The Whittington Hospital NHS Trust

Quality Report

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This report describes our judgement of the quality of care at this trust. 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 trust	Good
Are services at this trust safe?	Requires improvement
Are services at this trust effective?	Good
Are services at this trust caring?	Outstanding
Are services at this trust responsive?	Good
Are services at this trust well-led?	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

Whittington Health was established in April 2011 bringing together Islington and Haringey community services with Whittington Hospital's acute services to form a new Integrated Care Organisation (ICO). Whittington Health provides acute and community services to 500,000 people living in Islington and Haringey as well as other London boroughs including Barnet, Enfield, Camden and Hackney.

The hospital has approximately 320 beds, and is registered across 3 locations registered with CQC: Whittington Hospital (includes community services) , Hanley Primary Care Centre (GP practice and community centre) and St Luke's Hospital (Simmons House) multi-disciplinary MH service for 13-18 year olds with emotional and mental health problems.

We carried out an announced inspection between 8 and 11 December 2015. We also undertook unannounced visits on 14, 15 and 17 December 2015.

We inspected Whittington Health NHS Trust acute hospital, including the right core services: Urgent and Emergency Care, Medicine (including older people's care, Surgery, Critical Care, Maternity and Gynaecology, Services for children, End of life and Outpatients and diagnostic services.

We inspected Whittington Health NHS Trust CAMHS services, Whittington Health community services for adults, children and young people and families, and patients receiving end of life care.

This was the first inspection of Whittington Health NHS Trust under the new methodology. We have rated the trust as good overall, with some individual core services as requires improvement.

In relation to core services most were rated good with critical care and outpatients and diagnostics rated as requires improvement. Community end of life care and community dental services were rated as outstanding.

Our key findings were as follows:

- During our inspection we found staff to be highly committed to the trust and delivering high quality patient care.
- We saw staff provided compassionate and patients were positive about the care they received and felt staff treated them with dignity and respect.
- The trust had vacancies across all staff groups, but was recruiting staff and staffing levels were maintained in services through the use of bank and agency staff.
- Staff were aware of how to recognise if a child or adult was being abused and received good support and training from the trust's safeguarding team.
- The trust had an incident reporting process and staff were reporting incidents and receiving feedback. Learning was shared across ICSU's which encompassed acute and community service.
- The Trust had promoted duty of candour and this was seen to be cascaded through the organisation.
- We observed effective infection prevention and control practices in the majority of areas we inspected.
- Patient care was informed by national guidance and best practice guidelines and staff had access to polices and procedures.
- Patients had their nutritional needs met and received support with eating and drinking.
- There was good team and multidisciplinary working across all staff groups and with clinical commissioning groups, voluntary organisations and social services to deliver effective patient care.
- We found evidence of good compliance with the World Health Organisation (WHO) surgical safety checklist, with good completion of the three compulsory elements: sign in, time out and sign out.
- There were processes in place to ensure staff attended training on the Mental Capacity Act 2005 and the majority of staff demonstrated a good practical understanding of this, with variability in some services,

Summary of findings

- Staff understood and responded to the needs of the different population groups the trust served and worked hard to meet the needs of individual patients.
- Patients were largely treated in timely manner with the trust meeting national access targets and performing higher than the England average, with the exception of the cancer two week wait standard, although it was noted that improvements were being made against that standard.
- The emergency department (ED) performed better than the average ED in England in the speed of initial assessment, the timeliness of ambulance handover, and the percentage of people staying for more four hours in the department. However, there were times when there were no in-patient beds available and patients remained in ED for a long time.
- The trust had introduced the ambulatory care unit, which engaged stakeholders across the health and social care economy to avoid unnecessary hospital admissions and transfer their ongoing care needs to the most appropriate provider.
- Patient flow out of theatres and critical care, impacted on patient movement and service capacity.
- Executive and non executive members of the trust were visible in most areas, in both acute and community settings.
- The trust had a clear vision and strategy , the development of this into local strategies were in place in some areas, but were still being developed in some cases.
- Staff were positive about how their local and senior managers engaged with them.

We saw several areas of outstanding practice including:

At the Whittington Hospital:

- Whittington Health NHS Trust worked with clinical commissioning groups (CCGs) and other providers to improve the responsiveness of emergency and urgent care services for local people. The Ambulatory Care Centre, which opened in 2014, provided person-centred hospital level treatment without the need for admission.
- Within he Ambulatory Care Centre we observed good multidisciplinary working across hospital services, including diagnostics, care of the elderly physicians, therapists, pharmacists, and medical and surgery specialities to provide effective treatment and care.
- Elderly care pathways had been well thought out and designed to either avoid elderly patients having to go to ED or if they do, making sure that their medical and social care needs are quickly assessed.
- Within the ED there was outstanding work to protect people from abuse. The lead consultant and nurse for safeguarding coordinated weekly meetings attended by relevant trust wide staff to discuss people at risk and to make plans to keep them safe.
- Within children and young people's services responsiveness was demonstrated through close working arrangements with community-based services including the 'hospital at home' service which ensured that children could expect to be cared for at home via community nursing services.
- The trust provided 'Hope courses' for patients who had been on cancer pathways to get together outside of hospital, and hear from motivational speakers including talks on personal wellbeing, nutrition and recovery care.
- At Whittington Health community sites:
- Community teams told us they felt very integrated with the trust hospital services, GPs and nurses. We found examples of shared assessments within community settings, for example joint podiatry and diabetes assessments.
- Within community dental services we received consistently positive responses from patients, some describing the services as "Life changing" and others rating services as five-star on the NHS Choices website.
- Within community end of life care we found the service provided outstanding, effective services to children, young people and their families. We saw examples of very good multidisciplinary working and effective partnerships with the local GPs, other providers and hospices.

Summary of findings

- Within community end of life care services we observed exemplary care, delivered with respect and dignity. Everyone we spoke with told us they had entirely positive experiences of the service.
- Within community end of life services there was a commitment to offering an equitable service across the three boroughs. Data was collected on the patient's preferred place of death and discussed at a specialist network level.
- The service worked well with the local hospice to make the best use of day care and hospice at home services in response to patient need.
- The children's community palliative care service, Lifeforce, was exceptionally well led. The service was committed, adaptable and flexible to meet the needs of the patients and their families. The term going, 'over and above' was used on many occasions to describe the team's approach to their work.

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

Importantly, the trust must:

Trust wide:

- Review bed capacity to assess capacity across medicine, surgery and critical care to ensure patients are appropriately placed within the correct specialism and enhance hospital flow.

At the Whittington hospital site:

- Within the Emergency Department (ED) there was not sufficient consultant cover and there were vacant middle grade medical posts, covered by locum (temporary) doctors, which poses a risk to delivery of care and training staff.
- Within acute outpatient departments the hospital must improve storage of records and ensure patient's personally identifiable information is kept confidential.
- Within the acute outpatient setting, departments improve disposal of confidential waste bags were left in reception areas overnight.
- Within surgery and theatres review bed capacity to ensure patients are not staying in recovery beds overnight.
- Within critical care the trust must review capacity and outflow of patients. We observed significant issues with the flow of patients out of critical care and found data suggesting 20% of patient bed days were attributed to patients who should have been cared for in a general ward environment. This led to mixed sex accommodation breaches, a high proportion of delayed discharges from critical care and a number of patients discharged home directly from the unit
- Within critical care the service must review governance processes and use of the risk register. We were concerned there was a culture of underreporting incidents and near misses and the importance of proactive incident reporting be promoted.
- Within critical care staff did not challenge visitors entering the unit and we were concerned patients could be at risk if the unit was accessed inappropriately.
- Within maternity services the department must ensure the information captured for the safety thermometer tool is visible and shared with both patients and staff in accessible way.
- Within maternity the service must ensure the safety of women undergoing elective procedures in the second obstetric theatre and agree formal cover arrangements.
- Within palliative care the service did not meet the requirement set by the Association for Palliative Medicine of Great Britain and Ireland, and the National Council for Palliative Care related to number of palliative care consultant working at the hospital.
- Within palliative care services staff were not always aware of patient's wishes in regards to their 'preferred place of death'. They did not always record and analyse if patients were cared for at their 'preferred place of care'.

At CAHMS inpatient services

- Improve ligature risk assessments and the identification of associated risks

Summary of findings

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to The Whittington Hospital NHS Trust

Whittington Health was established in April 2011 bringing together Islington and Haringey community services with Whittington Hospital's acute services to form a new Integrated Care Organisation (ICO). Whittington Health provides acute and community services to 500,000 people living in Islington and Haringey as well as other London boroughs including Barnet, Enfield, Camden and Hackney.

The hospital has approximately 320 beds, and is registered across 3 locations registered with CQC: Whittington Hospital (includes community services) , Hanley Primary Care Centre (GP practice and community centre) and St Luke's Hospital (Simmons House) multi-disciplinary MH service for 13-18 year olds with emotional and mental health problems.

The health of people in Haringey is varied compared with the England average. Deprivation is higher than average and about 26.8% (14,200) children live in poverty. Life expectancy for both men and women is higher than the England average.

The health of people in Islington is varied compared with the England average. Deprivation is higher than average and about 34.4% (11,500) children live in poverty. Life expectancy for men is lower than the England average.

We inspected Whittington Health NHS Trust acute hospital, including the right core services: Urgent and Emergency Care, Medicine (including older people's care, Surgery, Critical Care, Maternity and Gynaecology, Services for children, End of life and Outpatients and diagnostic services.

We inspected Whittington Health NHS Trust acute hospital, Child and Adolescent Mental Health Services (CAHMS) and community services for adults, children and young people and families, and patients receiving end of life care.

Our inspection team

Our inspection team was led by

Chair: Alastair Henderson, Chief Executive, Academy of Medical Royal Colleges

Team Leader: Nicola Wise Head of Hospital Inspection Care Quality Commission

The trust was visited by a team of CQC inspectors and assistant inspectors, analysts and a variety of specialists.

There were consultants in emergency medicine, medical care, surgery, paediatrics, cardiology and palliative care medicine and junior doctors. The team also included midwives, as well as nurses with backgrounds in surgery, medicine, paediatrics, neonatal, critical care and palliative care, community services experience and board-level experience, student nurse and two experts by experience.

How we carried out this inspection

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

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

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

Summary of findings

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

The trust also provides community services and we inspected

- Community services for adults
- Community services for children, young people and

their families

- Community services for people receiving end of life care
- Community services for inpatients

The trust also provides mental health services and we inspected

- Mental health services for adults

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

As part of this inspection, we visited a number of health centres and community team bases at: St Anne's Hospital, Crouch End Health Centre, Hornsey Central Neighbourhood Health Centre, City Road Health Centre, Holloway Community Health Centre, Hornsey Rise Health Centre, Islington Outlook and the Partnership Primary Care Centre.

We observed how patients were being cared for, spoke with patients, carers and/or family members and reviewed patients' personal care or treatment records. We held focus groups with a range of staff in the hospitals and community services, including doctors, nurses, allied health professionals, administration, senior managers, and other staff. We also interviewed senior members of staff at the trust.

What people who use the trust's services say

Public Event

To capture the views of local people who use the trust we arranged market-style feedback stands. We received many positive comments about most of the services. Staff were described as caring and supportive.

Friends and Family Test

The percentage of patients who indicated they would recommend the trust met the England average in August 2015, however was consistently below the average between July 2014 and July 2015.

Patient led assessments of the care environment (PLACE)

The trust was above the England average in all measures (food, cleanliness, privacy, dignity and well-being) in 2013, 2014 and 2015.

Healthwatch

Healthwatch Haringey provided feedback from patients and relatives about a range of services including the emergency department, hospital outpatients, and pharmacy. There was a mix of positive and less positive experiences ranging from Reception staff attitude, appointment systems, interpreter services for hearing impaired patients and access to the PALS and complaints service.

Following the PLACE assessment feedback was assessors were impressed by the patient care, cleanliness and hygiene in the hospital. Comments and feedback made last year had been taken on board and there was a great improvement.

Clinical Commissioning Groups (CCGs)

Summary of findings

Islington and Haringey are the two main local commissioners. They were generally positive about services provided by the trust and believed quality and outcomes were good.

They commented on how the trust worked collaboratively to improve health care across the local health economy and had changed its' organisational structure since the formation of the ICO.

Areas of concern were highlighted as issues with the response time for urgent 2 hour assessment, access times for two week wait cancer assessments, six week diagnostic waiting times. Response rates to for Friends and Family indicators. Appraisals were highlighted as an issue for staff through the staff survey. Benchmarked against other London providers the Trust is in the bottom 50% for staff recommending the Trust as a place to work and also in receiving care.

Overall they described the trust as having "good relationships with commissioners and partners " that actively engaged in discussions about how to improve services.

Royal College of Nursing (RCN)

The RCN described past issues around waiting times in Accident and Emergency and failure to meet targets on patient flow and management. Some members had raised concerns about staffing levels and skill mix in the department as well as some issues around team dynamics, however these had since been resolved.

The RCN highlighted some concerns about the high level of sickness and work-related stress and highlighted the sickness absence policy as an area of concern.

The handling of disciplinary situations and investigations was also raised, feedback stating that a culture of learning and openness would be beneficial.

Overall the RCN described a good working relationship with the trust.

Trust Governors

The trust governors described Whittington Health as an Innovative Trust with an engaged top management team. The governors felt listened to and there was a degree of innovation across the Trust. The Trust did not handle Patient Experience in an integrated and proactive way. The Trust collected only quantitative data about Patient Experience, but there was a need for more in-depth, qualitative study.

Top level management were described as thoughtful and engaged. Issues were raised with interpreting services and the way in which the trust cancels appointments.

Facts and data about this trust

Whittington Health NHS Trust is a general district hospital and integrated community provider with approximately 23 wards and providers community care services to 500,000 people living in Islington and Haringey as well as other London boroughs. It receives 86 % of referrals for acute services from Haringey and Islington GPs.

The organisation is a teaching institution for undergraduate medical students (as part of University College London Medical School) and nurses and therapists (linked to Middlesex University School of Health and Social Sciences).

Whittington Health NHS trust had a recorded annual income of £295 million (2014/15) and employs in excess of 4,400 staff. The trust recorded a financial deficit of £7.3 million in 2014/2015 and as per many organisations is proposing cuts to its budget, in order to break even over the next 2 to 3 years.

The hospital houses in the region of 320 beds, flexing up to 360 beds during the winter periods and is registered across three site locations with the Care Quality Commission: (includes community services) , Hanley Primary Care Centre (GP practice and community centre) and St Luke's Hospital (Simmons House) multi-disciplinary MH service for 13-18 year olds with emotional and mental health problems.

Whittington Health reports having a slightly less Consultant grade Doctors (36%), compared to the England average of 39%, and less middle grade Doctors (5%) compared to an England average of 9%. Conversely

Summary of findings

the organisation houses a greater proportion of Registrars (42%) compared tp the England average of 38% and greater junior Doctors (17%) compared to an England average of 15%.

Safe?

- Number of delayed handovers in winter 2014/15 below the median of all Trusts
- The organisation reported one never event reported for misplaced naso or oro-gastric tubes during 2015.
- The ratio of all midwifery staff to births is better than the England average
- There have been no cases of MRSA since February 2015 and cases of Colostrum Difficile has varied over time compared to the England average.

Effective?

- In the Vital Signs in Majors audit 2010/11 the Whittington Hospital scored mostly in the upper England quartile
- Whittington Health scored above the England average for all but two of the indicators in the Heart Failure Audit.
- Performed better than the England average for two out of three nSTEMI indicators in the last two MINAP audits, the trust's performance has improved over time.
- Whittington Health performed well in the Hip fracture audit as 5 indicators were higher than the England average.
- In the bowel cancer audit the trust scored better than the England average and good for case ascertainment and data completeness.
- The lung cancer audit shows the trust as scoring higher than the England average for the two indicators
- The emergency re-admission rates within 2 days of discharge is lower than the England average for non elective admissions. There were no emergency re-admissions for elective admissions
- Unplanned re-attendance rate to A&E within 7 days was worse than the standard for 19 out of the 24 months.
- The trust's performance was also higher compared to the England average for those 19 months. Whittington Health scored similar to other trusts in the A&E survey for questions relating to effectiveness
- Whittington Health performed about the worse than other trusts for six out of the eight standards in the Mental health in the ED CEM audit 2014/15.
- In the national emergency laparotomy audit the trust's self-reported data indicated that the provision of facilities required to perform emergency laparotomy was unavailable for 11 out of the 28 measures reported on.

Caring?

- A&E Friends and Family Test (% recommend) is consistently above the England average.
- The response rate for the friends and family test are higher than the England average.
- In the friends and family test the postnatal ward is the only area to score consistently below the England average

Responsive?

- The percentage of emergency admissions waiting 4-12 hours from the decision to admit to admission below the England average for 49 of the 65 weeks.
- Only one patient who had their operation cancelled was not treated within 28 days, Q1 13/14 to Q1 15/16
- The average length of stay for elective and non elective is lower than the England average
- Since Nov'14 the referral to treatment (RTT) percentage within 18 weeks non-admitted and incomplete pathways (IP) is better than the standard and better than/similar to the England average.
- The percentage of patients (all cancers) waiting less than 31 days and 62 days from urgent GP to first definitive treatment is higher than the England average
- Percentage of patients leaving the A&E department before being seen is regularly higher than the England average. Average total time in A&E is higher than the England average for 25 out of 30 months.

Summary of findings

- The trust was meeting the 90% standard for percentage of admitted patients treated within 18 weeks of referral (RTT) however it has fallen below the standard after Jun'15. Particular areas of non-compliance are urology and general surgery.
- The percentage of patients (all cancers) seen by a specialist within 2 weeks from urgent GP referral to first definitive treatment is lower than the England average but has shown improvement since Q3 14/15.
- This trust had a high proportion of people waiting 6+ weeks for diagnostic appointments, from May'15 to Aug'15, when compared to the England average.

Well Led?

- Data analysis indicated that the organisation flagged against the Intelligent Monitoring risk for staff turn-over (leavers) rates within nursing and midwifery.
- The volume of written complaints reduced from 460 in 2013/14 to 357 during 2014/15, the lowest figure in the past five-year timescale.
- The trust performed lower than the national average in some areas of the NHS staff survey including: percentage of staff working extra hours, the percentage of staff appraised within the last 12 months and the percentage of staff suffering work related stress in the last 12 months.
- The NHS staff survey indicated there was a higher proportion of staff reporting the experience of harassment, bullying or abuse in the last 12 months, compared to the national average. With a lower proportion of staff believing the trust provided equal opportunities for career progression or promotion, compared to the national average.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? The trust is rated as requires improvement for safety. We found examples of safe care in many of the services we inspected but urgent and emergency services, medical care, maternity and gynaecology, end of life care, outpatients and diagnostics and community adults services were rated as requires improvement. For more detailed information please refer to the reports for the acute hospital, community dental, community adults, community children's and child and adult mental health services. Incidents We found systems for reporting and learning from incidents across services. Staff were aware of how to report patient safety incidents and knew about the trust-wide electronic system for incident reporting. Staff stated they were encouraged to report incidents. Staff told us they received feedback on the incidents they had reported. The trust reported a lower number of incidents per 100 admissions compared to the England average. We were concerned that the incident reporting culture on the critical care unit was not proactive as we expected more than 69 reported incidents in a twelve month period (other similar sized units reported approximately 25-45 incidents each month). Duty of Candour The trust had promoted duty of candour and this was seen to be cascaded through the organisation. Staff were aware of the requirements of the duty of candour, including apologising and sharing the details and findings of any investigation. Senior nurses and managers told us that a duty of candour presentation and email was sent to all senior managers describing their responsibilities in this area. Infection prevention and control The environment in the majority ofareas we inspected was clean and complied with infection prevention and control guidance. The exception to this was where we observed some areas where there were insufficient checks and audits on cleanliness and infection control practices. Where infection control audits demonstrated areas to be lower than the trust standard of 99%, we saw evidence of actions to address this.	**Requires improvement** 

Summary of findings

Environment and Equipment

We found evidence within adult community services that staff did not always carry items deemed as essential. We noted of an audit of essential items to be carried by District Nurses (DNs) in November 2015, only three of 14 items that were classed as essential were being carried by all DNs audited. We were informed that some agency staff did not have some basic equipment.

Within the Child and Adolescent Mental Health Services (CAHMS) inpatient unit we observed some blind spots, and ligature points which had not been identified via local risk assessments.

We found evidence of equipment being checked on a daily basis across the organisation, with the exception of maternity services where this was variable.

Records

We observed a mixture of paper and electronic records in use across the organisation. Concerns around the use of temporary records were evident across some services including the Emergency Department (ED) and outpatients.

We reviewed a sample of patient records and found that they were mostly completed in a comprehensive, legible way.

Within outpatients we found inconsistencies in the storage of records. Patients' personally identifiable information was not always kept confidential.

Safeguarding

In line with statutory guidance the trust had named nurses, named doctors and safeguarding teams for child protection and safeguarding vulnerable adults. The Trust had policies and procedures in place in relation to safeguarding adults and children. Safeguarding was embedded as part of mandatory training and induction. Staff were confident in reporting concerns to the relevant teams. Staff were able to explain what constituted a safeguarding concern and the steps required for reporting on these concerns.

Use of the ‘five steps to safer surgery’ procedure

The trust had not fully implemented the five steps of the World Health Organisation (WHO) Surgical Safety Checklist. We found evidence of good compliance with the three compulsory elements: sign in, time out and sign out. We followed the patient pathway through a number of different surgical procedures in main theatres and the Day Surgery Unit. Most of the procedures we witnessed completed the checklist comprehensively.

Summary of findings

The surgery service audited WHO checklist compliance in September 2015 over a period of 6-8 weeks. The audit found good general compliance with completing the checklist across the service

Staffing

The trust had vacancies across all staff groups, but staffing levels in most clinical areas were maintained at a safe level with the use of bank, agency and locum staff. Where agency staff were used there was an induction programme to help them become familiar with the environment.

Nursing and midwifery staffing levels were reviewed and assessed using the National Safer Nursing Care Tool which conducted every six months. Staff felt that senior managers would listen to their concerns about staffing levels. Safe staffing levels were updated on a constant basis using a safe care e-system.

Areas where we found some specific staffing issues were adult community, children's community, the paediatric Emergency Department (ED) and theatre recovery. We saw evidence of the trust attempting strategies to attract difficult to recruit staff cohorts, for example though the use of pay increases for Health Visitors and rotating staff through challenged areas.

We observed the number of consultants within the ED did not meet the Royal College of Emergency Medicine standards or the London commissioning standards to provide 16 hours consultant cover daily in the ED. Junior doctors in training told us they had concerns about the cover overnight, when consultants were not immediately available.

Assessing and responding to patient risk

The number of ambulance handovers delayed by over 30 minutes during the winter period of November 2013 to March 2014 was one of the lowest in the country, and better than the expected standard.

Within the community setting, services maintained a local database detailing 'patients of concern', these patients were reviewed more regularly by DNs and reviewed by a service manager monthly. Where risks were higher and cases more complex, other services could be called upon.

We observed careful consideration and planning for new patients coming into Simmons House CAHMS service. The unit accepted patients detained under the Mental Health Act. The team considered whether they could safely manage a patient within the unit or whether there was a more appropriate service for them.

Summary of findings

There was limited assurance about safety of women undergoing elective procedures in the second obstetric theatre.

Mandatory Training

The trust's corporate induction for a new staff was part of mandatory training. It included infection prevention and control, adult safeguarding, adult life support and resuscitation, fire safety, health and safety, duty of candour, mental capacity awareness and equality and diversity. This included two days of lectures and three days of shadowing in their assigned clinical area.

There were some areas of the trust where mandatory training was below the trust's benchmark of 90% compliance across a number of subject areas, with midwifery being an identified area below the target level.

Training in Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act (MCA) was variable with some services demonstrating compliance, whist others such as adult end of life care and midwifery having proportions of staff not trained.

Safety thermometer

The NHS Safety Thermometer is an improvement tool to measure patient harm and harm free care. It provides a monthly snapshot audit of the prevalence of avoidable harms in relation to new pressure ulcers, patient falls, venous thromboembolism (VTE) and catheters and associated urinary tract infections (UTIs).

We observed safety thermometer data displayed across the core services within the organisation, along with good performance for the months preceding our inspection. Maternity services were the exception where we found the service did collect this information but did but did not use the safety thermometer tool and the information was not visible on ward areas.

Medicines

Medicines including controlled drugs (CDs) were stored and managed appropriately in the majority of areas, however there were some areas where medicines management was poor, for example on Victoria Ward. Due the nature of this ward and the low levels of experience of many of the nursing staff, we found that practices and procedures were not always adhered to.

Within community children's services we observed that although checks showed medicines were stored at the correct temperature, the gauges used appeared to be incorrectly labelled. We were therefore not assured vaccines were always kept at an appropriate temperature.

Summary of findings

Restraint

Within CAHMS inpatient services staff used the PROACT-SCIP model of restraint. It aimed to support staff to identify patient triggers and recognise early behavioural indicators that could lead to challenging behaviour.

Are services at this trust effective?

Good

Overall we rated the effectiveness of the majority of services at the trust as good. Care was evidence-based and the majority of services participated in national and local audits. With the exception of community end of life care, which we rated as outstanding because we found the service provided outstanding, effective services to children, young people and their families.

Feedback from patients and families were positive about the care and resources available to across many of the services.

Within end of life care Lifeforce worked closely with UK charities to take into account the 'Together for Short Lives' eight priorities of care for children with life threatening and life limiting conditions.

Within community end of life services we observed excellent care in the home which provided the family and patients with comfort and reassurance. The team were able to review the patients needs to ensure they could continue with meeting their own particular wishes in the face of great difficulty.

For more detailed information please refer to the reports for the acute hospital, community dental, community adults, community children's and child and adult mental health services.

Evidence based care and treatment

The trust's policies and treatment protocols were based on organisational guidelines from professional organisations such as the National Institute for Health and Care Excellence (NICE) and the Royal Colleges. Staff were able to access guidelines on the intranet.

A central trust team was responsible for arranging an appropriate clinician to review new guidelines and for disseminating them when they were approved.

The ED had performed among the worst 25% of trusts in six of the eight standards in the RCEM Mental Health audit 2014-2015. The department introduced a revised mental health risk assessment form for doctors and nurses, which had improved documentation, but further progress was needed.

Patient outcomes

Summary of findings

The trust showed no evidence of risk against mortality rates, according to the Intelligent monitoring system.

The trust has mixed results in the national fractured neck of femur audit 2012 -2013. A multi-disciplinary group of staff from orthopaedics and ED worked to improve the outcome for these patients.

The number of day surgery cases was lower than the England average. Approximately 53% of surgery patients were day case. The trust was aware of this and was investigating ways to increase it.

Competent staff

DN compliance with clinical supervision was low. Documentation demonstrated that 10 of 65 were completed for the year. The DN professional development and quality lead indicated that clinical supervision was a 'work in progress.'

Appraisal rates across the organisation were variable, with some areas demonstrating highly trained and appraised staff, with other areas falling significantly below the internal target of 90% of staff having received an appraisals.

Multi-disciplinary working and coordinated care pathways

Multidisciplinary (MDT) working was embedded and effective across the trust. Staff spoke positively about MDT working and we found evidence of good multidisciplinary relationships supporting patients' health and wellbeing. We observed multidisciplinary input in caring for and interacting with patients on the wards.

In the ambulatory care unit we observed good multidisciplinary working across hospital services, including diagnostics, care of the elderly, physicians, therapists, pharmacists, and medical and surgery specialities to provide effective treatment and care.

Community teams told us they felt very integrated with the trust hospital services, GPs and nurses and we saw examples of services which had implemented shared assessments.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

Mental capacity and DoLS training was completed alongside the training for adult safeguarding level two, and was captured as part of mandatory training. The majority of nursing and medical staff we spoke with demonstrated a good understanding of mental capacity and knew about the importance of assessments of people with mental health needs or learning disability.

We found evidence that consent for surgery processes did not follow best practice, with records highlighting that patient consent for

surgery was in some cases being taken on the day of the procedure in the pre-operative admissions unit. This meant that some patients did not have a 'cooling off period' in advance of their surgery, should they wish to reconsider their procedure. This approach is suboptimal, although it is widely recognised as a difficult problem to solve unless the patient is seen on a separate occasion.

Access to information

Staff in the ED and ambulatory care had access to electronic patient information. There was also access to the trust community health records.

Ward staff were able to access patient notes from a locked notes trolley to read and add relevant information. Staff with access to computer workstations were able to access test results electronically.

Within the adult community service staff had to navigate their way around a number of information systems belonging to different care providers, in order to integrate patient care.

Access to information was inconsistent between teams depending on whether staff had tablets, laptops, or paper records.

Are services at this trust caring?

Outstanding ☆

The trust is rated as outstanding overall for caring. Many of the services we inspected were rated as good, but community end of life care and community dental services were rated as outstanding.

Throughout the inspection and across the trust it was evident that care was patient-centred and staff treated patients with dignity and compassion. Patients we spoke with were positive about their experience and staff caring for them. The trust used a range of mechanisms to obtain feedback from patients including national surveys and the Family and Friends Test (FFT).

For more detailed information please refer to the reports for the acute hospital, community dental, community adults, community children's and child and adult mental health services.

Compassionate care

We found compassionate and respectful care was present in interactions we observed across both acute and community settings. The trust met the England average in the Friends and Family Test for Aug'15, however was consistently below the average before.

Summary of findings

Within children's community services people we spoke with praised the service they received. Some commented that the care was "life changing" either for them or their children.

In some hospital outpatients clinics we did not find that there was adequate provision to protect a patient's privacy and dignity. For example; not all outpatients departments had suitable rooms for private consultations. In the anti-coagulant clinic patients were seen in a room that was the administration and clinical staff office.

Understanding and involvement of patients and those close to them

Across the organisation staff demonstrated compassion, kindness and respect for the patients and families they worked with.

Patients and relatives told us that doctors and nurses in ED and ambulatory care explained what they were doing and consulted them about treatment. One patient told us she chose to come to Whittington hospital because medical and nursing staff listened to what she said and answered her questions.

In critical care staff took time to get to know the patients and their relatives and made sure patients were comfortable on the unit. Patients and their relatives were involved in decision-making and had opportunities to ask questions about care plans and prognosis. Relatives were encouraged to fill in patient diaries.

Emotional support

We observed an understanding of the emotional impact to the patient of their condition. Patients in the surgery service had access to clinical nurse specialists for cancer support and guidance. Nurses on wards and service leaders told us that the cancer nursing service had transformed the support provided for patients with cancer. The trust had received sponsorship from a local football team to deliver a wellbeing course for patients to participate in after their treatment. The trust also provided 'Hope courses' for patients to get together outside of hospital, and hear from motivational speakers including talks on personal wellbeing, nutrition and recovery care.

There was a trust wide chaplaincy and spiritual support service available. There was no bereavement officer, their duties were performed by the mortuary clerical staff member. They were supported by the mortuary staff.

Are services at this trust responsive?

Good

Overall we rated responsiveness of services at this trust as Good. Many of the services were rated as good with the exception of community health for children's, surgery, critical care, and outpatients. Community end of life care was rated as outstanding.

Summary of findings

Patient flow through surgery and critical care was a significant issue. We heard that some patients remained in recovery area for long periods while waiting for an appropriate bed to become available, some staying in recovery overnight. We saw little evidence of local leadership in recognising and improving these issues.

Surgery wards were used as overflow wards for medical patients and there were considerable numbers of medical patients on surgical wards. This was a regular occurrence despite reorganisation of wards to allocate bigger wards to medical patients.

Within critical care the departmental risk register was sparse and did not reflect all risks we identified during our inspection. We were concerned there was a culture of underreporting incidents and near misses however senior staff did not recognise this.

We found that the trust did not monitor effectively discharge times and obstacles to patients' discharge to ensure prompt response and that patients died in their preferred location. Staff were not always aware of patient's wishes in regards to their 'preferred place of death' and did not always record this information. There was no formal rapid discharge pathway to ensure speedy discharge of patients who wished to die at home or another location.

We rated community end of life care as outstanding because patients and families were able to access 24 hour 7 day per week help and advice for end of life care. There was a commitment to offering an equitable service across the three boroughs. Data was collected on the patient's preferred place of death and discussed at the network MDT meetings. The service worked well with the local hospice to make the best use of day care and hospice at home services in response to patient needs. The team responded to families' needs with their ongoing bereavement work, Memory Day and annual party. The team demonstrated a flexibility of service provision and an attitude of going above and beyond to ensure the patients and families received the best service possible.

Planning and delivering services which meet people's needs

The trust's integrated care approach was designed to meet the wide-ranging needs of patients by providing a variety of services within the acute and community settings to meet the needs of different patient groups. The trust also stated that as an integrated care organisation they aimed to work closely with commissioners on integrated pathways.

Whittington Health NHS Trust worked with clinical commissioning groups (CCGs) and other providers to improve the responsiveness of emergency and urgent care services for local people. The Ambulatory Care Centre, which opened in 2014, was a trust-wide

initiative providing person-centred hospital level treatment without the need for admission. Elderly care pathways had been well thought out and designed to either avoid elderly patients having to go to ED or, if they do, making sure that their medical and social care needs are quickly assessed.

The nurses and doctors in children's services were highly complimentary about the hospital at home service developed by the trust.

We observed long waiting times in outpatient clinics, which resulted in patients complaining during the time of our inspection.

Meeting people's individual needs

We saw a strong focus on the patients' needs and preferences, and we saw many examples of person-centred care and treatment during our inspection. We found good use of interpreter services within medicine, however this was not as apparent in other areas such as CCU and outpatients.

In CCU staff we met were not aware of support processes for patients with a hearing impairment, learning disability, psychiatric needs or those living with dementia.

Meeting the needs of people in vulnerable circumstances

We observed services to be supportive of older patients they visited and understood the needs of working with this patient group.

Community dental services provided home visits for people who were unable to attend clinic. This included elderly patients with limited mobility and patients who had a physical disability that made it difficult for them to attend the clinic.

We observed that when looked after children moved out of area but were still within easy travelling distance, the Whittington NHS Trust kept them on their caseload instead of transferring care. This helped to ensure continuity of care for vulnerable children.

Access and flow

Healthwatch Haringey informed us of a long-standing concern about the functioning of the hospital's outpatient's appointment system. Patients told us getting through by phone to the trust to cancel or rearrange appointments was difficult, with no facility to leave messages.

We observed that the surgical floor was well managed, at the front end of the patient experience, from admissions through theatres and into recovery. However, post-procedure flow from the recovery

area onto surgical wards was impacted by the limited availability of beds in surgical ward. The surgery service was focused on reducing length of stay for surgery patients by using enhanced recovery pathways.

The 'bed management and transfer policy' identified patients should be admitted to the critical care unit within one hour of the decision to admit being made and the hospital target was to admit 95% of critical care patients within this time frame. Hospital audit data from October 2015 demonstrated 97% of patients were admitted within one hour of the decision to admit to critical care being made and the remaining 3% were admitted within 2 hours.

However, when examining critical care documentation we found ten patients were discharged directly home between 7 October 2015 and 7 December 2015. Staff told us some patients waited for a ward bed for so long that they were ready to go home directly from critical care.

The percentage of patients admitted, transferred or discharged from ED within the national target of four hours was regularly above 95%, and was 94.4% in the six months to September 2015. This was better than the England average and indicated that there was an effective initial assessment.

In information the trust provided prior to our visit, they stated they had responded to an increased demand in a number of ways. In relation to emergency activity, there were a number of initiatives in place to reduce demand. They told us there was an ambulatory care unit in place that worked to prevent emergency admissions and redirected patients away from A&E, as well as other community-based initiatives to help keep people out of hospital.

Learning from complaints and concerns

Information shared with us from external stakeholders indicated concerns in relation to access to the PALS and complaints service, particularly for hearing impaired patients.

The volume of written complaints reduced from 460 in 2013/14 to 357 during 2014/15, the lowest figure in the past five-year timescale.

We found local leadership on complaints responses, whilst the trust complaints staff reviewed comments on NHS choices website and if there was dissatisfaction with the service they responded to the comment by giving details of how to contact PALS.

Summary of findings

Are services at this trust well-led?

Good

The trust is rated overall as Good for well led. Critical care and outpatients and diagnostics were rated as requires improvement, whilst community end of life care was rated as outstanding.

Within surgery we found clinical governance structures beyond incident reporting were not robust. Staff were not able to articulate a clear structure for the escalation of risks, clinical governance or performance information. A number of identified risks remained on corporate risk registers for a long time and were not addressed adequately or in a timely way.

For more detailed information please refer to the reports for the acute hospital, community dental, community adults, community children's and child and adult mental health services.

Service vision and strategy

In 2015 the trust reorganised from three large divisions to seven smaller Integrated Clinical Service Units (ICSUs), led by a clinical director reporting directly to the Chief Executive. Staff of all grades and professions told us they welcomed this change because it had given clinical staff more control over developments in their service. The new ICSU enabled a focus on patient care, working across community services, ambulatory care, acute assessment and ED.

The trust's vision and values around providing integrated patient centred care were reflected by most of the staff that we spoke with and the trust values were included as part of the appraisal process.

We observed examples of strong local leadership, and services were able to articulate individual service strategies and plans, however not all services were able to produce business plans within each ICSU.

Governance, risk management and quality measurement

We found evidence of clear governance and risk management structures in place in the majority of areas, with regular patient safety meetings, monthly senior managers meetings and meetings of the risk board across both acute and community services. Local dashboards provided information on risks, targets, incidents, complaints and infection control. The general managers worked with the trust information team to check the reliability of data about performance. We noted that the Key Performance Indicators were more focused on acute services.

Risk registers were regularly updated and discussed during governance meetings. With the exception of surgery and critical care.

Leadership of this service

Summary of findings

Staff said they felt well supported in terms of training and development. Staff reported varied levels of visibility of the executive team across the community services.

The trust reorganisation had resulted in some uncertainty, but staff reported that the new ICSU had made the necessary change to systems without disruption to services.

Staff told us that they regularly saw divisional managers and clinical leads on the wards. The Director of Nursing, COO and Chief Executive were visible to staff on the wards.

Culture within the service

Senior managers told us they had been a clinically led integrated care organisation since 2011, which had a philosophy of 'local care for local people'. The culture of the trust was all about integrated care, with learning shared across the integrated ICSUs.

Staff felt informed by their local teams and the executive team about changes within the trust. They received newsletters and emails about any changes.

Many staff commented on the friendliness of the trust and the fact that everyone knew everyone else.

Ward nurses told us that Whittington Hospital was generally a very good place to work. There was recognition that ward staff worked hard, but understood their areas for improvement.

Innovation, improvement and sustainability

The trust set up the Ambulatory Care Centre after piloting a small service and engaging stakeholders internally and externally in planning its development. The service was well known nationally for its innovative approach to providing hospital level care without the need for patients staying overnight.

The Michael Palin Centre was able to rely on a high amount of research from Australia. The Centre for the study of such children is located at the Faculty of Health Sciences at the University of Sydney.

Whittington Health worked well to avoid patients needing to attend. As part of the drive to keep patients out of hospital, the integrated pathways respiratory team has developed a new model across acute, community and primary care. The CORE team is led by two integrated consultants working with respiratory nurse specialists, physiotherapists, clinical psychologies, stop smoking advisors and an integrated specialist registrar.

Overview of ratings

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

Outstanding practice and areas for improvement

Outstanding practice

We saw several areas of outstanding practice including:

At the Whittington Hospital:

- Whittington Health NHS Trust worked with clinical commissioning groups (CCGs) and other providers to improve the responsiveness of emergency and urgent care services for local people. The Ambulatory Care Centre, which opened in 2014, provided person-centred hospital level treatment without the need for admission.
- Within this unit we observed good multidisciplinary working across hospital services, including diagnostics, care of the elderly physicians, therapists, pharmacists, and medical and surgery specialities to provide effective treatment and care.
- Elderly care pathways had been well thought out and designed to either avoid elderly patients having to go to ED or if they do, making sure that their medical and social care needs are quickly assessed.
- Within the ED there was outstanding work to protect people from abuse. The lead consultant and nurse for safeguarding coordinated weekly meetings attended by relevant trust-wide staff to discuss people at risk and to make plans to keep them safe.
- Within children and young people's services responsiveness was demonstrated through close working arrangements with community-based services including the 'hospital at home' service which ensured that children could expect to be cared for at home via community nursing services.
- The trust provided 'Hope courses', for patients who had undergone cancer treatment, to get together outside of hospital, and hear from motivational speakers including talks on personal wellbeing, nutrition and recovery care.
- At Whittington community sites:
- Community teams told us they felt very integrated with the trust hospital services, GPs and nurses. We found examples of shared assessments within community settings, for example joint podiatry and diabetes assessments.
- Within community dental services we received consistently positive responses from patients, some describing the services as "Life changing" and others rating services as five-star on the NHS Choices website.
- Within community end of life care we found the service provided outstanding, effective services to children, young people and their families. We saw examples of very good multidisciplinary working and effective partnerships with the local GPs, other providers and hospices.
- Within community end of life care services we observed exemplary care, delivered with respect and dignity. Everyone we spoke with told us they had entirely positive experiences of the service.
- Within community end of life services there was a commitment to offering an equitable service across the three boroughs. Data was collected on the patient's preferred place of death and discussed at the Great Ormond Street MDT.
- The service worked well with the local hospice to make the best use of day care and hospice at home services in response to patient need.
- The children's community palliative care service, Lifeforce, was exceptionally well led. The service was committed, adaptable and flexible to meet the needs of the patients and their families. The term going, 'over and above' was used on many occasions to describe the team's approach to their work.

Outstanding practice and areas for improvement

Areas for improvement

Action the trust MUST take to improve
We saw areas of poor practice where the trust needs to make improvements.

Importantly the trust must:

Trust wide:

- Review bed capacity to assess capacity across medicine, surgery and critical care to ensure patients are appropriately placed within the correct specialism and enhance hospital flow.

At the Whittington hospital site:

- Within the Emergency Department (ED) there was not sufficient consultant cover and there were vacant middle grade medical posts, covered by locum (temporary) doctors, which poses a risk to delivery of care and training staff.
- Within acute outpatient departments improve storage of records and ensure patients' personally identifiable information is kept confidential.
- Within acute outpatient departments improve disposal of confidential waste bags left in reception areas overnight.
- Within surgery review local strategy for consent for surgery processes to follow best practice, to allow patients to have a 'cooling off' period in advance of their surgery, should they wish to reconsider their procedure.
- Within surgery and theatres review bed capacity to ensure patients are not staying in recovery beds overnight.
- Within critical care there were significant issues with the flow of patients out of critical care which meant 20% of patient bed days were attributed to level 1 and level 0 patients who should have been cared for in a general ward environment. This led to mixed sex accommodation breaches, a high proportion of delayed discharges from critical care and a number of patients discharged home directly from the unit
- Within critical care review governance processes and local ownership of the risk register. We were concerned there was a culture of underreporting incidents and near misses and the importance of proactive incident reporting be promoted.
- Within critical care staff did not challenge visitors entering the unit and we were concerned patients could be at risk if the unit was accessed inappropriately.
- Within maternity services ensure the information captured for the safety thermometer tool is visible and shared in patient areas, for both patients and staff.
- Within maternity services there was limited assurance about safety of women undergoing elective procedures in the second obstetric theatre. There was routinely insufficient staff presence when cases were conducted, and failure to formally agree for adequate cover by recovery nurses from main theatres meant pregnant women and their families were left without visible staff presence.
- Within palliative care the trust did not meet the requirement set by the Association for Palliative Medicine of Great Britain and Ireland, and the National Council for Palliative Care related to number of palliative care consultant working at the hospital.
- Within palliative care services staff were not always aware of patient's wishes in regards to their 'preferred place of death'. They did not always record and analyse if patients were cared for at their 'preferred place of care'.

At CAHMS inpatient services

- Improve ligature risk assessments and the identification of associated risks