were supported by a matron. These included 0.85 band 7, 6.85 band 6, 16.4 band 5, and one band 3 and 19.56 band 2.
- Nurses we spoke with told us there was enough staff to cover outpatient clinics effectively. We saw this to be the case.
- However, managers told us a lack of outpatient nurse availability limited options for additional service activity such as out of hours clinics.

Diagnostic imaging staffing

- During our inspection in July 2016, we reported that there were insufficient numbers of staff in the radiology and diagnostic imaging department to manage the volume of work. This situation which was reported on the Whipps Cross Hospital risk register.
- During this inspection, we found this situation was improved. A manager told us there had been a successful recruitment campaign, and new staff had joined the department in the last six months. We were told the main outpatient radiology, CT and ultrasound department had a total of 48 radiographers and 10 full time radiologists. The manager confirmed that despite

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improved staffing, they had submitted a recent business care for six more radiographers to manage increased demands, which was rejected. For this reason, staffing issues remained on the risk register until those newly appointed staff were fully trained and embedded and further staff were recruited.

- Staff we spoke with told us there was a definite improvement in staffing levels compared with the time of the previous CQC inspection. They said they felt under less pressure and were able to provide a better service to patients.
- We viewed the previous three months rotas and confirmed that there was a good skill mix and all areas were filled. We noted that where there were gaps, these were filled by bank (temporary) staff.

Medical staffing

- Data submitted by the trust following this inspection showed there were 10.5 whole time equivalent consultants in the Whipps Cross diagnostic imaging department.
- Outpatient department medical staffing was provided by doctors working in the specialty relevant to the clinic. They were of mixed grades, ranging from consultants to junior doctors. All clinics which we observed had a consultant to oversee them.
- Trust policy stated medical staff must give six weeks' notice of any leave in order that clinics could be adjusted in a timely manner. We were told where the policy was not met; staff escalated this to divisional leads to be investigated.

Major incident awareness and training

- We reported at our inspection in July 2016 that not all staff were aware of how to act in the event of fire. During this inspection, we found that staff correctly described what the fire safety evacuation protocols were.
- The trust had a major incident policy which staff were aware of. It identified key contact details and a process for staff to follow.
- However, whilst the trust had business continuity plans in place to ensure the continued delivery of most services, we were told that there was no business continuity plan in place to maintain service delivery at the time the picture archiving and communication system (PACS) and radiology information system (RIS) systems failed.

Are outpatient and diagnostic imaging services effective?

This service was inspected but not rated. Our key findings were:

- There was evidence of local audits taking place.
- Patient consent was gained for each diagnostic test or procedure.
- Pain relieving medicines were available and given with good effect.
- The radiographer training programme was comprehensive and all staff IR (ME) R competencies were up to date.
- Diagnostic and imaging staff followed national evidence based practice and guidelines such as World Health Organisation (WHO) guidelines with regard to safety checks.

However:

- There was limited evidence of multi-disciplinary working between specialties.
- There was an incomplete non-medical referrers list.

Evidence-based care and treatment

- We were told that guidelines, such as the National Institute for Health and Care Excellence (NICE) guidelines were followed where appropriate. Staff told us they worked in line with NICE guidance and local policies.
- There was access to specialist investigations such as magnetic resonance imaging (MRI) and a computerised tomography (CT) scan. A CT scan uses X-rays and a computer to create detailed images of the inside of the body. MRI is a type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body.
- Protocols were in place that followed national guidance for radiology examinations such as orthopaedic x-rays.
- We were told that an audit lead had been recently appointed. We saw evidence of on-going audits in the radiology department. These included an ankle image audit, a mobile chest film audit, a musculoskeletal audit for the knee joint and a horizontal beam lateral hip image audit.

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- Other local audits in the outpatients department included hand hygiene compliance amongst clinical staff; waiting times, late running and case note availability in clinics and completion of nursing documentation for patient transfers out of OPD.
- Staff we spoke with could explain the evidence-based systems, such as the standard operating procedures which were in place to ensure procedures were undertaken in line with best practice.

Nutrition and hydration

- Where relevant, patients were given information about when to stop eating and drinking prior to diagnostic procedures and understood the reasons for this.
- Patients told us they were satisfied with the food and drink choices available.
- We observed staff supported patients who had undergone imaging procedures to eat independently and drinks were placed within their reach. When required, nurses assisted patients with eating and drinking.

Pain relief

- There was a chronic pain and pain interventions clinic at the hospital, which took referrals from GPs, consultants and other departments within the hospital.
- Pain relief was prescribed within the outpatient's and diagnostic imaging departments and pain relieving medicines were dispensed by the pharmacy department in a timely manner.
- We saw pain assessments were carried out in the diagnostic imaging department after invasive procedures and that pain relieving medicines were available and given with good effect.

Patient outcomes

- From December 2015 to November 2016, the follow-up to new patient rate for Whipps Cross University Hospital was lower than the England average.
- Policies were in place to ensure patients were not discriminated against. Staff we spoke with were aware of these policies and gave us examples of how they followed this guidance when delivering care and treatment for patients.

- The trust confirmed that Whipps Cross did not participate in the imaging services accreditation scheme (ISAS). The trust confirmed that no services in clinical support services held improving quality in physiological services (IQIPS) accreditation.

Competent staff

- We found there was non-compliance with the Ionising Radiation (Medical Exposure) regulations (IR (ME) R) around non-medical referrers. The regulation states that non-medical referrers may make referrals for ultrasound, CT and MRI imaging, as long as they are registered with a professional body such as a health care regulator. The referrer must be competent to understand the significance of the referral and the examination must be justified under the IR (ME) Regulations or protocols. Details of all authorised non-medical referrers and their competency must be held and managed within the Medical Imaging Service.
- We saw that the trust non-medical staff imaging referrals policy was due to have been reviewed in January 2017. The policy stated that a list of approved non-medical referrers and referral criteria should be kept by both the referring specialty and Imaging. It also stated the referrer must undertake regular audit of their practice.
- We checked the non-medical referrer's list and found it was incomplete and not up to date. There were just two names on the computer list, though staff told us there were more non-medical referrers and there was no copy in paper form available for staff to access. Staff we spoke with were unaware of the need to check the non-medical referrer list for the referrer's competency to make appropriate referrals.
- This meant that radiation examinations might be undertaken where there was no evidence that the non-medical referrer was competent to justify the referral in the first instance.
- We saw computer held training records for each CT radiographer. There was a robust induction programme for new staff. This included a list of daily itemised tasks to be completed over a period of six weeks. We reviewed individual training folders and saw that their induction programme had been signed off by the senior radiographer.
- The induction programme also included an assessment of a radiographer's competency to administer or supply prescription-only medicines. This qualified the

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radiographer to prescribe certain drugs used in imaging such as a contrast agent used during X-rays and an antispasmodic drug to improve the quality of images of the bowel or pelvis and is known as a patient group directive (PGD). The assessment was carried out by a PGD named assessor and a signed copy was held in the radiographer's training file and also in the pharmacy. We did a check of three staff records and saw that there was one PGD which was expired since March.

- A radiographer manager told us they checked the electronic staff training record each week to ensure that training and IM(RE) competencies were up to date. We reviewed this record and found that all staff were compliant with IM(RE) regulations.
- All nurses and doctors were provided with medicines management training as part of their induction training. This covered management of oxygen and other gases, controlled drugs (CDs) and intravenous fluids.

Multidisciplinary working

- A senior manager told us they reinforced the importance of multidisciplinary working at every opportunity. They said they believed that the cross site profile of the outpatient department was better than it had been due in part to raising matters specific to the outpatient department through formal mechanisms such as trust level meetings.
- We saw evidence of staff working together in a multidisciplinary environment to meet patient's needs. For example we observed a discussion about a patient's treatment between a clinician and a physiotherapist.
- Consultants sent information about a patient's treatment to their GP. We saw evidence of this on the patient electronic filing system.

Seven-day services

- The outpatients department was open from 8.30am to 5pm, Monday to Friday. Most clinics in the main outpatient department did not routinely provide a seven day a week service.
- However, in order to deal with appointment backlogs some outpatient services ran extra clinics in the evenings and occasional Saturday mornings. These were mainly staffed by current trust staff working additional hours which limited the availability of out-of-hours clinics.
- Radiology and diagnostics had 24 hour cover Monday to Friday within normal contracted hours. However, 24

hour weekend cover was voluntary and relied upon established staff's agreement to work. The radiography department staffed the x-ray department 24 hours a day to provide an emergency out of hour's service.

- The voluntary radiography week-end emergency duty roster was on the risk register. Since participation was voluntary and non-contractual for radiographers, unavailability of radiographers would impact on patients. A reduced imaging service would significantly decrease patient flow from ED and admission to treatment and discharge to the care of a GP. It would also include delays in diagnosis for all acute care pathways.
- At the last CQC inspection in July 2016, we commented that it was difficult to contact the on-call locum radiologist for information or advice. During this inspection, we were told by a consultant that this situation had been addressed. There was always a local consultant on call in the event of the on-call locum being uncontactable.
- There was access to specialist investigations such as MRI and CT scans and to a radiologist to interpret scans out of hours. Plain film and CT services were available out of hours for emergency, in patients and theatres.
- The hospital pharmacy was open from 9am to 5pm Monday to Friday, and 10am to 2pm on Saturdays and Sundays. Access to the pharmacy during opening hours was by designated pharmacy staff only. In addition, there were documented procedures for other named staff (site managers) to gain emergency access out of hours, meaning that unauthorised access was not possible.
- Staff were able to access 24 hour pharmacy advice at the Royal London Hospital which is also part of Barts Health NHS Trust.

Access to information

- Staff we spoke with said they had access to policies, procedures, NICE and specialist guidance through the hospital's intranet. We saw nurses in the outpatient department ensured that protocols used in the pre-admission clinic followed guidelines from the National Institute for Care and Health Excellence (NICE).
- Information on sexual health services, screening and contraception was on the trust website.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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- Nurses and doctors we spoke with were clear about procedures they would follow should a patient's capacity to consent be in question. Staff were able to describe procedures such as mental capacity assessment and the procedure for reaching a decision about treatment.
- Within the outpatient department, we observed and staff confirmed they had access to a policy for consent, examination or treatment. We were told in most cases verbal consent was obtained; however, written consent was obtained and signed for where a patient was to have an invasive procedure.
- We observed radiographers followed the trust policy on consent. They ensured that patient consent was gained for each scan or procedure. We saw that the department's practice was in line with professional guidance from the Society and College of Radiographers.
- We observed a clinician discuss treatment options during consultation. They took time to ensure that the patient understood the available treatment options. In another clinic, we saw a clinician confirm a patient's written consent to treatment and subsequently saw a clinical assistant check with the clinician that consent had been obtained.
- Patients told us they had been asked for consent before their procedures and were given an explanation of what it was they were consenting to.

Are outpatient and diagnostic imaging services caring?

Good



We rated caring as good because:

- Patients were treated with dignity and respect. Most patients were positive about the care they received.
- Staff were observed to listen and respond appropriately to patient's requests in a kind and caring manner.
- Patients and relatives told us that they found the staff to be mostly kind, helpful and informative.
- Chaperones were made available at patient's request.

However:

- In some areas patients' privacy and confidentiality were compromised. For example, in the dental, inpatient and chest x-ray area of diagnostic imaging.
- There was no chaperone training programme in place.

Compassionate care

- Throughout the outpatient and diagnostic imaging departments, staff presented in a friendly manner, greeted patients and introduced themselves. They put patients and their relatives at ease and apologised where there were delays in appointments. We observed a general willingness amongst staff to help people who used the service.
- Most patients and relatives who spoke with us were positive about how they were treated during their contact with the service and said "everyone on the staff seem to have enough time for us, we don't feel rushed or that we are an inconvenience."
- We saw clerical staff in clinics assisted patients promptly and were friendly and efficient in busy clinics. We saw a receptionist from the outpatients department accompany an elderly patient to another department. One family member told us "without their help, I am sure I would get lost."
- The trust chaperone policy set out the right of all patients to have a chaperone present, irrespective of gender. All patients had the right, if they wished, to have a chaperone present during an examination, procedure, treatment or any care irrespective of organisational constraints or settings in which they were carried out. A chaperone is an impartial observer who is not a family member and wherever possible, should be the same gender as the patient.
- However, whilst the policy states the chaperone should act as an advocate for the patient it does not outline what training chaperones would be provided with for the role. The trust subsequently confirmed that there was no training programme in place but told us it was under review.
- We saw several notices which informed patients that they could request a chaperone and observed one consultation where the patient requested and was provided with a chaperone.
- However, we found that patient's privacy and dignity was compromised in the changing cubicles in the dental, inpatient and chest x-ray area of diagnostic imaging. There were disposable curtains which opened

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out onto the main corridor and did not give total privacy. Male and female patients dressed in hospital gowns which were opened at the back shared the same waiting area.

- Friends and Family Test (FFT) gives patients the opportunity to submit feedback to providers of NHS funded care or treatment, using a simple question which asks how likely, on a scale ranging from extremely unlikely to extremely likely, they are to recommend the service to their friends and family if they needed similar care or treatment. Data on all these services is published on a monthly basis.
- Trust wide FFT data for April 2017 showed that 91% would recommend the service to friends and family whilst 2% would not.

Understanding and involvement of patients and those close to them

- Patients and relatives who spoke with us in the outpatient clinics reported feeling involved and understanding what they were attending the departments for, the types of investigations they were having and the expected frequency of attendance.
- We were told staff communicated well with them and helped them to understand their care and treatment. One patient told us they had been treated by the same consultant for 10 years. They described the consultant as “fantastic” and was the reason why they did not move out of the area.
- Most patients told us they had received appointment letters and understood that information was sent by the hospital to their GP. However, we spoke with a patient in a pain clinic who turned up for their appointment which they discovered on arrival had been cancelled. They said they had not received notification of the cancellation and there was no-one available to speak with them. We subsequently confirmed that this patient’s appointment was rebooked by a receptionist.

Emotional support

- NICE QS 15 (Statement 10) requires that patients have their physical and psychological needs regularly assessed and addressed including nutrition, hydration, pain relief, personal hygiene and anxiety.

- We observed a consultant deliver sensitive information to a patient in a clear and kind manner. They allowed time for the patient to ask questions and we saw the consultation ended with a clear treatment plan formulated.
- Treatment options were discussed with patients and they were encouraged to be part of the decision making process.

Are outpatient and diagnostic imaging services responsive?

Requires improvement



We rated responsive as requires improvement because:

- There were capacity issues in certain clinics and some clinics were cancelled due to lack of clinician availability for example in ophthalmology.
- There was inconsistency of approach to appointment reminders across outpatient clinics.
- We found the environment in some clinics was over crowded with insufficient space for additional seating for patients.
- Some patients told us the signs showing the way to the outpatients department from other parts of the hospital were unclear. They said the inclusion of a map on their appointment letter would have helped.

However:

- Services were planned and delivered to meet the needs of most people.
- The trust performed better than the England average for patients receiving their first treatment within 62 days of an urgent GP referral for all cancers.
- Booking centre staff consulted with patients to ensure the appointment slot was convenient for them.

Service planning and delivery to meet the needs of local people

- A full range of outpatient services was available to meet the needs of the local population, including specialist clinics. These included: breast clinics, cardiac, colorectal, colposcopy, urogynaecology, urology, ophthalmic, orthopaedic, sexual health, oral and ear, nose and throat (ENT).

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- Outpatient services were supported by diagnostic imaging services including X-ray, magnetic resonance (MRI) computerised tomography (CT) and ultrasound scans.
- At the CQC inspection in July 2016, we reported there were capacity issues in some clinics that meant there were insufficient number of available appointments; these included fracture clinic and ophthalmology. During this inspection, we were told that these clinics continued to have similar capacity issues.
- Evening and weekend outpatient clinics were not commonly happening. Managers told us a lack of outpatient nurse availability limited options for additional service activity. Evening and weekend clinics were usually only run where it was anticipated the referral to treatment target would be breached.
- We found the clarity of signage varied. For example, the reception area in outpatients had good signage to indicate bathrooms and directions to other parts of the hospital. However, we found the signs to specific clinical areas were not very clear. Reception staff told us they frequently accompanied patients to their clinics.
- Patients told us that the current signage and directions for moving around the hospital were poor and it was difficult to find their way around. They said their appointment letter did not give any indication of how to find the clinic.
- There were desks staffed by volunteers strategically placed around access areas to the outpatients department and clinics. We saw these volunteers gave helpful advice to patients and visitors.
- We were told that the use of telemedicine as an alternative to face to face appointments was in a very early trial phase for some patients, which included those with diabetes and thyrotoxicosis. Governance around this type of interaction had yet to be clearly defined.
- Staff in the dermatology clinic told us they ran an increased number of skin clinics in summer to manage the rise in skin cancer referrals at that time.
- We saw evidence that appointment centre staff demonstrated great flexibility when arranging an appointment with a patient. We saw where a patient's work pattern meant they had limited availability in which to attend an appointment, a member of staff managed to book a series of appointments which fell within the patient's holidays.

Access and flow

- It was agreed with NHS England that the trust suspended monthly referral to treatment (RTT) reporting from September 2014 until October 2017.
- The data we looked at showed that the trust consistently performed better than the 93% operational standard and England average for people being seen within two weeks of an urgent GP referral for cancer. However capacity issues across most other NHS outpatient clinics in England were a problem.
- An access standards meeting for the beginning of April 2017 identified 11 breast patients that would breach the two week standard because of capacity issues. It was noted that two additional clinics were set up to mitigate against this.
- We saw that an extra colorectal clinic was scheduled for the following evening. A nurse told us this was set up to avoid potential waiting times breaches.
- For all cancer waiting times, the trust performed better than the 96% operational standard and was in line with the England average for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat).
- The trust performed similar to the 85% operational standard and better than the England average for patients receiving their first treatment within 62 days of an urgent GP referral for all cancers.
- Between February 2016 and January 2017 the percentage of patients waiting more than six weeks to see a clinician was lower than the England average for diagnostic appointments
- Hospital data indicated that 10% of patients waited over 30 minutes to see a clinician and 5% of clinics started late. Staff we spoke with attributed this to demand exceeding availability of medical staff in certain areas for example, trauma and orthopaedics and ophthalmology.
- We were told the recent failure of radiology information system (RIS) and picture archiving and communication system (PACS) impacted on the reporting of GP and plain film x-rays, and caused delays of up to three weeks. Data reflected below was up to March 2017 therefore does not include this time period.
- Whipps Cross diagnostic imaging reported 89% of plain film within 14 days. Submitted data for March 2017 showed that 598 plain film were reported within seven

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days; 164 within 7-13days, 25 within 14-20; one within 21-27; 9 within 28-42 days and three over 42 days. The data did not include targets so it was not possible to draw conclusions about performance.

- Staff in the appointments booking centre told us ophthalmology clinics were frequently cancelled, though there was no data recorded for cancelled ophthalmology clinics on data submitted to CQC following this inspection.
- We looked at minutes of ophthalmology clinical governance meetings for April and May 2017 in which it was acknowledged there were concerns about the high levels of patients on the appointment slot issue list. It was also raised that there was a high level of 'did not attend' patients. Suggested reasons for this included the fact that patients were notified of their appointment by text only, rather than in letter form as is the expectation.
- We reviewed submitted data for clinic cancellations. There was a total of 1992 clinics cancelled for the year 2016 – 2017. Cancellations for clinics included 297 ENT, 231 dermatology, 211 respiratory medicine and 202 rheumatology clinics were cancelled; as well as 182 trauma & orthopaedics, 181 gastroenterology and 179 urology clinics.
- We looked at data for appointment slot issues (ASI). Patients are placed on this list when it is not possible to book an appointment within the agreed booking gate due to lack of suitable capacity.
- We saw there was a combined total of 2022 patients on the ASI list in December 2016 for ENT, dermatology, respiratory medicine, rheumatology trauma & orthopaedics, gastroenterology and urology clinics. The total for January 2017 was 1435; February 2017 was 1165; March 2017 was 1328; April 2017 was 1574 and May 2017 was 1906.
- In addition, ophthalmology patients on the ASI list totalled 1866 for December 2016; 1626 for January 2017; 1410 for February 2017; 807 for March 2017; 914 for April 2017 and 914 for May.
- There was a target for booking centre staff to answer all calls within 60 seconds. We were told there had been challenges to meeting this target at the beginning of 2017 due in part to staff shortages and illness. Data submitted by the trust showed that 70% of calls were answered within 60 seconds between July 2016 and April 2017. This reflected a high of 87% in July 2016 and a low of 41% in January 2017. We noted that this figure had increased to 70% in March and April.
- We saw minutes of the April outpatients service group performance review which attributed the under performance of the booking centre to increased ASI and appointment issues in Ophthalmology and misdirected calls to the appointment centre from the switchboard.
- From December 2015 to November 2016 the 'did not attend' rate for Whipps Cross University Hospital was higher than the England average.
- Responsibility for appointment bookings was shared between a central booking office team and a team which dealt with 2 week wait appointments for those patients suspected of having cancer.
- We found during our inspection in July 2016 that consultants were not triaging patient referrals within the time set by the standard operating procedure guidance. Triage is where the clinician makes an assessment of urgency to decide the order of treatment of a large number of patients.
- Administrative staff told us this was no longer the case since the increase in booking centre staff meant that there was more capacity to follow up with consultants if they had not returned the patient's booking information.
- According to the outpatient services service level agreement a full booking approach was offered whereby two attempts to contact the patient are made to negotiate a convenient date or time on the telephone. If contact cannot be made an appointment will be sent to the patient via a letter.
- Staff told us they adhered to this and were usually able to make telephone contact with patients to ensure the most suitable appointments time for them.
- A member of the cancer two week wait team told us all patients who required an appointment within two weeks were contacted by telephone. Three attempts were made to reach the patient by telephone, after which a text message was sent, as well as an appointment letter sent by first class post. They also told us the referral indicated what the appointment would include. This information was given to the patient; for example, if the patient had to have a procedure such as a biopsy.
- Staff in the appointments booking centre told us ophthalmology clinics were frequently cancelled. Whilst it was the responsibility of the clinic staff to offer a new

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appointment to those patients, cancelled clinics impacted on the booking centre as their number was on the original letter and patients frequently called them for a new appointment.

- We were told that the problem with capacity in the trauma and orthopaedic clinic was due in large part to there being only one consultant available for spinal trauma. This meant that there was a large demand for appointments and the 22 week period, which was the time frame set for this clinic within which a patient should be offered an appointment was frequently breached.
- The general manager told us some areas for improvements had been identified to help reduce over-running (delayed) clinics. For example, we were told that some clinic templates were not fit for purpose. The current template in use in the fracture clinic had five minute appointment slots. It was the general manager's intention to change the standard operating procedure in order to extend the appointment time which in turn would reduce the over-running clinic times.
- There was no consistent approach across outpatient clinics to send telephone or text reminders to people in advance of appointments. Some specialties sent patients a text message to confirm their appointments. Patients we spoke with told us this was helpful. However, they said that the message did not include the specific location of the clinic which led to some patients going to the wrong part of the hospital.
- We observed that some patients in GP x-ray had been waiting for up to two hours to be seen. They told us staff kept them informed of progress.

Meeting people's individual needs

- A translation service was available to enable staff to communicate with patients where English was not their first language. We saw there were patient information leaflets available in clinics specific to the specialism for patients to take away.
- We saw written information was available in several languages and large print. We saw that patients who lived with dementia and those with a learning difficulty were identified on the electronic patient information system. Nurses told us they were alerted to these patients in the morning safety huddle before clinics began.

- Appointments centre staff told us they did not use the translation service when contacting patients by telephone to discuss appointment times. They told us if the patient did not speak English, then they would communicate with a family member.
- Clinic staff told us whilst they could access the translation service, patients usually chose to have their family member translate for them instead. We observed this to be the case with one consultation we sat in on.
- It should be noted that the use of family members as interpreters is not considered to be best practice.
- In May 2016 the patient led assessment of the care environment (PLACE) assessment identified areas within outpatients where seating did not provide for the range of patient needs including not having enough chairs of different heights, chairs with and without arms and bariatric chairs.
- We saw the environment in some clinics was over crowded with insufficient space for additional seating for patients. The phlebotomy clinic was especially crowded, with many patients standing in the corridor whilst waiting. Some patients who attended the pain clinic told us how the chairs in the waiting area were not height adjustable to enable them to get out of them as safely and as painlessly as possible.
- Vulnerable patients such as those living with dementia or a learning disability, and children and young people were flagged on the electronic patient record system in order to alert staff to their possible increased needs. In addition, for those patients living with dementia, a forget-me-not flower sticker was placed on their record to indicate to staff their vulnerability. Appointment centre staff told us where there was a flagged patient, they tried to accommodate their appointment at the beginning or end of a clinic to minimise their waiting time.
- Information was displayed in the various waiting areas about any support services available for patients. This included helpline numbers and support networks for specific illnesses. We saw a variety of information leaflets on display in corridors and waiting areas which could be accessed by patients. We saw leaflets in an 'easy to read' format were readily available.
- Most patients who spoke with us commented positively on the responsiveness of clinical staff and receptionists. They described the reception staff as excellent, always

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pleasant and helpful, providing explanations where able. One patient told us they could not fault the doctors and nurses in any way and stated “they do a very difficult job very well.”

Learning from complaints and concerns

- Information on how to raise a concern or make a complaint was displayed in most of the areas we visited. There were some leaflets available in outpatients departments including comment cards, which patients could complete and post. Staff confirmed that they were made aware of complaints and concerns if they were relevant or involved them and received feedback individually and via staff meetings and team ‘huddles’.
- From April 2016 to March 2017 there were 103 complaints about outpatients. The trust took an average of 25 days to investigate and close complaints, this is in line with their complaints policy, which states complaints have a standard 25 working day turnaround, however this may be increased to 40 or 60 days where the complaint is complex. Of the 103 complaints the category with the highest number of complaints was related to communication; verbal, written and electronic 33 complaints (32%), this was followed by diagnosis/treatment with 23 complaints (22%).
- There were 20 complaints made to diagnostics and imaging between May 2016 and May 2017, all of which were closed, with 9 complaints upheld and 7 complaints withdrawn. Seven of these complaints related to appointment/clinic issues.

Are outpatient and diagnostic imaging services well-led?

Requires improvement



We rated well-led as requires improvement because:

- The governance arrangements were not effective and risks were not always identified or reflect staff concerns. For example, the safety of patients as they were transferred between computerised tomography (CT) and accident and emergency.
- There was poor contingency planning for the failure of the radiology information system (RIS) and the picture archiving and communication system (PACS).

- Some specialities were working in silos with their own processes and booking systems.

However:

- Staff told us management was more visible.
- There was an improved staff culture, some of which staff attributed to a greater willingness amongst managers and the human resources department to tackle bullying issues.
- A senior manager was a trust wide mediator and they used their skills to develop a culture of discussion and negotiation.
- The most recent trust wide NHS staff survey showed improvements in responses from staff in outpatients and imaging.

Leadership of service

- The overall management responsibility for Whipps Cross University Hospital diagnostic imaging lay with the Barts Health NHS Trust lead for radiology based at the Royal London Hospital. Since the CQC inspection in July 2016, the trust had moved away from modality leadership, which meant the cross-site leadership team was replaced with a local site leadership team. This meant there was an on-site imaging lead and a core services lead.
- Whipps Cross Outpatients department was led by an assistant director of nursing who reported to the director of allied health professionals, nursing and governance. The non-clinical management structure included a general manager. They reported to the trust head of outpatients and records who was based at the Royal London hospital who in turn reported to the director of operations for clinical support services (CSS).

Leadership: Diagnostic imaging

- We spoke with the site imaging lead who told us their on-site management role began in October 2016. They said this role was not yet fully embedded and there was a need for them to work with the department as a whole to develop it in a way which would benefit patients.
- Whilst senior leaders were generally proactive, we found there was a lack of awareness around the responsibilities for equipment safety checks and radiation protection.

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- During the CQC inspection in July 2016, staff told us the leadership team was not very visible. Staff we spoke with during this inspection told us this situation had improved with the establishment of site based managers.
- They said managers were very visible and available to support staff and provided advice where needed.

Leadership: Outpatients department

- The outpatients leadership team was made up of a general manager whose line manager was the trust lead for outpatients and patient records. We were told that the outpatients department had seven interim managers in the two years prior to the current general manager, who joined the department three weeks before this inspection.
- The general manager told us they were aware of the issues identified in the last CQC report and these formed the basis of their immediate work plan in their new role. These included working with all staff to improve working relationships, ensure staff understood the importance of reporting all incidents and embedding an understanding of and application of duty of candour.
- At our inspection in July 2016, we reported that there was poor communication and staff felt unsupported. During this inspection, staff told us they were more positive as there were more staff recruited to manage the workload and they felt listened to. They attributed this to the newly appointed outpatient department general manager, who had instigated a series of staff engagement discussions and team meetings in which they could raise matters.
- At the CQC inspection in July 2016, we found that management and meetings structure in the outpatients department and design of the environment meant that opportunities to work together to resolve conflicts were limited.
- At our inspection in July 2016 staff told us there was a lack of clarity about who had the authority to make decisions and how individuals were held to account. They also said they did not report all incidents as they did not always receive feedback. The previous inspection found there was a general lack of knowledge about who was responsible for monitoring waiting lists across outpatients and ensuring patients were seen within the 18 week referral to treatment time (RTT).
- During this inspection, we found there were improvements in staff awareness of lines of

responsibility. They told us the new general manager had the overall management responsibility. They also said the monthly newsletter included a description of any incidents and outcomes which helped to inform them of departmental matters throughout the trust.

- This manager told us they were focussed on improving the operational issues within the outpatients department. For this reason, they wanted to ensure staff understood the importance of operating effective systems such as appointments and bookings in order to improve the patient experience. They also said there was a need to develop a culture of openness within the department, for which they had asked for support from organisational development at trust level.
- Staff we spoke with told us that although the general manager had been in post three weeks at the time of our inspection, their impact was already noticeable. Staff told us they felt included in a plan to take the outpatients forward and cited the reintroduction of regular staff meetings as evidence of this. They said morale was much improved and they felt better supported, despite the demands and challenges.

Vision and strategy for this service

- The majority of staff we spoke with were clear of the values of the trust. They told us they felt committed to work towards achieving the broad vision and strategy. Staff showed a good understanding of the values and vision of the trust. We observed a morning huddle held in the diagnostic imaging department where the trust values formed part of the discussion (WE CARE - welcoming, engaging, collaborative, accountable, respectful and equitable).
- The outpatients department general manager told us since their appointment they had begun to work on an improvement plan. They told us their priority was to develop a management structure as swiftly as possible which was robust and fit for purpose.

Governance, risk management and quality measurement

- There were processes to manage current and future performance. Managers we spoke with had oversight of the risks within their department and were able to tell us what the three top risks were. However, we were not assured that there was sufficient understanding or oversight of local risks at clinical support services trust leadership level. For example, we found there was a gap

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between trust perception of recent IT issues and how they impacted at a local level. They were unable to tell us of the contingency plan to manage local issues surrounding IT. They were unable to give us assurance of a systemic approach to resolve the IT failure.

- There were structures in place to maintain clinical governance and risk management in both the diagnostic imaging and the outpatient departments.
- There were weekly clinical support services senior team meeting updates. Minutes of the meeting held on 24th April reflected the major problems with the systems failure of the picture archiving and communication system (PACS) and radiology information system (RIS), as well as the patient electronic system. They referred to the issues related to the failure of and referred to the need to 'get through this safely'. The areas in which major issues were identified included the stock ordering service in pharmacy and imaging, where it was not known how many patients turned up who could not be scanned.
- It was agreed there would be a trust wide departmental updating conference call each day at 11am and 5pm daily for pharmacy, pathology, out patients and imaging.
- Minutes of 2 May recorded that there were still major problems as a result of the systems failures of radiology information system (RIS) and picture archiving and communication system (PACS). It was noted that some progress has been made, but there were still considerable backlogs with requests and referrals in both imaging and pathology and the twice daily calls should continue.
- These minutes also noted that the patient electronic system was working and patients were booked onto the appointment slot issue list. PACS was up and running for images only. The next step identified was the need to import images back to PACS and it was noted that this was proving very difficult in some cases with the emphasis on not losing any pictures. It was recorded that the machines were becoming full which posed 'enormous risks in some areas and we have not collated the risks to patients for each of these'. It was also noted that there was an impact on cancer patients in radiotherapy was that it was not possible to schedule new patients.
- Minutes of 8th May stated the situation with regard to pathology was still unclear; it was not known how many tests remained unprocessed and there was difficulty collating this data.
- Monthly clinical radiology governance meetings were held and these were used as an opportunity to discuss incidents, potential breaches of waiting times and general issues which could impact on patient safety or experience. The trust submitted meetings of minutes held between December 2016 and March 2017.
- We looked at minutes of these governance meetings and noted that the January minutes recorded there was no service contract for the second breast ultrasound machine, which broke down frequently. The action noted was this would be placed on the electronic incident reporting system and a risk assessment done. The same situation was noted in the February meeting where it was recorded 'second breast ultrasound is coming to the end of its days'. The March minutes recorded 'no issues for the breast ultrasound machine' and it was not clear whether or how the situation was resolved.
- Separate outpatient risk registers were shown to us and these all identified service related risks, which were rated by current risk status and target level of risk.
- We saw minutes of the April imaging service group performance review which noted there were 16 risks on the risk register in March 2017.
- We saw minutes of the April outpatient service group performance review which noted there were 6 risks on the risk register in March 2017. The three top risks identified by the outpatients department included paediatric patients seen in adult clinics; lack of outpatient capacity resulting in a large appointment slot issue list and poor lighting, décor and general environment.
- The hospital risk register identified 17 risks in relation to outpatients department and 8 relating to imaging and diagnostics. Some of the risks within the outpatient department related in particular to ophthalmological services. For example, where demand exceeded capacity, there was a risk of missed diagnosis with long-term effects. Additionally, diagnostic machine break down was registered, the consequence of which would be significantly reduced throughput and possible compromise of patient care.

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- Risks identified by the diagnostic imaging department included frequent breakdown of magnetic resonance scanner, the consequence of which was recorded as last minute clinic cancellations and increased number of outsourced MRI scans with associated financial risk.
- The risk register logged that the dosimeter readings of interventional radiologists in the x-ray department exceeded the expected recommended safe level each month; this was added to the register in February 2017, with a review date of June 2017. Dosimeters are devices used to measure the amount of energy deposited by ionising radiation. This measurement is used to estimate the effective dose received by the human body through exposure to external ionising radiation. It was recorded that radiation doses received by medical staff was routinely higher than that recommended by the radiation protection advisor. This measurement was made against staff who performed similar procedures using x-ray equipment with modern dose limiting technology for the patients and operators. The harm identified was 'increased incidence of radiation related injuries such as cancer to the operators and patients'.
- The minutes of the April ophthalmology meeting recorded that a broken machine was missing from the department. It was due to be returned to the manufacturer and contained a large amount of patient details. It was agreed that this was a serious incident and would be placed on the risk register. However, the risk register we saw which included all risks up to the beginning of June 2017 did not include this missing machine.
- The trust continued to make progress since the CQC inspection in July 2016 to ensure all patients had notes available in time for their clinic attendance. Audits we looked at demonstrated that patient records were available 99% of the time for all clinics.
- The trust had suspended collection of referral to treat data in 2014 due to data collection being unreliable. Since then they had put in place internal processes and systems to collect RTT figures for all outpatient clinics.
- The CQC inspection in July 2016 reported governance procedures to monitor waiting lists, waiting times, frequency of cancelled clinics, and RTT timelines for patients were not robust enough which meant the impact on patients was not fully known. We were not assured during this inspection that this situation had improved as this evidence was not available to us.
- We also commented that there was no coordinated approach to running additional clinics to manage the waiting list.
- We found this was still the case during this inspection. Clinic staff told us how the provision of additional clinics was dependent on the availability of clinicians and clinic space and nursing capacity available to run clinics.
- There were established forums to monitor and review medicines management against national and local standards, including NICE guidance and Royal Pharmaceutical Society standards. These included the Whipps Cross Hospital medicines safety and management committee.
- The pharmacy staff identified and reported risks on the clinical support services risk register. Managers told us the main identified risks were: a lack of ward based pharmacy staff, no pharmacy assistants, and a shortage of pharmacy technicians, three different pharmacy stock control systems across the four hospital sites, and information technology system break down. Mitigation of the risks included a business case for additional staffing.
- The chief nurse was the accountable officer for controlled drugs in the trust. Any discrepancies in controlled drugs would be investigated and reported to the accountable officer for controlled drugs if there was no reasonable explanation. The accountable officer or a nominated deputy attended local intelligence network meetings.

Culture within the service

- During our previous CQC inspection in July 2016, we found there was a culture of bullying in the outpatients department in particular.
- During this inspection, staff told us this was much less the case for a variety of reasons. They told us there was a greater willingness amongst managers and the human resources department to tackle bullying which meant that staff felt more confident to report it.
- We spoke with senior managers about this and were told that this culture was less of a problem as a result of certain organisational changes, an increased amount of forums in which staff could openly discuss concerns and greater management availability should staff want to speak privately with them.
- Managers told us they were working with staff to foster a culture of negotiation. Previously, where there were inter-staff problems the pattern was to initiate a

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grievance rather than try to resolve the problem face to face. One manager told us they were trained as a trust wide mediator and provided us with examples of where they brought those skills to their work.

Public and staff engagement

- The trust told us they used volunteers to provide support to patients in outpatients; this included running information points throughout outpatients. We observed volunteers directing patients to various departments.
- Patient Advice and Liaison Service (PALS) information was available on notice boards in waiting areas. These informed patients of the PALS service and invited patients to provide feedback and comments.
- The trust gained patients views about services through friends and family trust ('I want great care') responses. Where the trust target was 100% for patients likely to recommend the service, we saw data for March 2017 that recorded 100% of breast screening patients, 87% of core imaging and 97% of ultrasound patients would recommend the service.
- Friends and Family responses indicated that 87% of respondents said they would recommend the hospital to family and friends.
- The 2016 trust wide NHS staff survey showed improvements in responses from staff in most areas; the figures in brackets represent results of the 2015 survey. Staff recommendation of the organisation as a place to work or receive treatment 58% (47%); experienced harassment, bullying or abuse from staff in last 12 months 32% (37%); believed the organisation provided equal opportunities for career progression 72% (70%); those who felt pressured to attend work in previous three months despite feeling unwell 51% (55%); good communication between senior management and staff 34% (28%).

- The hospital management board decided a corporate approach would be undertaken in response to the staff survey. A 'listening into action' event was planned for June 2017 to share the results with staff and develop a local approach to particular areas for development and actions to be taken.
- In addition, the general manager of the outpatient department carried out a recent 'pulse' survey with staff, to get a snapshot view of the department. 17% of staff felt supported working in their team or department; 12% felt managers sought their views on how to improve services and 21% felt they were providing a high quality service to patients. 8% of staff felt organisational structures and processes helped them to do their job properly and 8% felt environment, facilities and systems enabled them to do their job properly. 45% of staff felt they could prioritise patient care over other work. The manager told us whilst these results were poor, the expectation was that the next survey would see improvements due to greater consistency of management and efforts to change the culture.
- Throughout the inspection we found staff were welcoming and willing to speak with us. Many said they could see improvements were taking place and they felt better informed of changes that were happening that affected them.

Innovation, improvement and sustainability

- The general manager of the outpatients department expressed optimism for the future direction of the department. They acknowledged that sustainability was dependent upon the development of a strong local management team and the continued support of trust level managers.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The trust must ensure governance systems are embedded in practice to provide a robust and systematic approach to improving the quality of services. This should capture relevant elements of good governance including an adopting a positive incident reporting culture where learning from incidents is shared with staff and embedded to improve safe care and treatment of patients.
- The trust must improve bed management, theatre management and discharge arrangements to facilitate a more effective flow of patients across the hospital and to improve theatre cancellation and delayed discharge rates.
- The trust must improve its referral to treatment time performance in line with national standards.
- The trust must improve staff compliance with mandatory training including safeguarding training.
- The trust must improve staff compliance and awareness of trust infection prevention and control policies and processes.
- The trust must improve compliance with venous thromboembolism (VTE) assessments.
- The trust must ensure all patients are screened for malnutrition as required by NICE guidelines.
- The trust must ensure that patient records are stored securely in line with information governance standards.
- The trust must ensure the hospital's physical environment, including operating theatres, is fit for purpose and meets required standards.
- The trust must continue to work towards improving the organisational culture to reduce instances of unprofessional behaviours and bullying and ensure all staff feel sufficiently supported by their managers.
- The trust must ensure there are sufficient numbers of qualified, skilled and experienced staff employed and deployed to meet the needs of patients. This should include ensuring staff have the right skills to recognise and manage the deteriorating patient.
- The trust must ensure all staff receive appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.
- The trust must ensure that risks to patient safety and service delivery are appropriately identified, recorded and escalated effectively.
- The trust must ensure governance systems are embedded in practice to provide a robust and systematic approach to improving the quality of services.
- The trust must ensure compliance with radiation protection regulations.
- The trust must ensure that timely arrangements are in place to replace diagnostic imaging equipment identified as at risk of failure.
- The trust must ensure there are functioning panic alarms across the outpatients department.
- The trust must ensure that the environment is safe where children and young people are treated in adult clinics.
- The trust must ensure that equipment used for moving deceased patients from the ward to the mortuary are properly maintained and suitable for the purpose for which they are being used.
- The trust must ensure that systems and processes are in place to enable proper management and oversight of the mortuary and are understood by staff who provide mortuary duties out of hours and in the absence of regular staff from the outsourced third party.
- The trust must have systems in place to assess and monitor their performance for rapid discharge and its effect on patient care.
- The trust must assess the quality of services provided (including the quality of the experience of service users in receiving those services) in relation to its current palliative care consultant resource and with consideration to meeting the national guidance ['Commissioning Guidance for Specialist Palliative Care: Helping to deliver commissioning objectives']

Outstanding practice and areas for improvement

(Dec 2012.)) which recommends a minimum requirement of 1 whole time equivalent consultant in palliative medicine per 250 hospital beds. The hospital has 586 beds.

- The trust must ensure that ward staff are provided with appropriate support and training in end of life and palliative care to enable them to carry out their role effectively.

Action the hospital SHOULD take to improve

- The trust should ensure staff always have access to reliable equipment to minimise potential delay to treatment.
- The trust should ensure that timely arrangements are in place to replace ageing theatre equipment identified as at risk of failure.
- The trust should ensure the needs and preferences of patients and their relatives are central to the planning and delivery of care at the hospital.
- The trust should review, and take action to address, feedback from staff raised in the NHS staff survey.
- The trust should act upon the results of national audits to address areas of poor performance and to help drive improvement in services.
- The trust should ensure that surgical site infection (SSI) data is appropriately captured and reviewed.
- The trust should ensure the safety of patients as they are transferred between CT and accident and emergency.
- The trust should ensure training is provided for the role of chaperone.
- The trust should ensure the physical environment is fit for purpose and maintained in a good state of repair.
- The trust should ensure the business continuity plan is updated to reflect systems failures in outpatients and diagnostic imaging services.
- The trust should ensure privacy for patients who attend the CT scanning unit.
- The trust should ensure best practice around the use of appropriate interpreters.
- The trust should ensure a consistent approach to sending reminders to patients about their appointments.
- The mortuary audit from March 2017 reported on the age and number of the fridges available and recommended it for entry onto the trust risk register. The trust should ensure this issue is given proper consideration.
- The trust should ensure that the second mortuary viewing room (in the accident and emergency department) is in a good state of repair.
- The trust should ensure that the new clinical records system that contains mechanisms for patient outcome data to be collected is utilised. The outcome measures had been on the new system since March 2017. The SPCT had used it for a matter of weeks and were not yet in use.
- The trust should ensure that work taking place to increase the limited multidisciplinary input in to the Margaret Centre and SPCT such as social work, therapy and psychological services, is continued.
- The trust should ensure that it conducts a review regarding the inconsistency of provision available for relatives who were at the hospital with their loved ones for long periods of time. For instance, in relation to items such as tea and coffee, and for relatives staying overnight.
- The trust should ensure that religious texts are readily available to patients of all major faiths who use the hospital.
- The trust should ensure that information gathered from both 'Have Your Say' and the bereavement survey are used to improve care.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Surgical procedures	<p>Regulation 9 HSCA (RA) Regulations 2014 Person-centred care</p> <p>9(1) The care and treatment of service users must— (a) be appropriate, (b) meet their needs, and (c) reflect their preferences.</p> <p>Providers must do everything reasonably practicable to make sure that people who use the service receive person-centred care and treatment that is appropriate, meets their needs and reflects their personal preferences, whatever they might be.</p> <p>Patients were frequently discharged out of hours (after 8pm) due to delays. Patients had their operations cancelled on the day of surgery due to delays in theatre lists and poor theatre utilisation. Patients stayed overnight in recovery areas due to lack of available beds on surgical wards. Therefore, this regulation was not being met.</p> <p>9(3)(i) where meeting a service user's nutritional and hydration needs, having regard to the service user's well being</p> <p>Providers must make sure that they assess each person's nutritional and hydration needs to support their wellbeing and quality of life.</p> <p>Not all patients were screened for malnutrition.</p> <p>Therefore, this regulation was not being met.</p>
Regulated activity	Regulation
Surgical procedures	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p>

Requirement notices

12(1) Care and treatment must be provided in a safe way for service users.

Providers must comply with this regulation by:

- (a) assessing the risks to the health and safety of service users of receiving the care treatment;
- (b) doing all that is reasonably practicable to mitigate any such risks.
- (c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely
- (d) ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way;
- (h) assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated.

Staff did not always comply with the trust's infection prevention and control policy. The trust's incident reporting process was inconsistently applied and learning from incidents was not consistently shared with staff. Surgical wards were not compliant with the trust's target for the completion of venous thromboembolism (VTE) assessments. Surgical site infection data was not effectively captured and the risks to health and safety were always not captured or escalated effectively. We observed a number of infection control issues related to the operating theatre environment which did not meet the Department of Health's standards. Not all staff had completed mandatory training. Therefore, this regulation was not being met.

Regulated activity

Surgical procedures

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

17(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.

Requirement notices

17(2) such systems or processes must enable the registered person, in particular, to-

(a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);

(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;

(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

Providers must have systems and processes such as regular audits of the service provided and must assess, monitor and improve the quality and safety of the service. Providers should have effective communication systems to ensure that people, including staff, know the results of reviews about the quality and safety of the service and any actions required following the review.

Clinical governance meetings were not well embedded and there was a lack of consistency between surgical specialities in the format and quality of the meeting minutes. Ward meetings did not always take place and therefore information and feedback about the quality and safety of the service was not always shared with staff.

We did not see evidence that national audit results were being used to improve services

Providers should actively seek the views of a wide range of stakeholders, including staff about their experience of, and the quality of care and treatment delivered by the service.

A number of staff in different areas told us about ongoing issues of bullying, favouritism or unfair treatment. Staff lacked confidence in the hospital's HR department and felt reluctant to raise concerns.

Requirement notices

In the NHS staff survey 2016, the staff response rate for the surgical and cancer division was 29.4%, which was significantly worse than the overall trust response rate of 47.3%. The service also performed significantly worse than the trust average in questions related to staff engagement with senior managers.

Providers must monitor progress against plans to improve the quality and safety of services, and take appropriate action without delay where progress is not achieved as expected.

Progress against the service's action plan was slow and there was little evidence of improvements in the areas raised as concerns during the previous inspection in July 2016.

Providers must have systems and processes that enable them to identify and assess risks to the health, safety and/or welfare of people who use the service. Where risks are identified, providers must introduce measures to reduce or remove the risks within a timescale that reflects the level of risk and impact on people using the service. Providers must have processes to minimise the likelihood of risks and to minimise the impact of risks on people who use services.

Identified risks to people who use services and others must be continually monitored and appropriate action taken where a risk has increased.

The risk register did not reflect all current risks to the service. Some risks had been on the register for several years and it was not clear when these had last been reviewed. The risk register did not show what controls were in place or actions taken to mitigate risks.

Significant data quality concerns led to suspension of the monthly 18-weeks referral to treatment time (RTT) reporting. Continuing data quality issues meant that the risk of harm to patients might not always be identified and addressed.

Records relating to the care and treatment of each person using the service must be kept and be fit for purpose. Fit for purpose means they must be kept secure at all times and only accessed, amended, or securely destroyed by authorised people.

This section is primarily information for the provider

Requirement notices

We found that patient records were not always stored securely in line with information governance standards. Therefore, this regulation was not being met.

Regulated activity

Surgical procedures

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

18 (1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.

18(2) Persons employed by the service provider in the provision of a regulated activity must— (a) receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

Providers must deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that they can meet people's care and treatment needs.

The use of agency staff was high and the quality of the agency staff compromised patients' care and treatment.

Staff should receive regular appraisal of their performance in their role from an appropriately skilled and experienced person and any training, learning and development needs should be identified, planned for and supported.

Not all staff received an annual appraisal.

Therefore, this regulation was not being met.

Regulated activity

Diagnostic and screening procedures

Nursing care

Treatment of disease, disorder or injury

Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Requirement notices

Despite issues being identified through audit and reported as acted on in March 2017, we found there was a lack of working equipment available within the mortuary. The patient slide (PAT slide) used for moving patients was missing and the concealment trolley used to remove a deceased patient from the ward to the mortuary was broken. This piece of equipment was essential and was reported to have been broken and out of use for a month. There was no replacement available and no temporary trolley was provided. The mortuary had to use a normal hospital bed with a covering instead.

This was in breach of regulation 15 (1)(c)(e) equipment used by the service provider must be suitable for purposes for which they are being used and properly maintained.

The provider must ensure that equipment used for moving deceased patients from the ward to the mortuary are properly maintained and suitable for the purpose for which they are being used.

Regulated activity

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

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

There were systems in place that were not universally recognised and could lead to confusion if the mortuary manager from the outsourced third party was not present. For instance, there was a system of identification based on numbers on a whiteboard that correlated with individual items of human tissue stored in a freezer. The system lacked transparency, which meant that anyone other than the mortuary manager from the outsourced third party would not be able to understand it. This included porters and site managers who both covered out of hours duties.

There were 20 fridge spaces available in the mortuary. There were no bariatric fridge spaces available. Deceased patients were frequently transferred to other

Requirement notices

premises that were owned and managed by the outsourced third party providing mortuary services. The trust had no oversight regarding this movement of deceased patients.

Out of hours mortuary viewings were arranged and managed by the porters from an outsourced third party who had not been trained in any mortuary duties.

Although the mortuary appeared clean, there were no cleaning schedules available.

This was in breach of regulation 17(2)(b) systems and processes must enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others

The trust must ensure that systems and processes are in place to enable proper management and oversight of the mortuary and are understood by staff who provide mortuary duties out of hours and in the absence of regular staff from the outsourced third party. 17(2)(b)

The discharge team told us they tried to meet a national target of 48 hours for rapid discharge. However, although they monitored this on a day to day basis they did not measure this in any other way, such as over time or through any sort of audit and did not understand their effectiveness against this target or its effect on patient care.

A full time palliative care consultant covered SPCT community and SPCT hospital work 50/50. There was also a full time consultant who covered the MC duties.

Officially both consultant posts were split 40/60 to cover MC and SPCT work, but in reality one covered SPCT and the other the MC. These roles were interchangeable when this was called for. Either way, it meant there were currently eight consultant sessions in total shared between the hospital and community.

Another consultant was due to be appointed soon and we were told there was an applicant. It was intended for them to do seven sessions in the MC and three on education. However, we were also told a further three sessions would be available to the hospital when this post had been recruited to.

Requirement notices

Consultant levels were below the Commissioning Guidance for Specialist Palliative Care: Helping to deliver commissioning objectives' (Dec 2012.)) which recommends a minimum requirement of 1 whole time equivalent consultant in palliative medicine per 250 hospital beds. The hospital has 586 beds.

This was in breach of regulation 17(2)(a) systems and processes must enable the registered person to assess, monitor and improve the quality and safety of the services provided , including the quality of the experience of the service users in receiving those services.

The provider must have systems in place to assess and monitor their performance for rapid discharge and its effect on patient care. 17(2)(a)

The provider must assess the quality of services provided (including the quality of the experience of service users in receiving those services) in relation to its current palliative care consultant resource and with consideration to meeting the national guidance ['Commissioning Guidance for Specialist Palliative Care: Helping to deliver commissioning objectives' (Dec 2012.)) which recommends a minimum requirement of 1 whole time equivalent consultant in palliative medicine per 250 hospital beds. The hospital has 586 beds. 17(2)(a)

Regulated activity

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

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

There were meant to be two link nurses for each ward. However, current systems and turnover of staff meant that this had not proved effective. The SPCT did their own link nurse training, which stopped when the trust wide end of life education facilitator left. This post was currently vacant. It was reported that there was a new starter in this role commencing in June 2017; a month after our visit.

The SPCT reported that they had tried running education sessions for hospital staff as a drop in, which had not

Requirement notices

proved to be an efficient way of delivering training due to poor turnout. It was widely felt that this was due to the wards being pressurised which accounted for the low attendance by ward staff.

We asked if providing training at nurse handovers had been considered. We were told that the shift structure meant there were no split shifts at the hospital now, which meant training would be outside of normal SPCT working hours.

We were provided with details of a specialist palliative care study day that took place once in May and once in November 2016. It was presented by members of the MC and SPCT and covered aspects of care such as spirituality, nausea, vomiting and constipation, pain and terminal agitation. We were provided with attendance figures for May's session, which showed that out of 26 attendees, 14 were from a mix of hospital wards.

The Margaret Centre (MC) and the SPCT staff worked on relationships with services within the hospital to promote better end of life care. Ward staff we spoke with thought both the SPCT and the MC staff were helpful. Although they engaged well with ward staff and supported teams to deliver end of life care, it was a widely held belief among senior staff at the Margaret Centre and SPCT that a barrier to promoting a positive culture of end of life and palliative care being everyone's responsibility, lay with the education of ward staff. It was also a widely held belief that if ward teams in the hospital did not feel every patient had to come to the Margaret Centre to die and the SPCT received referrals sooner, it would be a better scenario all round.

This was in breach of regulation 18(2)(a) persons employed by the service must receive appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out their duties they are employed to perform.

The provider must ensure that ward staff are provided with appropriate support and training in end of life and palliative care to enable them to carry out their role effectively. 18(2)(a)

Requirement notices

Regulated activity

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

17(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.

17(2) such systems or processes must enable the registered person, in particular, to-

(a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);

(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;

Incidents were not always reported or actioned in line with trust policy. The trust had identified capability issues with staff using the incident reporting system, however we were told this training was not included in induction training.

Risk registers did not reflect all areas of concern, for example; concerns about transfers of patients between the emergency department and imaging department or lack of accessible resuscitation equipment

Safety equipment was not always maintained or replaced to ensure the safety of patients or staff. In particular lead aprons, which provided radiation protection. The outpatient department lacked functioning panic alarms.

There was limited oversight of the extent or depth of potential patient harm as a result of a recent information technology systems failure.

Governance systems were not always embedded in practice to provide a robust and systematic approach to improving the quality of services.

Therefore, this regulation was not being met.