The Whittington Hospital NHS Trust

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

Summary of findings

Letter from the Chief Inspector of Hospitals

The Whittington 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 eight 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.

This was the first inspection of Whittington Hospital 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**.**

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 care 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,
- 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.

Summary of findings

- 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:

- 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 the 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.

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

Importantly, the trust must:

- 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, improve disposal of confidential waste bags 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 should 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.

Summary of findings

- 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'.

In addition the trust should:

- Take further action to improve safe nurse staffing levels across the surgery service, particularly within main operating theatres and recovery.
- Improve consistency of labelling medical equipment that is clean across surgery wards and operating theatres.
- Ensure healthcare assistants on surgery wards are given competency appropriate tasks and supervision at all times.
- Improve bed management across the hospital to ensure post-operative patients are allocated to a ward in a safe and timely way.
- Ensure all recorded risks in the surgery service are addressed in a timely way.
- Improve engagement with consultant surgeons and anaesthetists working in the surgery service.
- Improve leadership support and capacity within operating theatres.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Good	We gave an overall rating for the urgent and emergency services of **good** because: Some aspects of these services were outstanding. The multi-disciplinary working within the services, with other departments within the hospital and with external organisations put the patient at the centre of care and treatment. The Ambulatory Care Centre for adults provided an innovative service to patients, with access to diagnostic, therapeutic and specialist medical and surgical services in one place. 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 timeliness and quality of medical review was sometimes compromised because of the low number of consultant posts and the difficulty recruiting middle-grade doctors. Consultants worked hard to maintain standards in the ED, to review patients with complex needs, and to provide supervision and training to junior and middle grade doctors in training. This was not sustainable with the current consultant numbers. The nursing numbers and skill mix on ED were suitable. Nurses of all grades received excellent training and development opportunities. ED and ambulatory care took part in national and local clinical audits to monitor the effectiveness of care and treatment. The analysis of incidents, complaints and staff feedback contributed to initiatives to make services safer and more responsive. There was action to improve services, and the action monitored to assess their impact. There was outstanding work in the ED to protect people from abuse. Staff were well-trained and aware of their responsibilities. The lead consultant

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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.
The Ambulatory Care Centre environment was bright and welcoming and there had been other improvements in the ED, but some areas required further renovation. There were some shortcomings in cleanliness and waste disposal on ED.
The leadership of the newly formed ICSU were clear about their purpose and were confident in achieving this. There was an exceptionally positive culture in ambulatory care, reflected in the views of staff and patients.

Medical care (including older people's care)

Good

We rated Medical care (including older people's care) as good overall because most patients were kept safe while they are being cared for at The Whittington Hospital. Patients who are at risk of deteriorating were monitored and systems were in place to ensure that a doctor or specialist nurse was called to provide the patient and ward staff with additional support. The trust had an open culture and had systems that allowed them to learn from clinical incidents. The medical wards had enough doctors and nurses to keep people safe.
We found that care on medical wards was provided in line with national and local best practice guidelines. Audits were being undertaken and there was good participation in national and local audits that demonstrated good outcomes for patients. Patient morbidity and mortality outcomes were well within what would be expected for a hospital of this size and complexity and no mortality outliers had been identified. Although there was a good knowledge of the issues around capacity and consent, the levels of staff training in these areas was low.
Patients received compassionate care and were treated with dignity and respect. Most of the patients and relatives we spoke with said they felt involved in their care and were complimentary about the staff looking after them. One person told us: “It’s great, they look after me well here. They are

Summary of findings

so nice and take an interest in how I am getting on".
The medical division had good results in patient surveys and results indicated an improvement in the views of patients over the last 12 months.
The medical division is effective at responding to the needs of its patients from all parts of its community. The hospital operational management team had a good understanding of status of the hospital at any given time. Bed availability was well managed. Elderly care pathways had been well designed to ensure that elderly patients were assessed and supported with all their medical and social needs. The hospital had designed pathways that if possible kept patients out of the emergency department (ED). The Ambulatory Care Unit and Hospital at Home provided effective alternate pathways for GPs and other referrers.
The Medicine, Frailty & Networked Service Integrated Care Service Unit (ICSU)is well led. Divisional senior managers had a clear understanding of the key risks and issues in their area. The division had an effective meeting structure for managing the key clinical and non-clinical operational issues on a day to day basis. Staff spoke positively about the high quality care and services they provided for patients and were proud to work for the hospital. They described the hospital as a good place to work and as having an open culture. The most consistent comment we received was that the hospital was a friendly place to work and people enjoyed working with their teams.

Surgery

Good

We rated the surgical services as good overall because:
We found that the surgery service at Whittington Hospital was effective and caring. However, improvements were needed to ensure that the service was safe, well-led and responsive to patients' needs.
The surgery service had a good overall safety performance with low rates of serious incidents and few surgical site infections. We found good processes for reporting and escalation of incidents and good sharing of learning from incidents. All of the clinical areas we visited were clean and there

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were good infection control systems in place. However, there were significant staffing pressures across the service, particularly around recruitment and retention of nursing staff.
The surgery service at Whittington Hospital was effective. There were good patient outcomes across surgical specialties. The trust performed well in national clinical audits. There were short length of stay and low readmission rates. There was good multidisciplinary team (MDT) working. There were enhanced recovery processes for different patient groups. Good learning and development opportunities were available to staff.
Staff across the surgery service were friendly, caring and professional. Patients told us that nurses and doctors had a caring approach and they were treated with dignity. There was good family involvement and we found a very good approach to partnership care and keeping family members engaged at all stages of the surgery process.
There was good provision and systems in place to support patient's individual needs, including those with complex needs. Flow within the surgery system was well managed, particularly at the front end of the patient experience, from admissions through theatres and into recovery. However, flow was impacted by significant bed pressures on surgery wards. Surgery wards were used as overflow wards for medical patients.
We found a cohesive and supportive leadership team and there was a clearly defined strategic plan for the service. Leadership of the service was clinically led. Matrons were very visible on the ward and consultants provided clear clinical direction.
The escalation of risks was not robust. A number of identified risks were not addressed adequately or in a timely way. The service required investment by the trust to alleviate pressure and build capacity.
There were some challenges with the organisation culture within the service, which impacted on staff morale.

Critical care **Requires improvement**

We rated critical care overall as requires improvement because;
There were significant issues with the flow of patients from critical care which meant 20% of patient bed days were attributed to level 1 and level

Summary of findings

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. There was little evidence the critical care leadership team were pushing to address these issues and some senior staff failed to acknowledge the problems. The departmental risk register was sparse and did not contain matters identified during our inspection. We were concerned at an apparent under-reporting culture relating to incidents and near misses and senior staff on the unit did not recognise this.

We observed some occasions where patient privacy and dignity was not wholly maintained. Staff were not fully aware how to support people with specific needs such as those with a hearing impairment and staff knowledge of Deprivation of Liberty Safeguards (DoLS) was variable. Staff did not challenge visitors entering the unit and we were concerned patients could be at risk if the unit was accessed inappropriately.

The critical care unit contributed data to national and regional monitoring bodies, allowing outcomes to benchmarked. Patient outcomes were in line with or better than other similar critical care units and use of evidence-based practice was embedded throughout the unit. Safety thermometer results were good and we saw evidence demonstrating staff knowledge and understanding of safeguarding principles. Patient and visitor feedback about critical care was complimentary and staff routinely provided emotional support to patients and their relatives. There was a positive culture on the unit and staff spoke highly of the approachable and supportive leadership team.

Maternity and gynaecology

Good

We rated the service a Good because our main concerns were limited to safety issues within the service.

Patient risk assessments were undertaken in a timely and comprehensive manner. Across both services medical, midwifery and nursing staff provided safe care; staffing levels were in line with national averages and were regularly reviewed.

Summary of findings

Staff delivered evidence-based care and treatment and followed NHS England and the National Institute for Health and Care Excellence (NICE) national guidelines and policies and procedures were accessible to staff. Staff were competent and understood the guidelines they were required to follow

There was multidisciplinary working that promoted integrated care. The audit programme monitored whether staff followed guidelines and good practice standards.

Staff were caring and thoughtful, and treated women with respect. Patients' confidentiality and privacy were protected. All the patients and relatives we spoke with gave positive feedback about their care and how staff treated them.

Women and their partners felt involved with their care and appropriate explanations were given to them.

Referral to Treatment Times (RTT) for gynaecology patients were routinely above 90%. Appropriate arrangements were in place for patients who could not make informed decisions about their care.

Systems were in place to support patients who had a learning disability. Complaints were dealt with effectively and improvements made, where necessary

Whilst there were established local governance and risk management arrangements, safety risks we identified in our inspection had not been addressed. The leadership team was not yet fully established and the vision and strategy of the service was not formal and plans to expand the service had not been fully communicated to staff.

There was limited assurance about safety of women undergoing elective procedures in the second obstetric theatre. Safety information, including staffing levels, was not displayed in any public area.

Incidents were reviewed and learnt from, though there were some gaps in ensuring all actions listed on serious incident investigations were completed.

Equipment was not readily available in the community and resuscitation equipment was not always checked. Mandatory training rates were, in some areas, well below the trust's levels of expected compliance.

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Services for children and young people

Good

We rated services for children and young people as good overall because;
We saw that there were systems in place to ensure good governance and monitoring of standards for children, young people and infants who required acute medical care and surgical intervention and investigations.
Staff were proud to work for the trust and it was clear from speaking to parents that the public perception of the Whittington trust was very good.
Inter-professional working was exemplary throughout children's services.
Staff were aligned to, and supported the trust wide mission and vision. Leadership of individual aspects of children's services was good with staff speaking positively about their immediate team leaders. The aspirations of the chief executive and his management team were fully supported by the staff.

End of life care

Good

We rated End of Life Care as good overall because;
We found that staff providing end of life services were caring, the service was effective and well led. However, the safety of end of life services provided at Whittington Hospital required improvement. The end of life services also required improvement across the responsive domain.
Patients told us staff were caring and compassionate and that they were involved in planning their care and making decisions. We observed staff being respectful and maintaining patients' dignity, there was a strong person centred culture. Patients in their last days were suitably assessed and their nutritional and hydration needs were met. Care and treatment was delivered in line with current evidence-based standards. Patients had appropriate access to pain relief. The trust had scored much better than the national average for clinical indicators in the national care of the dying audit. Palliative care and end of life team members were competent and knowledgeable.
There were no serious incidents relating to end of life care in the hospital. Staff received appropriate end of life training. They knew how to report concerns.
There was good end of life care awareness across the hospital. The trust appointed both, a

non-executive lead, and an executive director to take lead and provide representation of end of life care at board level. Specialist palliative care team members felt supported in their work and worked well as a team. Staff were clear about their roles and their involvement in decision making and demonstrated a positive and proactive attitude towards caring for dying people.
However, not all staff had received adequate training including training in operating syringe pumps, Mental Capacity Act or training related to patients' deprivation of liberty. Patients DNR CPR forms were not always completed accurately. 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 and provision of seven day services. They did not monitor discharge times and if there were any obstacles to patient's discharge. There was no formal rapid discharge pathway to ensure speedy discharge of patients who wished to die at home or another location. Staff did not always record and analyse if patients were cared for at their 'preferred place of care'. The trust did not gather and analyse patients and relatives views in relation to end of life care to inform service delivery and planning.

Outpatients and diagnostic imaging

Requires improvement

We rated the outpatient services overall as **requires improvement** because;
Effective and safe systems were not always in place to monitor and manage risks to patients.
Outpatient staff showed an understanding of the need to report incidents, However, staff were not consistent in reporting incidents and they were not always reported in line with trust policy. This meant the trust did not have an oversight of all incidents that occurred within outpatient services.
We saw that learning from incidents was inconsistent across the specialities and learning from incidents was not shared across the outpatient department as a whole.
Patients' personal identifiable information was not always kept confidential or stored securely. We saw patient personal information left on top of open trolleys in some clinics unobserved by staff and

Summary of findings

confidential waste and patient records left unsecured in reception areas overnight. This meant there was a risk of patient records and personal details being seen or removed by unauthorised people.

Systems and processes were not always reliable or appropriate to keep people safe. This meant there was a risk patients were waiting longer than appropriate to be seen.

Infection control standards required improvements. For example, we found risk assessments were not always completed and all nursing staff did not follow infection control processes.

Outpatient and diagnostic imaging services did not identify all risks to patients or effectively manage risks that had been identified.

Patients were not always treated with dignity and patient's privacy was not always respected.

Trust-wide governance systems were not strongly established and there was a lack of adherence to, and knowledge of, policies and procedures.

Most patients were positive about the care they received.

Managers of outpatient departments were accessible and respected by staff.

The Whittington Hospital

Detailed findings

Services we looked at

Urgent and emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and gynaecology; Services for children and young people; End of life care; Outpatients and diagnostic imaging; Child and adolescent mental health services.

Detailed findings

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Background to The Whittington Hospital

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.

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.

Detailed findings

How we carried out this inspection

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

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

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

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

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

Facts and data about The Whittington Hospital

Whittington Health NHS Trust is a general district hospital and integrated community provider with approximately 23 wards and provides 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 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 the organisation houses a greater proportion of Registrars (42%) compared to 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 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 procedures 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 referral 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.

Detailed 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.

Our ratings for this hospital

Our ratings for this hospital are:

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

Detailed findings

Notes

Urgent and emergency services

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

Information about the service

The emergency department (ED) at The Whittington Hospital is open twenty-four hours a day, seven days a week. It treats people with serious and life threatening emergencies and those with less serious injuries and illnesses that need prompt treatment, such as suspected broken bones. The resuscitation area, for the most seriously ill or injured patients, has three bays for adults and one for children. Next to this is the majors area for people with serious injuries or illnesses that are not immediately life threatening. This has 15 beds including an isolation room and two rooms for people living with mental health conditions to be kept safe. Patients who come to ED other than by ambulance go to the waiting room, and have an initial assessment (triage). There is a rapid assessment area, which is open from 8am to 8pm. The area is run by Emergency Nurse Practitioners and is used to assess non-priority ambulance patients as well as those in the waiting area. Following initial assessment, patients may be sent to the majors area, see a GP or go to the Urgent Care Centre. The Clinical Decision Unit, next to the majors area, has eight beds for patients who may need a longer period of observation.

The Ambulatory Care Unit is next door to the ED and provides hospital care for people during the day who do not need to be admitted.

We visited the ED and the Ambulatory Care Unit over three weekdays during our announced inspection. We observed care and treatment and looked at patients' records. We spoke with over 30 members of staff, including nurses, consultants, doctors in training, receptionists, managers, therapists, domestic staff, security staff and ambulance staff. We also spoke with 10 patients and their relatives who were using the service at the time of our inspection. We received comments from people who contacted us to tell us about their experiences. We also used information provided by the trust and additional information we requested.

Urgent and emergency services

Summary of findings

We gave an overall rating for the urgent and emergency services of **good** because:

Some aspects of these services were outstanding. The multi-disciplinary working within the services, with other departments within the hospital and with external organisations put the patient at the centre of care and treatment. The Ambulatory Care Unit for adults provided an innovative service to patients, with access to diagnostic, therapeutic and specialist medical and surgical services in one place.

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 timeliness and quality of medical review was sometimes compromised because of the low number of consultant posts and the difficulty recruiting middle-grade doctors. Consultants worked hard to maintain standards in the ED, to review patients with complex needs, and to provide supervision and training to junior and middle grade doctors in training. This was not sustainable with the current consultant numbers. The nursing numbers and skill mix on ED were suitable. Nurses of all grades received excellent training and development opportunities.

ED and ambulatory care took part in national and local clinical audits to monitor the effectiveness of care and treatment. The analysis of incidents, complaints and staff feedback contributed to initiatives to make services safer and more responsive. There was action to improve services, and the action monitored to assess their impact.

There was outstanding work in the ED to protect people from abuse. Staff were well-trained and aware of their responsibilities. 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.

The Ambulatory Care Centre environment was bright and welcoming and there had been other improvements in the ED, but some areas required further renovation. There were some shortcomings in cleanliness and waste disposal on ED.

The leadership of the newly formed ICSU were clear about their purpose and were confident in achieving this. There was an exceptionally positive culture in ambulatory care, reflected in the views of staff and patients.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement

We rated safe as requires improvement because:

The Emergency Department (ED) did not have sufficient consultant cover and there were vacant middle grade medical posts, covered by locum (temporary) doctors. There was a risk of junior doctors in training receiving inadequate support at nights because of the inconsistent quality of locum staff. The ED assessed safe nursing numbers and skill mix, but there were some shifts when it was difficult to roster appropriately experienced and trained paediatric nurses.

There were good infection protection and control practices, but there were insufficient checks and audits on cleanliness and infection control.

The ED and ambulatory care promoted openness and transparency about safety. Staff shared learning about incidents in discussions, teaching sessions and newsletters. There were clearly defined systems to safeguard children and vulnerable adults. Safeguarding adult meetings on ED provided a forum, with participation from specialist workers at the hospital, to raise concerns and plan how to keep people safe.

Staff assessed patients promptly on arrival at ED and referred them to the most appropriate place for further review. Nursing staff monitored patients who remained in ED and there was clear guidance on how to obtain medical opinion when needed.

Incidents

- The process for reporting incidents, and reviewing, investigating and learning from these had improved with the organisational changes that created the Emergency and Urgent Care ICSU and the appointment of a risk manager The risk manager worked with the ED matron in an initial review of all incidents, and there was prompt action to look in more detail at those categorised as medium or high. Senior staff were consulted about further investigation of serious incidents. However, there were sometimes delays in closing incidents. The risk manager told us there was a backlog of 1400 open incidents in April 2015, reduced to 300 by December 2015. She expected to eliminate the backlog by March 2016.
- There were no patient safety incidents categorised as never events in the year to August 2015, in ED. We saw evidence of learning from the prescription error incident for insulin, with the department providing an additional guide for staff to reduce the chances of a reoccurrence
- Medical, nursing and security staff on ED told us of patient safety incidents they had reported, and some of them were able to tell us of action arising from the review of the incident. We saw examples of incident reports by middle grade and junior medical staff that included information about their own errors. This corroborated senior staff statements about the department and trust emphasis on openness and learning that did not focus on blaming the staff involved in the incident. The medical director spoke to new staff at the trust induction event of his personal experience of patient safety incidents. He also sent emails to trust staff describing incidents and the learning from them. The trust performed better than the England average in the staff survey question about feeling secure in raising concerns about unsafe clinical practice. A nurse told us that the consultant supported her after she escalated concerns about a middle grade doctor discharging a child before staff had looked into possible safeguarding issues.
- There had been regular, usually weekly, patient safety meetings since the autumn of 2015, attended by the risk manager, senior nursing and medical staff including the lead consultant for safety. The meeting discussed patient safety incidents and learning or action for the ED that arose from them.
- There was feedback to staff about incidents, investigations and case reviews through notice boards, the trust intranet, and at daily meetings of 10 minutes at 10 am. There were monthly mortality and morbidity meetings in ED to review cases and the care and treatment provided to patients. There was also regular review of patients re-attending ED within seven days.
- The Ambulatory Care Centre, which did not have patients staying overnight, reported only 20 patient safety incidents in the year to October 2015. The

monthly multidisciplinary meeting, attended by senior nursing and medical staff, discussed clinical issues arising from incidents and cases with unintended outcomes or readmissions. Action arising from these discussions included working with staff in other specialities in the hospital to clarify responsibilities for patient treatment. The monthly newsletter and regular teaching sessions included learning from these discussions.

- The trust had put in place processes to check compliance with the duty of candour (DoC) in notifying the relevant person of a suspected or actual reportable patient safety incident. We saw examples of action, including apologies to the patients or relatives. Staff of different grades and professions told us there was an expectation of openness with patients, and this was included in the trust induction. All senior nursing staff (band 7 or above) had received duty of candour training. Senior staff recognised there was further work to make sure that the trust DoC policy was fully embedded in practice, including staff recording action in the notes and senior staff sending a written acknowledgement and apology.

Cleanliness, infection control and hygiene

- There were some good infection control practices in ED and ambulatory care. However, we found some shortcomings, which staff responsible for regular checks had not identified.
- The trust Infection Prevention and Control Environmental Audits (ICAM) had green rated the ED (score of 97%) in March 2015 and green rated the Ambulatory Care Centre (score of 98%) in April 2015. ED staff routinely swabbed patients who were admitted to the hospital for Methicillin-resistant Staphylococcus aureus (MRSA) and screened patients for Carbapenemase-producing Enterobacteriaceae (CPE), another antibiotic resistant bacteria. This reduced the risk of the spread of infections for patients in ED and hospital inpatient areas. There had had been no hospital acquired Clostridium difficile or MRSA infections in ED in the six months to September 2015. There was a room available for isolating patients who were a possible cross-infection risks.
- There were hand gel dispensing points and hand-washing facilities throughout ED and ambulatory care. We looked at the results of the seven hand-hygiene audits conducted by the ED infection control link nurse between April and September 2015. Seven to twenty staff were included in each audit, including nurses, doctors, students, allied health professionals (AHP) and health care assistants (HCAs). The results ranged from 55% to 100%, with five audits recording compliance of less than 80%. There was an expectation of 100% compliance set by the trust. Doctors and AHPs performed less well than nurses. There was no record of any ED staff undertaking hand hygiene training in this period.
- Staff used personal protective equipment, including gloves and aprons when required and followed the trust's 'bare below the elbows' policy. Staff were reminded to challenge any member of staff who was not following the policy.
- We saw dusty sharps bins with their lids open in three bed areas of ED. Nurses were responsible for closing the bins, used for the disposal of syringes and other sharps.
- Domestic staff disposed of clinical and non-clinical waste in colour-coded plastic bags. However, we saw the storage area for collection of waste and sharp bins was not locked on the second day of our inspection. Domestic staff told us the key was missing. The storage area was close to the public entrance to the ED department and was easily accessible by members of the public. We informed the nurse in charge, who immediately took action to get a key so that staff could lock the storage area.
- Storage and resuscitation trolleys were dusty in the assessment area, the resus area and in the majors area. The trolleys in the resuscitation area had notices attached with sticky tape that was peeling off. The room designated as an infection control room had a storage trolley covered in a layer of dust and a sharp bin covered with dust and bits of hair. We did not see a rota for cleaning trolleys. Other equipment, such as commodes and machines for monitoring patients were clean and were marked with the date to indicate when domestic staff cleaned them.
- Domestic staff had a rota to undertake regular cleaning and we saw them cleaning the areas of the ED and Ambulatory Care throughout our inspection. For example when a patient left the majors or assessment

area domestic staff quickly came to clean the bed area in preparation for the next patient. However, during our inspection, we saw that a bed area prepared for a patient in ED by domestic staff was not thoroughly clean. The sink was dirty and a mop in dirty water was left outside the cubicle. There were dried spillages and rubbish on the floor in the paediatric emergency department. The door and the floor of one of the secure rooms for mental health patients was dirty. The disabled and women's toilets in the reception area were clean when we checked them. Senior nursing staff worked with the cleaning contractor to identify gaps and improve the services. For example, there had been complaints about the toilets and domestic staff now checked them every two hours.

- Patient-led assessments of the Care Environment (PLACE) at the trust in 2015 scored better than the England average for cleanliness. However, the trust performed worse than the England average in the national survey of A and E patients on the question about cleanliness of the department.

Environment and equipment

- The new ambulatory care centre was a welcoming space, which was bright and well designed, with comfortable seating areas and a small number of bed spaces providing privacy. The relatives' room in the ED was clean with suitable seating. The trust had recently refurbished the area designated for rapid assessment and treatment.
- There was poor lighting in the main ED waiting area, and a dark unwelcoming main reception area. An external review by an architect's firm had identified these areas as needing improvement. On the first day of our inspection, the public entrance door to the ED had smashed glass; it had not been mended by the end of our inspection on the third day. Staff told us the response to requests for repairs was often slow unless it was urgent.
- During our previous inspection in 2013 we found that there were inadequate storage facilities in the department and bed linen was stored in the corridor, through which ambulances passed to reach the main part of the ED. During our recent inspection, there had been little improvement and the corridor was still used as a storage area and remained cluttered.
- During our previous inspection in 2013, we found the area used as a clinical decision unit was too small for the number of patients, and was in poor repair with inadequate lighting. There had been a review of the unit, but the estates department had not identified an alternative space in the ED area, and had worked with ED staff to improve the current environment. The area was redecorated, there was more privacy and the nursing station was better organised. There were now two bays, one with three and one with four beds, and a side room, which was used flexibly to comply with single sex requirements. The trust recognised that this was not an ideal space for patients staying for more than a few hours, and therapists still found it challenging to support patients with rehabilitation because of the restricted space.
- The cubicles in majors and the rapid assessment area were well equipped. Staff told us they had all the equipment they needed and if there was any shortage they had access to the equipment library. ED management had taken action recently to improve the supply of pressure relieving mattresses and at the time of our inspection there were spare mattresses available.
- We saw the logbook for checks on equipment in the resuscitation area. An operation department technician came to the ED every day to check the ventilators. We noticed that the clocks in different parts of the resuscitation area and in ED bays were showing slightly different times. This might be a risk to patients if staff were undertaking a time critical task and looked at different clocks.

Medicines

- There was a pharmacist readily available to the ED department to assist with medicines management and the pharmacy team did trust wide audits, such as storage, medicines reconciliation and omitted doses. On the first day of our inspection, we saw that medicines in the resuscitation area were stored on shelves in each cubicle and we raised this with the ED matron. He said ED had already purchased lockable boxes and when we returned to ED later, the medicines were safely stored. We saw that medicines in other areas, for example the clinical decision unit and ambulatory care were secured in trolleys or cupboards. The ED was piloting the use of electronic medical storage cupboards that ensured that stock was re-ordered when needed.

- Controlled drugs (CDs) were stored in separate locked cabinets and nursing staff checked these drugs daily. The pharmacy department conducted quarterly audits to check compliance with the trust CD policy. The ED had introduced ambient room temperature checks to identify areas that were more than 25°C. The pharmacy team gave advice to nursing staff to mitigate the risk to medicines when this happened. There was a plan to procure temperature-controlled medicines cabinets.
- The medicines formulary, with information about medicines and prescribing guidance, was available to all staff on the trust intranet. Staff were able to generate patient information leaflets, tailored to the medicines taken by a specific patient.
- We looked at medicine administration records, which was part of the ED nursing notes, and saw staff completed these appropriately. A pharmacy inspector had contributed to the redesign of the drugs chart in the nursing notes to make it easier to use and review.

Records

- The ED used paper records, which reception staff scanned into the electronic patient record system. Reception staff registered the patient's arrival in the department and generated a paper record (referred to by departmental staff as a 'Cas Card'), which recorded the patient's personal details, initial assessment and treatment.
- The ED had revised the paper nursing notes form in 2015 to improve ease of completion and readability. An example of changes was using a different assessment for pressure care so that nurses did not need to weigh the patient, and this had improved the recording of this risk assessment. In addition to risk assessments, the form had space for recording initial observations, medicine prescriptions and administration, test results, handover information (for patients admitted to the hospital) and handwritten clinical notes. All sections of the report had to be completed with a 'yes', 'no' or 'n/a' (not applicable).
- The matron had introduced a new audit tool in November 2015. All nursing staff of band 6 and above took part in auditing a small number of nursing notes every two weeks. We did not see any results of this audit. We reviewed the nursing notes of 20 patients who had attended ED the previous day. We found all sections were appropriately completed, with good nursing documentation, and handwritten notes with the time and initial of the member of staff.
- The reception staff supervisor reviewed 10% of the Cas cards on the system to check that staff scanned them correctly. Records were returned to main health records department once validated. We reviewed six sets of notes of recently discharged patients on the electronic system. There was one record where the information was not clear, as the clinician's writing was not legible.
- There had been concerns about ED staff creating temporary notes for existing trust patients, with the risk that the full notes were not available to clinical staff. Reception staff created about four temporary records every 24 hours, mostly at night. A trust review of the creation of temporary records had identified the reasons for this. For example staff unable to retrieve notes as clinics or offices were closed, and temporary staff unable to access the health records store because their I.D Badges did not give them access. Reception staff on nightshift told us that they were usually on their own at reception and sometimes were not able to leave the reception area to collect health records. Work was underway to address the issue of temporary records, including reducing temporary staff so that there was greater access to the health records store.

Safeguarding

- Senior nursing and consultant staff told us everyone in the ED and ambulatory care unit was responsible for safeguarding, and the evidence we collected indicated this approach was well embedded in practice. All the staff we spoke with, including receptionists, nursing and medical staff were aware of signs to look for when a child or adult came to ED. We saw examples on the incident reporting system of staff, including medical staff, raising alerts because of relatives' behaviour towards a child or vulnerable adult.
- During our inspection, we observed the weekly ED safeguarding adults meeting, which discussed concerns raised in the department in the preceding week. Two consultants, two ED nurses, a member of the trust safeguarding team, and the trust domestic violence lead were at the meeting. We saw that the learning disability nurse, the mental health liaison nurse and the alcohol

liaison nurse also attended when appropriate. A middle grade doctor came to the meeting to discuss a vulnerable patient who had disclosed an episode of violence. The meeting brought up the patient notes and discussed the next steps, including assigning a care of the elderly physician, and finding a place of safety.

- There were appropriate policies in place for the protection of vulnerable adults and the nursing and medical staff we spoke with in the adult ED demonstrated a thorough understanding of these policies and of their implementation. All trainee doctors had received safeguarding training as part of their induction. ED nurses completed level 2 and 3 adult safeguarding training. Nursing and doctors in training commented on the visibility and availability of the named consultants and nurses for safeguarding. They also discussed cases with the trust learning disability nurse and the trust safeguarding team.
- All nursing staff working in children's ED were up to date in level 2 and 3 child protection training. They attended the weekly multidisciplinary meeting at least every three months. The designated paediatric ED consultant shared learning from case reviews with nursing staff.
- There was a flag system in place to identify children or adults who might be at risk, which the receptionist identified on booking patients. There was close working between the hospital and the local social services in addressing possible safeguarding risks for children and vulnerable adults, and trust staff had access to one local borough's electronic records.
- When a child arrived at ED, nursing staff asked about social work involvement at the initial assessment. Staff talked to the paediatric team or a social worker for further advice and identified children who might be at risk. The multidisciplinary team of paediatric medical and nursing staff, ED staff, social worker and the GP on duty at the trust met weekly to share their expertise in assessing the risks and deciding whether to make an immediate referral to the local children's social work team in the area the family lived.

Mandatory training

- Mandatory training for emergency and urgent care staff included basic and intermediate life support, safeguarding, conflict avoidance, blood transfusion, and infection control. 92% of the 27 health care staff in ambulatory care, 82% of the 107 health care staff in ED, 81% of the 16 reception staff in ED had completed mandatory training.

Assessing and responding to patient risk

- Paramedics took patients arriving by ambulance as a priority ('blue light') call immediately to the resuscitation area. The ED knew of the patient's arrival in advance and an appropriate team prepared for their arrival. There was a fully equipped dedicated area for children in the resuscitation area.
- The ED had processes in place to ensure all other patients, arriving by ambulance or coming to the public entrance, received a clinical assessment promptly. The trust met the target of 95% of patients waiting less than 15 minutes for initial clinical assessment. In the six months prior to September 2015 the average time was 14 minutes. This was an improvement of the findings of our previous inspection, when we found that only 78% of patients had an initial assessment within 20 minutes in the last three months of 2013. However, the hospital failed to meet the national target for time to treatment in less than 60 minutes, with an average wait of 81 minutes in the six months to September 2015
- 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. There were only 13 occasions of handover delays of more than 30 minutes, and no occasions when ambulance handovers exceeded 60 minutes in the six months to September 2015. We spoke with ambulance paramedics waiting with non-priority patients to register with the receptionist in the majors area of ED. They confirmed that there was rarely a long wait. They said the process for handover was efficient and professional and that ED staff had 'good eye contact' and awareness.
- A receptionist at the public entrance to the ED booked patients onto the electronic system and directed adult patients to the waiting area. Nurses or Emergency Nurse Practitioners (ENP) assessed adult patients promptly and decided on the next step. They transferred patients needing urgent and more intensive intervention through to the resuscitation or majors part of the ED. They redirected other patients when appropriate, for example

to the ambulatory care centre, or to a clinic, such as the sexual health clinic. People with injuries or illnesses that were less serious but requiring prompt treatment, such as broken bones, saw the GP on duty or the ENP in the Urgent Care Centre (UCC). Nursing staff in the UCC were trained in applying casts.

- RAT was at the entrance to ED, accessible to the waiting room and to the ambulance entrance, and was usually open from 8 am to 8 pm. The area was set up to assess and treat non-priority patients arriving by ambulance and those in the waiting room. For example, nursing staff were able to provide a patient with an ECG (electro-cardiogram), or to carry out other observations. However, there were insufficient consultant staff to provide senior medical review and treatment, which was the aim of the service. The medical rotas showed that consultants were only rostered to RAT occasionally in the middle of the day.
- When police brought a patient to the ED as a place of safety under section 136 of the Mental Health Act, the liaison team of Camden and Islington Mental Health Trust responded promptly to requests for a psychiatric assessment. The response was slower when the referral was less urgent.
- Nurses in ED followed prompts on the nursing notes to carry out further risk assessments for patients. The falls risk assessment included a screen for alcohol. ED nurses worked with the trust tissue viability nurse to improve the response to patients who were at risk of or who had existing pressure ulcers. They had introduced the use of heel protectors and improved the supply of pressure relieving mattresses. There were escalation prompts for patients monitored using Glasgow Coma Scores (GCS). The ED completed VTE risk assessments for over 90% of patients allocated a bed in the majors area or the clinical assessment unit of ED in October 2015 and 94% in September 2015. This was slightly lower than the trust target figure of 95%, but there were systems in place in the trust to highlight those patients admitted who did not have a VTE risk assessment.
- Nursing and junior medical staff in paediatric ED checked accessible policies about referral to paediatric colleagues, for example in the case of fever, and children readmitted within 24 hours. A nurse completing her handover from the night shift described how she had received immediate support from medical staff on ED and on duty in the paediatric ward when a very sick baby arrived during her shift.
- Babies, children and young people were transferred from ED to paediatric inpatient or high dependency beds in the hospital when needed. When they required intensive care, ED called the Children's Acute Transport Service (CATS), which provided a service to stabilise and safely transfer to intensive care units in other hospitals.
- The trust was part of the major trauma network for adult trauma patients with clear guidance on when a patient should be transferred to the main trauma centre at the Royal London Hospital.

Nursing staffing

- The trust had used a recognised 'safer nursing care' tool adapted for ED to establish the number of permanent nurses and health care assistants employed in the department (adult and paediatric ED, CDU and UCC). This had led to an increase in nursing staff numbers, with a successful recruitment programme. There remained difficulties in recruiting paediatric nurses. Adult ED nurses worked shifts on children's ED under supervision of paediatric nurses to gain experience. The paediatric practice development nurse assessed their competencies. There were two paediatric nurses in charge in addition to a paediatric advanced nurse practitioner, who worked flexibly to improve senior nursing cover on shifts.
- The planned rota had 15 nurses in the day and 13 at night with two health care assistants in the day and one at night. This included a more senior paediatric nurse (band 6 or 7) on duty on all shifts. The charge nurse requested an additional member of staff when a patient required one to one care, for example because they were living with dementia. There were sometimes staff shortages because of sickness. Matrons can make requests for temporary staff to fill gaps in the rota via the Head of Nursing for the ICSU; there were sometimes delays in obtaining the staff or there were none available.
- The safer staffing guide for ED used amber and red ratings for staffing levels that fell below the green rating of the established numbers. The nurse in charge escalated to the appropriate manager on duty when

there was a red rating. We reviewed the planned and actual rotas for one of the days of our inspection and for one day in the previous month. Agency staff filled gaps in the rota to avoid a red rating in adult ED. However, we noted from the November planned rota that there were three occasions (two nights and one day) when there was only a junior paediatric nurse (band 5) on duty, instead of a more senior (band 6 or 7). This also happened on one night of our inspection. Staff told us the nurses on duty in paediatric ED asked for support from paediatric ward nurses when they needed it.

Medical staffing

- The number of consultants did not meet the Royal College of Emergency Medicine standards or the London commissioning standards to provide 16 hours consultant cover daily on ED. There were 6.5 whole time equivalents (wte) posts at the time of our inspection. Two consultants were on maternity leave and only one of these posts had an allocated temporary (locum) consultant to cover the absence. Consultant cover was 8am to 8pm weekdays and 12 pm to 8 pm on weekends, with on-call cover out of hours. Some consultants worked paid overtime to cover gaps in the rota.
- There are 20 wte medical posts at a level greater than Foundation Year 2, including nine specialty doctors in training (STRs). There were vacancies because of the difficulty in recruiting middle grade doctor, a common problem in EDs nationally, and locum doctors filled the gaps in the rota. There were seven or eight middle grade doctors rostered for each 24 hour period, including weekends. We looked at two weekly rotas, one for November and one for December 2015 and saw there were only six doctors on duty on five of the 14 days. Three of the doctors on the rota during the week were locum doctors and there were four, five or six locum doctors on duty on weekends. There were eleven or more junior doctors in training on duty during the week and seven on duty on weekends. Junior and middle grade doctors told us they felt comfortable contacting consultants on call for advice by telephone, and consultants occasionally came into the hospital if needed. ED staff were also able to call the medical or surgical registrar on duty, and there was a prompt response in emergencies.
- Junior doctors in training told us they had concerns about the cover overnight, when consultants were not immediately available and locum doctors sometimes did not provide the quality of support they needed. We saw a report of an incident when action to address the deterioration of a patient was delayed because a medical registrar was not immediately available. This lack of ED medical staff was a risk to patients. We were not clear what action had been taken to make sure that ED medical staff took responsibility for their patients and did not rely on other hospital doctors.
- During the CQC inspection in November 2013, we highlighted the risk of the low number of consultant posts combined with the vacant middle grade posts. The ED had recruited additional emergency nurse practitioners (ENP) to improve the skill mix in the ED, and was shortly appointing a paramedic to join the ENP team. The trust was examining further options, but there was no agreement to increase the number consultants at the time of our inspection.
- A paediatrician with sub speciality training in emergency medicine, worked part- time on the paediatric ED and consultant cover was 8am to 9pm Monday to Friday and 9am to 3 pm Saturday and Sunday. This did not meet the recommendation of a consultant presence every day for 12 hours a day. The ED had made a business case for additional cover, but the trust had not agreed this at the time of our inspection.

Major incident awareness and training

- There was a major incident plan in place, with clear allocation of responsibilities and triggers for escalation, to deal with a major external incident and with internal incidents, including failures in electronic information systems. All ED staff had training in dealing with a major incident. The general manager described the arrangements to deal with casualties contaminated with chemical, biological or radiological material or hazardous materials and items.
- When an incident affected electronic information systems, personnel were allocated responsibility to regularly update the affected user group or trust customers and to inform senior management when a workaround has been identified or implemented.

Are urgent and emergency services effective?

Urgent and emergency services

(for example, treatment is effective)

Good

We rated effective as **good** because:

Emergency Department (ED) and Ambulatory Care Centre staff worked collaboratively with others in the trust and with external health and social services to deliver effective care to patients. Ambulatory care was open seven days a week.

The ED submitted results to the The Royal College of Emergency Medicine (RCEM) audit programme and took steps to improve practice by providing tools and other resources to prompt staff to follow appropriate assessment and treatment processes. Ambulatory care reviewed its practice to drive improvements, which were then monitored to identify further action.

There was a dynamic approach to learning that enhanced the skills of nursing and medical staff. Nurses were supported to develop their professional skills. Consultants provided teaching to doctors in training, but there was no protected time for learning away from the shop floor.

Evidence-based care and treatment

- A central trust team was responsible for arranging an appropriate clinician to review new guidelines and for disseminating them when they were approved. The trust guideline committee met monthly to ratify guidelines. Two doctors in training on ED told us it was easy to find clinical guidelines on the intranet and showed us how to access guidelines for a relevant treatment. They told us that they were informed about new guidelines in their teaching sessions. The central team oversaw the processes to approve audit to monitor adherence to guidelines and to put in action plans to address any shortcomings. The consultant audit lead for ED led the audit programme and liaised with the trust team. Doctors in training and nurses contributed to the collation of information for audit. The ED audit programme included national and local audit activity.
- The ED regularly reviewed policies and protocols and provided resources, such as flow charts and checklists, to promote adherence to relevant national guidelines and the Royal College of Emergency Medicine (RCEM) clinical standards. The ambulatory care service promoted evidenced-based practice with 'how to' advice for medical staff on common conditions, such as headaches and renal colic, with prompts to remember key steps, and links to guidelines or pathways. We saw evidence of action to improve adherence to evidence based care and treatment in response to incidents, national publications and the results of audits.
- An example of improving adherence to evidenced-based treatment in ambulatory care was a project to encourage appropriate diagnostic tests for people with possible deep vein thrombosis (DVT). This had reduced costs and improved adherence to NICE guidance. There was a plan for continuing improvements and re-audit.
- In the RCEM Mental Health audit 2014-2015 relating to documentation of assessments and patient history, the ED had performed above the national average in two out of eight MH audit standards. The remaining six were below the national average. They introduced a revised mental health risk assessment form for doctors and nurses, and this had improved documentation, but further progress was needed as some results were still below the national average.
- The trust also took action following a national audit into seizure management which found that for the majority of patients no documentation on managing seizures had been given to patients. The neurology consultants produced a patient information leaflet for staff to give to patients. A re-audit did not find significant improvement and the ED matron took further action to remind nurses and doctors to give relevant patients the information and to document this in the patient's notes.
- The ED complied with recommendations on screening patients for alcohol and having links to an alcohol specialist. The ED introduced scratch cards, which provided patients with an incentive to self-screen for alcohol consumption. The results were recorded in the nursing documentation.
- The results of the 2014-2015 national audit of standards on the initial management of the fitting child showed that the hospital met the RCEM standard of 100% for recording clinical information about the child. They

were among the best 25% of trusts in providing written safety information to parents or carers, and managed 80% of children according to expected standards, placing them among the middle 50% of trusts.

Pain relief

- The trust performed about the same as other trusts in the questions about pain relief in the 2014 national accident and emergency survey of patients. The ED was taking steps to prioritise patients in pain at initial assessment so they received prompt analgesia. People in the waiting room told us staff came to check whether they were in pain when they arrived and immediately gave them pain relief if they needed it.
- The work to improve adherence to the pathway for patients with facture neck of femur included immediate pain relief.
- The clinical record for children's ED had a space for recording pain, but this was not present on the adult record.

Nutrition and hydration

- We saw staff providing drinks and snacks to patients during our inspection. The trust scored about the same as other trusts in the question about getting suitable food or drinks in the 2014 national A and E survey of patients.
- We observed that intravenous fluids were prescribed and recorded appropriately.
- Domestic staff provided meals to people staying in the Clinical Decision Unit.

Patient outcomes

- ED participated in RCEM audits and was able to benchmark its performance against best practice standards and the performance of other EDs.
- 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. They introduced a rapid hip assessment pro-forma, to allow suspected hip fractures to be prioritised for medical assessment. This had improved the outcome from 23% to 36% of patients receiving x-rays within one hour of arrival at ED in 2014. Doctors in training presented the results in a poster which won a clinical audit award from Clinical Audit Support Centre (CASC).
- There was a national expectation to improve the speed of response to patients with sepsis, as most EDs, including the Whittington, were not meeting the RCEM standards. ED had taken steps to improve the adherence to the standards by redesigning the flowchart for the assessment of sepsis, and having a visible 'Sepsis Box' in the department. Nursing notes had a section for assessing clinical signs of infection ('Think Sepsis'), on the front of the nursing notes.
- The percentage of ED attendances resulting in admission was below 20% from June to August 2015, better than the national average of 22.2%. This indicated that patients were less likely to be admitted to an inpatient bed than other trusts because of the alternative treatment options available.

Competent staff

- ED and ambulatory care supported learning through formal and informal routes. On the first day of our inspection, we saw a '10 at 10' (10 minutes at 10 am) meeting in adult ED, led by doctors in training and attended by medical and nursing staff. There was an informative discussion about the management of sickle cell disease in the ED. Nursing, health care assistant and doctors in training told us they found these sessions constructive. Topics included sepsis, safeguarding, falls, oxygen prescribing, the mental capacity act and treating people who were under the influence of alcohol. The sessions were based on true scenarios, referred to best practice and reminded staff of resources available. The sessions were repeated at different times to capture staff on different shifts. We observed a nurse providing a teaching session attended by five nursing staff. Other trust speciality nurses, such as the learning disability nurse and the tissue viability nurse also came to the ED to deliver training.
- There were sufficient numbers of senior staff in ED and ambulatory care to take responsibility for the supervision and appraisal of nurses, health care assistants and reception staff. Senior nurses (band 7) were given management time for this role. Staff told us they found appraisals useful in identifying development

opportunities and additional training. Seventy percent of staff in the adult and children's ED, and adult ambulatory care had completed an appraisal in the previous year. ED managers expected this to improve with a stable nursing workforce and clearer accountability structures. The trust had revised the appraisal scheme in 2015 to incorporate 'coaching conversations' which was expected to improve the understanding of performance and improve development plans. We noted that a small number of reception and administrative staff had been on temporary contracts, sometimes for two years or more, and therefore did not have the opportunity to have an appraisal. The service manager told us the trust had made these posts permanent.

- Nursing and health care assistant staff had access to a comprehensive training programme and opportunities for professional development. The ED practice development nurse (PDN). worked with line managers to identify development for staff. She also ran an innovative eight week in-house training module for nurses in the essentials of emergency care, which was accredited towards a Master degree. More senior nursing staff told us of working towards advanced nurse practitioner qualifications and of attending leadership courses.
- Consultants told us they did not have an individual job plan and the trust system for consultant job planning was under review. There was a group job plan in ED and designated areas of responsibilities for each consultant.
- All locum doctors and agency nurses received an induction and many locums were familiar with the service. There had been occasions when locum doctors did not perform satisfactorily; the ED informed the agency and the trust did not employ them again.
- Doctors in training told us consultants provided opportunities for regular teaching. However, the small number of consultants had to work hard to provide effective teaching and supervision. ED had responded to criticism in the General Medical Council survey of doctors in training by rescheduling teaching sessions so that they did not clash with lunch breaks. However, junior doctors told us they did not have protected time for learning away from the shop floor, which on a busy ED might result in losing learning opportunities.
- Two medical students told us they had chosen to come back to the Whittington because of how well consultants supported them. They were encouraged to take on tasks supervised by medical staff when they felt able to do so, and also felt they could ask any questions at any time.

Multidisciplinary working

- We found many examples of multidisciplinary working, with professionals with a variety of skills contributing to the treatment and care of patients. We saw good communication between nurses, medical staff, domestic staff and security staff within the ED. There was also evidence of working relations with other specialities within the hospital, with the trust community services, and with external agencies. Acute medical consultants and their staff regularly attended the ED and the clinical decision unit to review medical patients who might be admitted or who had stayed overnight in ED. The consultants often started their ward round in ED before going to the inpatient wards. Consultant general surgeons and orthopaedic surgeons also regularly attended ED to assess patients for emergency surgery.
- Ambulatory care worked with hospital services, including diagnostics, care of the elderly physicians, therapists, pharmacists, and medical and surgery specialities to provide effective treatment and care. We heard of many examples of individualised care, which engaged consultants and others in the diagnosis and review of patients. Consultants from all specialties reviewed patients who attended ambulatory care as a day patient, following an outpatients appointment or after discharge as an inpatient. We observed one of the weekly meetings, attended by a medical consultant, a microbiologist a pharmacist and the lead nurse for ambulatory care, which reviewed all patients on long-term antibiotics to optimise their care.
- The therapists providing the Facilitated Early Discharge Service (FEDS) on ED, CDU and ambulatory care, worked closely with social and health services in the community to prevent re-admission. A member of the team told us about the early assessment of those patients whose needs could be met at home. She was able to send an assessment to social services for a care package to be

put in place for patients with complex needs. The team also worked with the rapid response service and the virtual ward on ambulatory care to arrange services rapidly in people's homes.

- We heard a middle grade doctor on CDU requesting a member of domestic staff to come to take a patient to radiology, and saw that someone came straight away. Domestic staff told us they undertook this additional role in ED to make sure patients are transferred quickly when they needed tests.
- The ED worked closely with the Mental Health Liaison team of Camden and Islington Mental Health Trust. When police brought a patient to the ED as a place of safety, the team responded promptly to assess and access a psychiatric assessment to make a decision about whether the patient required an inpatient bed. Staff refer people who were not at immediate risk to the Mental Health Liaison Team. Following this assessment they were sometimes referred to local community mental health teams.

Seven-day services

- The ambulatory care service was open seven days a week. This enabled patients to continue their treatment, and provided a safety net for GPs who wanted their patients reviewed over the weekend.
- ED staff told us, and the rotas we checked confirmed, that although nurse staffing at nights and weekends reflected seven day working, consultant cover after 8 pm was on an on call basis only.
- There was access to X-rays at all times. Staff came in out of hours to provide access to computerised tomography (CT), but staff told us there were sometimes delays in obtaining a scan. There were also sometimes difficulties for ED staff in obtaining magnetic resonance imaging (MRI) scanning for patients. ED consultants worked with the spinal consultant to produce back pain guidance and there was now an agreement with radiology about the criteria for access to a scan.
- Two therapists and a support worker provided a weekend service for ED, ambulatory care and the acute assessment wards.
- The pharmacy provided a full clinical pharmacy service to the whole organisation from 9am to 6pm Monday to Friday. On Saturdays and Sundays there was a full clinical pharmacy service supporting the acute admissions unit, intensive care unit, neonatal unit, children's wards and acute surgical wards 9am -5.30pm. For the rest of the organisation there was a pharmacy service provided between 10am and 1.30pm on weekends. The department was also open on bank holidays and Christmas Day. All trust sites including ED had access to an on-call pharmacist out of hours who could be contacted for advice and supply of medicines.

Access to information

- ED and ambulatory care staff, with the exception of temporary staff, had access to electronic patient information. There was also access to the trust community health records. ED used paper notes, which were accessible to locum and agency staff.
- The nurse in charge on the majors area, where patients coming to ED were allocated a bed, monitored patients' arrival and allocated them to bed areas. Staff entered information about patients' arrival time, location and their review on the electronic system, which staff could view on the computer.
- There was a section on the ED nursing notes to summarise test results and other relevant clinical and non-clinical information on a patient's transfer to an inpatient area or on discharge.
- The children's emergency department sent the discharge letter to the child's GP. They sent a letter to the child's health visitor if the multidisciplinary team discussed the case at the weekly meeting where risks were assessed. This meant that the health visitor did not receive immediate information about a child's attendance at ED, which is usual practice.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The ED met the expected standard of 100% for the use of structured tool for cognitive impairment assessment for people who might be living with dementia. The process for undertaking mental capacity assessment and for decision making about the deprivation of liberty was part of the electronic patient record dementia screening tool.
- All 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. Not all nursing or junior doctors understood in detail the deprivation of liberty process, but some middle grade and the senior nursing and medical staff we spoke with understood the application process when making decisions about restraining people. They also understood the decision making process about patients' treatment in their best interest. We saw evidence of the dissemination of this information during a patient's journey

Are urgent and emergency services caring?

Good

We rated caring as **good** because:

Reception, nursing and medical staff treated patients with kindness and respect in the Emergency Department (ED) and in the Ambulatory Care Centre. There were times when the ED was very busy, but staff still took time to listen to patients and to explain things to them.

Patients in the ambulatory care area were overwhelmingly positive about the way staff kept them informed and explained their tests and treatment. ED staff had access to training in supporting bereaved families, although not all staff had attended the training.

Compassionate care

- Patients and relatives we spoke with during our inspection were nearly all positive about the kindness of staff in the ED and ambulatory care. Patients' views left on the NHS choices website were mixed, with some very positive comments about the staff and some complaints about their attitude. A typical comment of the patients we spoke with was "very good care; staff are excellent". We also observed staff communicating with patients with respect and taking steps to maintain their dignity, even when the department was busy. Patients said, and we observed, that medical, nursing and therapy staff always introduced themselves. A relative of a patient on the clinical decision unit said all the staff had been kind and respectful and were a "great team". She commented on the "kind and patient" night nurse and said the member of domestic staff serving food was "lovely".
- On the first day of our inspection when the ED was busy, we pointed out to a member of staff that a patient waiting on an ambulance trolley appeared cold. The nurse brought a blanket. In contrast, a patient complimented staff on NHS choices. 'The staff were professional and friendly - even when I was out in the corridor on the trolley for just a couple of minutes a member of staff asked if I was cold and gave me a blanket.' A patient commented on the website about the poor attitude of a doctor who the patient identified as a locum. Senior ED staff confirmed they sometimes had complaints about locum doctors and would take action to address this, for example by informing the agency and not using the locum again.
- We spoke with a patient detained under the Mental Health Act waiting for an assessment by an approved mental health professional. They said that they had visited the ED frequently and they were happy with the support offered by the staff working there. They knew staff working in the department and felt comfortable spending time there while waiting for the mental health assessment. We observed staff, including security staff, interacting with patients with mental health needs in a calm and kind manner.
- ED scored about the same as other trusts in England in response to questions about caring in the national A and E survey 2014. For example, about being treated with dignity and respect.
- The Friends and Family test (FFT) is a single-question survey that asks patients whether they would recommend the NHS service they have received to friends and family. The ED score was consistently better than the national average, and had been 94% or more in the three months up to October 2015. However, the response rate to FFT was not included in the dashboard information collated by the trust and as response rates are generally low for EDs, the results may not be representative of attenders to the ED.
- Ambulatory care regularly scored 100% in responses to FFT. They also regularly asked patients other questions, such as their views on the explanation and information given, and the results were overwhelmingly positive. The patients we spoke with endorsed these views had said everyone was very friendly and polite. They said the receptionist was very kind and reassuring, and kept them informed about what was happening. When there

was a wait, for example for test results, she suggested they go for a walk and come back. We saw the receptionist leave her desk to welcome a man with a visual impairment by name and take him to the seating area.

Understanding and involvement of patients and those close to them

- 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. She said "they (staff in ED) take time with you", even though they were often very busy. Patients attending ambulatory care might have a series of tests and see medical staff from different specialties. The patients we spoke with said staff always explained what was happening and gave them choices. For example, a patient attended ED the previous night where she had tests. There were no inpatient beds available in the hospital so she had the choice about going home and returning to ambulatory care for the test results and further consultation the next day. She was happy to go home for the night.

Emotional support

- Staff were aware of the need for a relative to be involved in patients' care and informed of decisions related to their treatment, especially when in a critical condition or while a patient was provided with a lifesaving treatment. There was a relative's room near the resuscitation room that provided privacy. A senior nurse said staff felt confident discussing issues related to end of life and were aware of the bereavement support available to friends and family. Staff had access to brochures, which explained where the family could obtain support and what steps to take after their relative died. This also included contact details for the hospital's chaplain. Brochures were available in English only.
- The specialist palliative care team provided training to ED staff. The bereavement midwife also regularly attended ED to provide training for staff about miscarriage. However, not all nursing staff had attended bereavement support training.

Are urgent and emergency services responsive to people's needs?

(for example, to feedback?)

Good

We rated responsive as **good** because:

The Emergency Department (ED) and the Ambulatory Care Centre worked within the trust, with commissioners and with other providers to develop services to respond to patients' needs and to improve the access and flow of patients through the department and the hospital.

Ambulatory care provided responsive alternatives to inpatient care focusing on the individual and their needs and preferences.

ED had adjusted staffing and facilities to improve the timeliness of assessment and treatment and fewer people stayed longer than four hours in ED than the England average.

However, at times of high demand some patients waited a long time in ED before they received a medical review and a decision about the most appropriate place to treat them. ED worked with the bed management team to improve the flow of patients through the trust, but further work was needed to avoid unnecessarily long stays on ED.

Service planning and delivery to meet the needs of local people

- 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.
- Ambulatory Care Unit does not have primary care services. Some local GPs work with the virtual ward team based on the Ambulatory Care Unit.
- The trust funded the mental health trust Integrated Liaison Assessment Team (ILAT) to support mental health patients in ED. There was a local resilience group of service providers and commissioners who planed

services for mental health patients. The ED shared data on MH patient attendances with the group, including delays in transfer because of shortage of beds. There were plans for an increase in step down beds for mental health patients who did not require an acute placement.

- The trust worked with trust specialties and those at other trusts to enhance the care pathways for patients coming to ED. For example, this had resulted in improvements in the referral pathway to ear, nose and throat (ENT) services in the hospital and in other trusts.
- There was a daily 11am teleconference with all EDs in the area discuss resources and pressures on emergency care in North Central London.

Meeting people's individual needs

- There was a strong focus on the patients' needs and preferences, and we saw many examples of ED and ambulatory care providing person-centred care and treatment during our inspection.
- The Ambulatory Care Centre worked with other services in the trust and with GPs to be responsive to each patient's needs. Care and treatment were tailored to the individual, not dictated by who was providing the service.
- ED referred older people with complex needs to the Care of Older People team for review before discharge. A consultant in care of older people and acute medicine reviewed older patients attending ambulatory care.
- There had been work in the ED to ensure that patients with learning disabilities received adequate diagnosis and treatment to meet their needs. There was a named consultant and a named nurse for learning disability and a section on the staff notice board displayed their contact details and those of the trust learning disability nurse. Since April 2015 the trust learning disability nurse received an automated email alert when a patient with learning disabilities attended the hospital and was flagged on the electronic patient record system.
- ED staff work closely with mental health services to meet the needs of mental health patients. An assessment is completed by the Emergency Department nurses and, if required, an RMN is booked and allocated to the patient. Security staff we spoke with undertook Mental Health Act training and they demonstrated an awareness of the legislation and how to protect patients' rights. The trust also provided them with training in restraint that was proportionate and addressed de-escalation. The two secure rooms in ED were not separate from the majors area, where other patients were treated, as recommended by the Psychiatric Liaison Accreditation Network. The rooms were scruffy and poorly decorated, and a mattress was put on the floor when people stayed overnight. The trust had agreed funding to refurbish the rooms and to install a bed.
- Paediatric ED screened adolescents for low mood and asked those who were assessed as in a low or anxious mood if they would like to be referred to the paediatric mental health team.
- ED and ambulatory care staff worked with the alcohol liaison nurse, funded by Islington CCG, to identify and assess patients for whom alcohol was a contributory factor in their attendance at the hospital. Staff offered patients who came to ED a referral to the nurse, who organised a detoxification programme in the community or in ambulatory care. There was a high rate of attendance at the programme for people who accepted a referral. Adolescents attending paediatric ED were screened for alcohol and drug use.
- ED staff contacted the trust domestic violence lead when there were indications that patients were at risk or had suffered abuse. She had close links with the safeguarding leads for children and vulnerable adults.
- There was a play area in the paediatric ED, and there were toys and games, including video games, suitable for all age groups. A play specialist worked four days a week. No young people under the age of 16 had been admitted to adult facilities in emergency and urgent care services in the three months to October 2015.
- Staff told us how they used the interpreting service for people who communicated in a language other than English. We saw a folder in the ED staff to assist them in accessing interpreters appropriately.

Access and flow

- The trust had developed its services so that patients were assessed promptly and provided with treatment in the most appropriate setting.
- 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.

- The average time spent in ED often exceeded the trust threshold of 240 minutes and was worse than the England average. ED staff attributed this to delayed senior medical review, delays in the assessment of non-urgent mental health patients and a shortage of beds. The ED weekly attendance summaries confirmed the reasons for delays. The week before our inspection, ending 6 December 2015, the percentage of the 1,971 attendees spending less than four hours in the ED was 88.5%, worse than usual. The number of delays for an ED assessment (18), for a specialist opinion from within the trust (20) and for a specialist mental health opinion (14) were higher than usual that week. The most usual reason for the breach was bed management (117). When the trust met the 95% target in the week ending 15 November 2015, only 19 patients stayed for more than four hours for bed management reasons.
- There were often delays obtaining a secure inpatient bed for those patients living with mental health conditions who needed one. There was also a shortage of other facilities suitable for people with mental health needs.
- Patients who needed further observation, for example those with head injury or chest pain, or older people who had fallen, were transferred from the majors area to the Clinical Decision Unit (CDU) for additional observation, tests and medical review. A decision was then made about whether to admit the patient, discharge them, or to arrange for them to attend ambulatory care. The revised guide to the service stressed that the unit should not be used as an inpatient bed or for critically ill patients and if a patient deteriorated they would be transferred back to the majors area. However, there were times when patients stayed more than 24 hours in the unit, which did not have the facilities of an inpatient ward.
- The bed management team was part of the Emergency and Urgent Care ICSU division and held operational bed meetings three or four times a day. The service manager and/or ED matrons usually attended the meetings. We saw the electronic bed management system displayed in the team's office, which tracked patients requiring beds and the beds that were or would become available on the wards. The team worked dynamically to improve the flow of patients in the hospital and encourage the view among all hospital specialties that everyone had responsibility for every patient being in the right place at the right time. ED staff tried to prepare patients for admission, for example by doing observations and ordering medication. Nevertheless, the bed management team found that some wards were slow to release beds and there were some clinicians who were less willing to take advantage of the alternative treatment options to inpatient care. The bed management team worked with ED, ambulatory care and inpatient areas to limit the number of times the patients moved before getting to the 'right place'.
- There was an operational manual with action cards to aid assessment of pressures on ED and to prompt a response in collaboration with the bed management team. For example, there was a red rating when there were over 75 patients on ED. Staff were allocated specific tasks to address the pressures, such as moving staff or getting additional staff. Nurses and junior doctors in training were aware of using those escalation pathways.
- ED reviewed frequent attenders at ED to discuss how to provide more appropriate care and treatment. There was an average of 22 patients a month who attended ED nine or more times in a three month period. Some frequent attenders preferred to come to ED because it was convenient or they preferred it to other services. The consultant for care of older people reviewed older people who re-attended and staff told us of a review, which identified the support the patient needed at home to address their needs. The trust senior management were also looking at how community and other services might engage with this group of patients.
- The Ambulatory Care Centre offered an alternative to patients who might otherwise go to the ED or be admitted. Patients referred by their GPs, discharged from inpatient wards, or directed by ED or outpatients were able to receive hospital care without the need for an overnight stay. Patients had access to diagnostic tests, assessment, treatment by an appropriate specialist, antibiotic intravenous medication and therapy. The unit saw 60 to 70 people a day. In addition, there was a consultant on call on weekdays from 9am to

5pm to provide support with decision making on the most appropriate place to treat medical patients. The majority of calls were from GPs and ED. About 70% of patients discussed were subsequently seen at ambulatory care (over 80% on the same day) and 15% were referred to ED. Out of hours the calls were taken by the duty medical registrar.

- The 'virtual ward', which was run from ambulatory care, provided nurse and GP reviews in people's homes so that people did not have to attend the ED or be admitted to hospital. The rapid response service, which also ran from the ambulatory care unit, helped to prevent admission and to speed discharge by arranging services in people's homes.

Learning from complaints and concerns

- There was information about how to make a complaint in the ED and staff gave us examples of when they encouraged people to go to the patient advice and liaison service (PALS). 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.
- The general manager and the matrons managed complaints. PALS worked closely with them to resolve patients' and relatives' concerns. The matron gave us an example of when he explained to a relative that ED staff had tried to contact them about a patient and this was recorded in the notes. The relative was satisfied with the explanation and did not make a formal complaint.
- The Emergency and Urgent care ICSU had improved the timelines of the response to complaints, with a response within 25 working day to all four complaints in August and four out of six in September. The quality dashboard for the ICSU included a summary of complaints and action taken to address the issues raised. For example, an action point arising from a complaint was that staff attend training from the learning disability nurse.

Are urgent and emergency services well-led?

Good

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

The emergency department and ambulatory care were clear about their purpose and took steps to improve the experience for patients and the effectiveness of care and treatment.

There was a consistent approach to risk management, with risks assessed and monitored. There was a positive culture among staff, which resulted in good communication within the recently formed Emergency and Urgent Care Integrated Clinical Service Unit, across the trust and externally with other services.

However, the shortage of consultant staff limited the ability of ED to maintain improvements.

Vision and strategy for this service

- 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. The EUC ICSU is made up of ED, urgent care, ambulatory care, the acute assessment unit and Hanley Road GP practice, site management, community district nursing services and the primary care alcohol and drug service. 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 Emergency Department and Urgent Care Centre strategy 2015 -2020 was based on the priorities set out in the trust clinical strategy. An external facilitator ran a meeting attended by 16 staff, including the trust chief operating officer and chief executive to decide on the principal goals of the service. One of these was to develop preventative strategies by working with Public Health England to understand the needs of the local population. to integrate and co-ordinate care, to deliver high quality and safe care and involve patients as active partners in their care.

- The Ambulatory Care Centre was central to the trust's priorities of providing alternatives to inpatient care and placing the patient at the centre of service delivery. Staff we spoke with in ambulatory care, including administrative, nursing and medical staff supported these priorities. The service was continuously monitoring its performance.

Governance, risk management and quality measurement

- There was a clear governance and risk management structure in place, with regular patient safety meetings, monthly senior managers meetings and meetings of the risk board. The Emergency and Urgent Care dashboard provided information on risks, targets, incidents, complaints and infection control. The general manager worked with the trust information team to check the reliability of data about ED performance.
- The risk register was regularly updated, with risks added to the register relating to patient care, technical issues, and recording failings. A manager took responsibility to monitor each risk, and they recorded regular updates, with mitigation plans put in place and action to eliminate risk when possible. The appointment of a risk manager for the ICSU had helped with the management of the register. Some risks had been on the register since 2013, for example responding in a timely way to mental health patients, and a shortage of middle grade doctors. We saw there had been action to mitigate risk, but the risk had not been eliminated. There were regular meetings with the mental health trust to come to agreement about the way forward, and trust staff took part of a wider commissioning initiative to improve services for mental health patients. The matron had contributed to the mental health trust investigation of the death of a patient with mental health needs who had attended ED. The report identified a number of actions for joint work to improve the response to mental health patients coming to ED.
- The ED clinical lead had led two information-gathering exercises in two years to examine the flow of patients through ED and to tackle the problems of the shortage of middle grade doctors. The 2013 report focused on the peak times and on 'decision makers' available. This had led to an increase in nursing staff to improve the skill mix, and the appointment of emergency nurse practitioners, who were able to make decisions about treatment and were added to the medical rota. However, there had been no decision about creating additional consultant posts at the time of our inspection. The risks posed by the shortage of consultant staff was not on the risk register.

Leadership of service

- The clinical director worked closely with the Director of operations, the Head of nursing and senior medical and nursing staff to provide leadership to the ICSU. The trust reorganisation had resulted in some uncertainty, but the new ICSU had made the necessary change to systems and personnel without disruption to services. The nursing director was focusing on district services, so was less visible in the hospital. However, we saw that nursing, medical and operational managers had common goals and worked together to achieve these. For example, the ED matron worked closely with the general managers and the risk manager. There was also effective joint working between consultants and nurses, such as the weekly safeguarding meetings.
- There was strong, non-hierarchical working in ambulatory care, with commitment from clinical and non-clinical staff to running the service effectively.
- Staff at all levels were able to identify the chief executive and describe the key trust values of compassion and respect of others. ED nursing staff commented on the trust board engagement in promoting safeguarding adults and children.
- In the 2014 national NHS staff survey, the hospital scored worse than the average on the question relating to competing demands of the job. ED managers were aware the constant pressure on staff in ED, exacerbated by the lack of permanent middle grade doctors, which inevitably had an effect on staff morale. There had been changes in anticipation of the CQC inspection, which put additional strain on very busy staff. The trust were taking steps to engage frontline staff in developments, and staff told us of meetings they attended when information about proposals to changes were shared and discussed. The national NHS staff survey results also indicated that staff felt they were able to contribute to discussions about the team's effectiveness.

Culture within the service

- The positive culture within ambulatory care was evident from the way staff interacted with each other and with patients. A consultant commented that the service was 'psychologically healthy for staff and patients'. This positivity had an impact on other parts of the trust too, with the emphasis on different departments working together to improve effectiveness and provide holistic care and treatment to patients.
- Many people we spoke with, including medical students, receptionists, health care assistants, mental health liaison officer and paramedics reported that ED engaged well with staff and patients. We saw that even at busy times, staff communicated with each other. For example the receptionist described how the nurse in charge on the busy night shift asked her whether she needed help (with booking patients in). A paediatric nurse told us everyone in the department was ready to offer help and support. She said "I've never felt I wasn't listened to". Positive feedback was displayed on the staff noticeboard, including cards from patients and comments from the NHS choices website.
- Senior and front line nursing staff praised the commitment and innovative work of the ED practice development nurse, both in the education of nursing staff and in promoting good practice. The approach to development opportunities and shared learning had contributed to the positive culture of the department.
- Many staff commented on the friendliness of the trust and the fact that everyone knew everyone else. We saw many examples of the advantages of this, for example the charge nurse telephoning a nurse on an inpatient ward to check on when a bed would become free for an ED patient.
- Nursing staff in the paediatric ED said they could tell if someone was affected by their work, such as the death of a child. Senior staff referred staff to occupational health for support and debriefing. However, there was no formal process for debrief on adult or paediatric ED.

Public engagement

- The trust had involved members of the public in the planning of the Ambulatory Care Centre and was working on ways to engage patients or ex-patient's in planning developments for the service by inviting them to take part in focus groups. Patients were asked to complete a survey in addition to the Friends and Family test, and there was evidence of actions in response to comments in the survey.
- The ED participated in a production with a theatre company at the beginning of 2015. Staff and actors acted scenarios based on actual events and the audience of trust staff were invited to suggest alternative ways to deal with the situation.

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. Trust staff worked together, and with external organisations, to provide care and treatment to patients with complex needs. ED was continually reviewing demand and resource in order to improve its responsiveness to patients. The opening of the Rapid Assessment and treatment area (RAT**)** was intended to provide a more prompt response. There had also been changes to medical and nursing staff shifts so that more staff were available at the busiest times in the department. Matrons came to the floor at the busiest times to help staff with tasks. We did not see any review of the effectiveness of these initiatives.
- There had been improvements to the flow of patients, for example, time to initial assessment had fallen. ED senior staff and the site management team were determined to improve the service further so that patients did not stay longer than necessary on ED. However, this was difficult to achieve because of the shortage of consultant and middle grade medical staff, and the difficulty finding beds in the hospital at busy times.
- There was evidence of staff using audit and other information to drive improvement. However, ED consultants were over-stretched and this limited the department's ability to implement initiatives effectively. The rapid assessment and treatment area was unable to operate as planned because of shortage of consultant staff to attend and treat patients.

Medical care (including older people's care)

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

Information about the service

Medical care including older peoples care includes the broad range of specialities not included in the other core services. In general terms, medical care can be thought of as those services that involve assessment, diagnosis and treatment of adults by means of medical interventions rather than surgery.

At the Whittington Hospital these services are delivered under the Medicine, Frailty & Networked Service Integrated Care Service Unit (ICSU). Between January 2014 and December 2014 there were 18,631 inpatients spells.

The ICSU covered a large number of medical specialities including: cardiology; gastroenterology; respiratory medicine; endocrinology and haematology services. The trust also provides services to elderly patients and people living with dementia.

We inspected all of the medical wards within the ICSU which were : Acute Medical Unit (AMU), Seacole North and Seacole South, Bridges, Cavell, Cloudesley, Meyrick , Montuschi, Victoria, and the Chemotherapy Day Unit.

We spoke with 49 patients, 17 family members and 71 staff members that included: clinical leads; service managers; matrons; ward staff; therapists; junior doctors; consultants; and other non-clinical staff. We observed interactions between patients and staff, considered the environment including medical equipment and looked at 71 medical records and attended medical and nursing handovers. We reviewed other documentation from stakeholders and performance information from the trust.

Medical care (including older people's care)

Summary of findings

Most patients were kept safe while they are being cared for at The Whittington Hospital. Patients who are at risk of deteriorating were monitored and systems were in place to ensure that a doctor or specialist nurse was called to provide the patient and ward staff with additional support. The trust had an open culture and had systems that allowed them to learn from clinical incidents. The medical wards had enough doctors and nurses to keep people safe.

We found that care on medical wards was provided in line with national and local best practice guidelines. Audits were being undertaken and there was good participation in national and local audits that demonstrated good outcomes for patients. Patient morbidity and mortality outcomes were well below what would be expected for a hospital of this size and complexity and no mortality outliers had been identified. Although there was a good knowledge of the issues around capacity and consent, the levels of staff training in these areas was low.

Patients received compassionate care and were treated with dignity and respect. Most of the patients and relatives we spoke with said they felt involved in their care and were complimentary about the staff looking after them. One person told us: "It's great, they look after me well here. They are so nice and take an interest in how I am getting on". The medical division had good results in patient surveys and results indicated an improvement in the views of patients over the last 12 months.

The medical division is effective at responding to the needs of its patients from all parts of its community. The hospital operational management team had a good understanding of status of the hospital at any given time. Bed availability was well managed. Elderly care pathways had been well designed to ensure that elderly patients were assessed and supported with all their medical and social needs. The hospital had designed pathways that if possible kept patients out of the emergency department (ED). The Ambulatory Care Unit and Hospital at Home provided effective alternate pathways for GPs and other referrers.

The Medicine, Frailty & Networked Service Integrated Care Service Unit (ICSU)is well led. Divisional senior managers had a clear understanding of the key risks and issues in their area. The division had an effective meeting structure for managing the key clinical and non-clinical operational issues on a day to day basis. Staff spoke positively about the high quality care and services they provided for patients and were proud to work for the hospital. They described the hospital as a good place to work and as having an open culture. The most consistent comment we received was that the hospital was a friendly place to work and people enjoyed working with their teams.

Care and outcomes on Victoria ward did not always achieve the high standards of the rest to the medical division. However the trust had recognised this and had put plans in place to make improvements.

Medical care (including older people's care)

Are medical care services safe?

Good

We rated the safety of medical care as **Good** because;

Staff reported incidents when things went wrong. The trust had effective processes in place for reporting, investigating and learning from incidents. Most staff we spoke with were able to describe learning from incidents that had been provided to them through training and other methods of communication.

We observed that clinical staff regularly washed their hands in between seeing patients, used personal protective equipment (PPE) such as gloves and aprons and adhered to the trusts 'bare below the elbows' policy.

The trust is good at identifying patients who may deteriorate. The 'site team' are well qualified and provided good support to staff and patients.

There were enough medical and nursing staff to keep patients safe at all times. Staff handovers were well managed with key issues identified, recorded and action to ensure patients who were unwell were monitored and supported.

However;

Medicine management on Victoria ward was poor. Medicines were not always available and the poor processes lead to a high risk of errors.

Mandatory training rates for staff were well below the trust target of 90% in most areas.

Incidents

- Staff we spoke with stated they were encouraged to report incidents. Staff knew how to report an incident and said they reported incidents frequently. Nursing staff told us they received feedback on the incidents they had reported. For example, a nurse was able to describe an incident where a patient had a naso gastric tube incorrectly placed and the learning that had come from the trust investigation.
- Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers. There had been one never event relating to a misplaced naso gastric tube. Staff we spoke with were aware of this incident and the learning from it.
- The prevalence rate of pressure ulcers, falls and CUTIs reported via the Patient Safety Thermometer show low numbers and no discernible trends.
- We found staff in the Endoscopy unit were able to describe their learning from events where patients had been given a drug to prepare for a colonoscopy but it was a stomach scope. Staff showed learning to make sure this did not happen again.
- Evidence seen during inspection of action taken as a result of medicines incidents and learning disseminated across teams. As part of incident management, the trust used a reflective tool to help staff think through an incident after it had occurred.
- Staff we spoke with did not have a good understanding of the recent duty of candour legislation and its requirements. However, we found that the principles were being followed. Staff were able to give examples of where things had gone wrong and how patients and families had been immediately informed and provided with support.

Safety thermometer

- We found on every ward a notice board with safety thermometer information. This had up to date safety information such as numbers of falls, pressure ulcers and urinary tract infections.
- On a set day per month, all patients that are inpatients or seen on the day are surveyed. The aim of Safety Thermometer was for patients to receive 95% harm free care against the four harms of: Pressure Ulcers, Falls, Catheters with urinary tract infection and Venous Thromboembolism (VTE). We examined the trust's latest report and found that the target had been exceeded and was 95.5%.
- We looked at data for the previous 12 months (Nov 2014 to Oct 2015) and noted that on six of those months the target had been exceeded with the highest score of 97.9% in December 2014. The lowest score in the 12 month period was 92.1 in May 2015.

Medical care (including older people's care)

- Venous thromboembolism (VTE) risk assessments were completed in the vast majority of cases. A list of all the newly admitted patients who were yet to receive a VTE risk assessment was sent to all the doctors and senior nursing staff to prompt the completion of the online VTE risk assessment form, and any subsequent prescription that may be required.
- Of the four fridges that were checked during the inspection, we found three occasions where the minimum and maximum temperatures were not being recorded, and only the current temperature was being taken. This meant that there was no assurance that the fridge temperatures had remained within the recommended range for the storage of medicines (2 – 8°c).
- Ambient room temperatures where medicines were stored were observed to be higher than 25°c on three occasions during the inspection. The pharmacy team were aware of the problem, and had given advice to nursing staff in an attempt to mitigate this risk. There was a future plan in place to eventually procure temperature controlled medicines cabinets.
- There was poor management of the Patient Group Directives (PGDs) in use across various clinical areas. The Senior Pharmacy team were aware of this and had implemented a management plan to improve the way that the PGDs were controlled.
- EPMA had not been implemented in the Emergency Department which had resulted in some previous issues around duplication of medicine doses.
- The EPMA system does not allow two people to administer or prescribe on the same drug chart simultaneously but does allow multiple people to view a drug chart simultaneously.
- The trust had implemented the use of a medication safety thermometer.

Cleanliness, infection control and hygiene

- All of the wards we visited were visibly clean and cleaning schedules were clearly displayed on the wards. Domestic staff had a rota to undertake regular cleaning and we saw them cleaning ward areas throughout our inspection We found that weekly cleaning schedules for wards had been properly completed.
- Staff followed the trust infection control policy. We observed that most staff regularly washed their hands in between seeing patients, used personal protective equipment (PPE), such as gloves and aprons when needed, and adhered to the trust's 'bare below the elbows' policy.
- On Nightingale ward we noted that two of the side rooms were being used for 'barrier nursing' to reduce the risk of cross infection to other patients. However, these two rooms did not have a sign on the door to warn staff and visitors that the occupants might be infectious and special precautions should be used.
- The Trust achieved their national threshold for C.Difficile in 14/15 and are below trajectory for the year to date with 5 reported cases and no lapses in care identified. There have been no MRSA Bacteraemias to date.
- Patient-led assessments of the Care Environment (PLACE) at the trust in 2015 scored better than the England average for cleanliness.

Environment and equipment

- Equipment was maintained and checked regularly to ensure it continued to be safe to use .The equipment was clearly labelled stating the date when the next service was due.
- We examined the resuscitation equipment on each medical ward. We found that there had been daily checks of resuscitation equipment which had been documented. All staff we spoke with knew where the ward resuscitation trolley was located.
- Office space for doctors is restricted which means that they are not always able to access computers and write up notes in a timely manner.

Medicines

- We observed that medicines, including controlled drugs (CDs,) were stored and managed appropriately across the trust.

- The use of summary care records (SCR) had been implemented at Whittington hospital to assist pharmacy staff with the completion of medicines reconciliation, which both pharmacists and some Medicine Optimisation Pharmacy Technicians were trained to do.
- Quarterly CD audits were conducted to ensure compliance to the trust CD policy.
- The medicines formulary, with information about medicines and prescribing guidance, was available to all staff on the trust intranet. Staff were able to generate patient information leaflets, tailored to the medicines taken by a specific patient.
- The EPMA system was used to identify missed doses of medication. However, the EPMA system was unable to pick up dose errors.
- We found that unlike most other medical wards, medicines management on Victoria Ward was poor. Because of the nature of patients on the ward and the low levels of experience of many of the nursing staff practices and procedures were not always adhered to. For example, the ward often ran out of required stock and had to borrow from other wards. Medicines often did not follow patients to other wards due to nurses not following procedures. Staff told us that the sickle cell patients were demanding to look after as they often needed regular pain relief (CDs) which required two nurses to administer.
- One patient we spoke with who had been on Victoria ward told us, " I was given medication one evening and 30 minutes later another nurse came to give me the same medication again. I was alert enough to point out the mistake but not all of the patients can do that".

Records

- We examined ten sets of patients' notes for each of the medical wards we visited. We found that in the vast majority of cases the notes were properly completed and entries were timed and dated with a legible signature. For example, we found that risk assessments had been completed and there were documented care plans.
- We examined ten sets of notes on each ward we inspected. We found that in most cases nutritional charts, pain assessment tools and care plans had been completed. Safeguarding information was present and comprehensive.

Safeguarding

- There were appropriate policies in place for the protection of vulnerable adults and the nursing and medical staff we spoke with demonstrated a thorough understanding of these policies and of their implementation. All trainee doctors had received safeguarding training as part of their induction. Nurses completed level 2 and 3 adult safeguarding training.
- Staff we spoke with were able to describe situations in which they would raise a safeguarding concern and how they would escalate any concerns. Staff we spoke with were able to give examples of when they had used the trust's safeguarding policy to raise concerns. For example, one nurse told us of a case where she raised a safeguarding alert for the family of a patient who could be violent when he drank excessively.
- The trust had a safeguarding policy, a designated consultant safeguard lead and a designated safeguarding nurse. Staff were fully aware of the process of engaging with the safeguarding policy and all we interviewed were able to describe the mechanisms for doing so

Mandatory training

- Mandatory training covered a range of topics including, child protection, equality and diversity, safeguarding adults,resuscitation, fire safety, infection control, moving and handling and conflict avoidance. Most staff we spoke with told us they were up to date with their mandatory training.
- Mandatory training rates for staff in the Medicine, Frailty And Networked Services ICSU varied greatly. As of November 2015 the trust reported that only 39% of medical staff had completed infection control training compared to 94% of nursing staff against the trust target of 90%. 100% of nursing staff had completed safeguarding training. For resuscitation training 78% of doctors and 81% of nurses had completed this

training against the 90% target. Individual areas had the following compliance rates; 81% for health and safety;65% for moving and handling; 61% for resuscitation and 74% for infection control.

- There was an induction programme for all new staff and staff who had attended this programme felt it met their needs. All new staff we spoke with said they had completed the induction programme.

Assessing and responding to patient risk

- Staff used the National Early Warning Score (NEWS) process and medical and nursing staff were aware of the appropriate action to be taken if patients scored higher than expected. We examined a number of NEWS records during our inspection. We found that scores had been calculated correctly, and where concerns had been raised by a high score the issue had been escalated.
- Staff told us they felt well supported by doctors when a patient's deterioration was severe and resulted in an emergency. Medical staff we spoke with told us that they were called appropriately by nursing staff when patients had deteriorated.
- Allergy status was completed for each patient record that we looked at on the electronic prescribing and medicines administration (EPMA) system, and on the corresponding handwritten drug charts.
- The EPMA system had a function that was able to prompt the nurses and doctors to review the need for an antibiotic each day prior to administration.
- The trust had a critical care outreach team consisting of two senior nursing staff during the day and one at night who were available 24/7. Patient notes we saw showed outreach reviewed a patient very quickly after being alerted.
- The clinical site practitioners' team consisted of senior nurses who were able to provide support to nursing staff who were caring for very sick patients. The members of the clinical site teams we spoke with knew exactly where the very ill patients were and had plans in place to provide extra support if needed.
- We observed the medical handover at 8 am. The handover was attended by six junior doctors and three consultants. Although there was no clear structure to the handover, the small number of patients who needed to be discussed, did allow enough time for all their key safety issues to be discussed. We observed good learning with junior doctors being able to be open and reflect on their practice. For example, one junior doctor said, " I could have done that instead".

Nursing staffing

- Nursing staffing levels had been reviewed and assessed using the National Safer Nursing Care Tool which was conducted every six months. Staff felt that senior managers would listen to their concerns about staffing levels. Managers told us that when there were nursing shortages on the roster, these would usually be made up from bank or agency staff. Managers told us they were trying to reduce the number of agency staff needed by increasing recruitment.
- Our inspection of the rosters showed that the staffing levels were compliant with the RCN recommended staffing levels. Where gaps in staffing were identified in advance for certain shifts in the month, the risk was controlled by the use of bank staff.
- Nursing vacancy rates were relatively low for medical wards generally running at around 10% of the whole time equivalent.
- The trust had reduced its usage of bank and agency nursing staff from April 2014 to February 2015. In April 2014 7.57% of all nursing pay was on bank and agency staff by February 2015 the trust had reduced this figure to 6.07%.
- Wards used a bank/agency staff check list which ensured that staff who were not familiar with a ward were informed of key procedures and where important equipment such as resuscitation trolleys were located.
- We had specific concerns with nursing staffing levels and on Victoria ward. This ward was expanded in August 2015 to take 33 patients. In the day, there are six registered nurses and three health care assistants (HCAs). At night, there are four registered nurses and three HCAs. In addition there is a senior (band 6) nurse on duty at all times and a ward manager in the day. The main concern is not the nursing ratio but the fact that most of the nurses working on the ward have

either been recently transferred from other wards or newly recruited to the trust. This meant that there were low levels of knowledge and experience in the wards practices and procedures.

- Victoria ward had six band 5 registered nurse vacancies and six HCA vacancies which lead to high levels of bank and agency staff usage. When we inspected the ward three of the nurses on duty were newly qualified with less than a month's experience in the trust. The trust was aware of the issues on Victoria ward prior to our inspection and had recently appointed a dedicated Matron as the ward manager. The ward deals with a wide variety of patients and during our inspection there were patients with sickle cell, patients detoxing from excessive alcohol consumption and many patients living with dementia. The variety of conditions and inexperience of nursing staff creates an additional risk to patient safety.
- Nursing staff we spoke with told us that they felt there were enough nurses to keep patients safe. One nurse told us "There are enough nurses on the ward, we get very busy but can keep everyone safe".

Medical staffing

- There were enough doctors to keep patients safe at all times. The hospital had 130 medical doctors to cover 197 in-patient beds. 31% of doctors were consultants compared to an NHS average for England of 34%. The hospital had a slightly larger percentage of junior doctors making up 28% of doctors compared to an NHS average of 22%.
- Doctors we spoke with felt there were adequate numbers of doctors on the wards during the day and out of hours and that consultants were supportive when present and contactable by phone if they were needed for support out of hours.
- The trust had reduced its usage of locum medical staff from April 2014 to March 2015. In April 2014 3.67% of all medical pay was on locum staff by March 2015 the trust had reduced this figure to 3.35%.
- The medical handover in the morning and at night with the 'hospital at night team' was observed. The process was led by the day acute medical consultant. The hospital at night team medical cover consists of one registrar and two core trainees.

Major incident awareness and training

- There was a major incident plan in place, with clear allocation of responsibilities and triggers for escalation, to deal with a major external incident and with internal incidents, including failures in electronic information systems. Many of the staff we spoke with had not had recent training in major incident preparation.
- There was an effective bed management system in place that ensured managers had a clear picture of where the demands and spare beds were in the hospital at any given time. This meant that in the case of space being needed in an emergency, the hospital was able to respond quickly and effectively.

Are medical care services effective?

Outstanding ☆

We rated the effectiveness of medical care as **Outstanding** because;

Care was provided in line with national and local best practice guidelines. Clinical audit was being undertaken and there was good participation in national and local audit that demonstrated good outcomes for patients.

We observed good clinical practice by clinicians during our inspection. Nursing and medical handovers provided evidence that key issues in patient care were being handed over and acted on. Senior clinical staff gave clear direction and support to junior staff to ensure patients received appropriate care.

The Hospital Standardised Mortality Ratio (HSMR), which is a score based on the expected mortality rate of 100, was below 67 for the hospital in October 2014, the lowest score for a non-specialist acute trust in England. The score remained under 70 in 2015.

The standardised risk of readmission for elective treatment in the trust is excellent with an overall score of 66 compared to a baseline of 100. For non-elective admission the score is worse than would be expected at 118.

The trust performed above the England average in heart failure, diabetes and myocardial Ischemia audits.

Medical care (including older people's care)

Evidence-based care and treatment

- NICE and trust guidelines were available on the trust intranet. Staff we spoke with told us that guidance was easy to access, comprehensive and clear. Nurses and Doctors were able to find guidance easily on the intranet when we asked them. For example, a nurse was able to describe NICE guidance on critical care and how it was complied with.
- A central trust team was responsible for arranging an appropriate clinician to review new guidelines and for disseminating them when they were approved. The trust guideline committee met monthly to ratify guidelines
- Staff told us that wards held weekly clinical governance meetings at which every death and transfer to the critical care unit was discussed with a view to developing leaning.
- For each death a letter is sent to the patients family within 14 days inviting them into a meeting to discus their relatives care.
- The medical division adhered to National Institute for Health and Clinical Excellence (NICE) guidelines for the treatment of patients. The trust had an effective process of monitoring the implementation of NICE guidance.
- A number of medicines related audits were conducted. Some examples include: Safe storage of medicines (conducted across the acute and community sites),Medicines Reconciliation, Non Formulary Prescribing for outpatients, Perioperative management of patients on long-term steroids, Effectiveness of prescribed pain relief medication in paediatric patients,Antipsychotics in dementia,Helicobacter pylori eradication prescribing, Omitted doses audit and Medical gases cylinders audit.

Pain relief

- The hospital had a pain service available for patients. This was staffed by a small team of nurses. Patients we spoke with told us that their pain was well managed and staff would respond promptly if they needed pain relief.
- On Victoria ward staff we spoke with told us that when they are busy they are not always able to provide pain relief quickly to sickle cell patients. This was partly because the controlled drugs needed have to be administered by two registered nurses.
- We observed staff monitoring the pain levels of patients and recording the information. Pain scores were recorded in most of the patients' notes we examined. Staff told us that the pain team were very responsive.

Nutrition and hydration

- A dietician was available on referral for the service and all the nutrition assessments and fluid balance charts we examined in patients' records were complete and up to date with documented dietician reviews. Nutrition and fluid plans were followed with fluid balances totalled and acted upon appropriately.
- Staff told us that patients were offered regular hot drinks and in addition, there were regular water rounds. Patients were offered three main meals and two snacks each day. We observed that the trust was using the Red Tray system to identify patients who may need support with eating. Patients we spoke with were generally positive about the quantity and quality of the food they received.
- We observed a number of mealtimes on wards and found that patients were given support when needed. The trust uses a number of volunteers who have be trained to help patients with nutrition.
- Two patients on Victoria ward we spoke with told us that they did not get the food they had ordered.

Patient outcomes

- The Hospital Standardised Mortality Ratio (HSMR), which is a score based on the expected mortality rate of 100, was below 67 for the hospital in October 2014, the lowest score for a non-specialist acute trust in England. The score remained under 70 in 2015.
- The standardised risk of readmission for elective treatment in the trust is excellent with an overall score of 66 compared to a baseline of 100. For non-elective admission the score is worse than would be expected at 118.

Medical care (including older people's care)

- The trust manufactured common cancer chemotherapy on-site, and had a close link with University College London Hospital (UCLH) for supplying more complex cancer treatments.
- We undertook an inspection of the Endoscopy unit which has its own designated area with separate male and female facilities. The unit had JAG accreditation which means that it is meeting a national agreed set of quality criteria for endoscopy. Staff followed all national guidelines and were in excess for example their monitoring frequency. We found the unit to be clean and tidy. Equipment was stored safely and had been serviced regularly.
- The trust has not recently been identified by the Dr Foster/CQC Outliers programme which identifies mortality outliers for a range of clinical issues.
- N-Stemi percentages in the Myocardial Ischaemia National Audit Project (MINAP) had been consistently better than the England average for both 2012/13 and 2013/14.
- There was a designated Diabetes Specialist Nurse (DSN) for all adults wards. The DSN carries out ward rounds on Mondays, Weds and Fridays routinely and identifies all patients with diabetes. The DSN can be contacted via a bleep should urgent advice be required for those presenting in ED or who require more urgent referral.
- The National Diabetes Inpatient Audit (NaDIA) – September 2013 showed performance as "better than other trusts" for 14 of the 20 indicators. However comparison between 2012 and 2013 showed that performance had decreased for 12 of the 20 indicators
- Trust performed well in the England and Wales Heart failure audit. The trust performed above the average score in 10 out of 12 areas of assessment. It scored above the average in all five areas of inpatient care.

Competent staff

- Staff we spoke with told us that the trust's initial induction programme was detailed and comprehensive.
- Continuing professional development time put aside and funding available.
- The trust had revised the appraisal scheme in 2015 to incorporate 'coaching conversations' which was expected to improve the understanding and of performance and improve development plans.
- Students felt supported in their learning and development by their more senior colleagues.
- Information from the trust indicated for the medicine division between October 2014 and October 2015 only 77% of staff appraisals had been completed against a trust target of 90%.
- During our inspection we observed a 'Grand Round' on the subject of infection control. This was an learning opportunity for all clinicians within the trust. There were 24 attendees including doctors, nurses and other health care professionals. The presentation was led by a consultant microbiologist supported by two junior microbiologist. The presentation was interesting and informative and gave staff opportunities to improve their own clinical practice.
- Nurses told us that they were given developmental opportunities, for example; nurses in the AMU had undertaken the AIMS course which further developed their skills in supporting sick medical patients.
- The pharmacy team were involved in the training of ward staff on how to use the EPMA system and were able to deliver this training on request.
- Nurses we spoke with were positive about the opportunities they had been given to develop new skills. Many nurses had undertaken additional training in areas such as phlebotomy, cannulation, IV administration and tracheostomy care.

Multidisciplinary working

- Throughout our inspection, we saw evidence of multidisciplinary team working in the ward areas. Clinical staff told us nurses and doctors worked well together within the medical speciality. There was a daily multidisciplinary board round which includes, doctors, nurses, and allied healthcare professionals.
- Physiotherapists, occupational therapists, pharmacists, dieticians, and social workers we spoke

with all told us that multi agency working was generally effective. Most of the allied healthcare professionals we spoke with told us that they felt part of the team.

- Mental Health services were provided by another provider. Staff we spoke with were aware of the steps they needed to take to access support from SLAM.

Seven-day services

- There were medical consultants working seven days a week in the trust. At weekends, consultant cover was 12 hours a day from 8am to 8pm. The ambulatory care unit has dedicated consultant cover five days a week with cover between 9am and 5pm at weekends. At other times, a consultant is always available for advice or to attend the hospital in an emergency.
- The Pharmacy department provided a full clinical pharmacy service to the whole organisation from 9am - 6pm, Monday to Friday. On Saturdays and Sundays there was a full clinical pharmacy service supporting the acute admissions unit, intensive care unit, neonatal unit, children's ward the acute surgical wards from 9am – 5.30pm. For the rest of the organisation there was a pharmacy service provided between 10am – 1.30pm on weekends. The department was also open on bank holidays and on Christmas Day.
- Staff we spoke with told us that the five consultant cardiologists do not have a weekend rota.At weekends cardiology advice has to be obtained from either Barts of the Royal Free hospital. However staff told us that getting advice was not easy and sometimes there would be a delay in the patients treatment as a result.
- All trust sites had access to an on-call pharmacist out of hours who could be contacted for assistance with medicines supply issues.
- At weekends, medical ward cover is provided 0900-2100 by a Core Trainee and a junior trainees, plus a ward cover Specialist Registrar 0900-1700. Consultant on site presence is for 12hr, 0800-2000 every day, to enable early senior review and decision making. Mon-Fri this is provided by a Consultant in Acute Medicine, at weekends by the on-call Consultant for Medicine.
- The radiography department was open seven days a week but with limited hours on Saturday and Sunday. A radiologist is on call at home and available to attend the hospital if needed. Staff we spoke with said that the radiography department was responsive to their needs and results were available promptly.

Access to information

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- Doctors and nurses we spoke with were able to show us on the trust intranet where NICE, Royal College and trust guidance could be found. For example a nurse was able to show us the NICE guidance on critical care, and another nurse was easily able to find the trust guidance on extravasation of patients receiving IV drugs.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We found that staff had a good understanding of capacity and consent issues and were able to describe the correct process for establishing capacity and obtaining consent. They were also able to describe where they would get further advice and support if needed.
- The trust had a target of 90% for the training of staff on the Mental Capacity Act and the deprivation of liberty safeguards. Training records provided by the trust showed that in the Medicine, Frailty And Networked Services ICSU only 55% of doctors and 76% of nurses had received this training.
- Deprivation of liberty assessments and documentation was not always being undertaken. For example, on Cloudesly ward we found that of six sets of notes were we would have expected to have found DoLS documentation it was only present in one set of notes.

Are medical care services caring?

Good

We rated caring in medical care as Good because:

Most patients received compassionate care and patients were treated with dignity and respect. Staff were focused on the needs of patients and improving services for them. Most patients and relatives we spoke with said they felt

involved in their care and were complimentary and full of praise for the staff looking after them. One person told us: "It's fine, I have no complaints, the staff are friendly and always come when I call them".

However:

Patients on Victoria ward were not receiving the good standards of caring that were apparent in the rest of the hospital. One patient on Victoria ward told us, " There just aren't enough staff working on the ward. They can't look after everyone properly".

Compassionate care

- The NHS runs a Friends and Family Test (FFT) which asks patients and families about their experience as in patients. In the medical division the response rate was 42% compared to a national average of 30%.
- To the core FFT question "How likely are you to recommend our ward to friends and family if they needed similar care or treatment?" The medical wards performance was variable. The best performing ward was Mercers with an average score between September 2014 and August 2015 of 98%. The worst performing ward was Nightingale with an average score of 78% for the same period.
- Patients we spoke with on Victoria Ward raised concerns about their care. Patients felt that there were not enough staff on the ward. Patients said that call bells were not answered within a reasonable time. Some patients had to wait over an hour for their call bell to be answered and four hours for a commode to arrive.
- The 2014 national inpatient survey gave a final response rate for Whittington Health of 29% compared with 35% for the previous year and 48% nationally. The Trust was in the top 20% for highest scoring in 7 survey indicators and in the bottom 20% for 17 indicators. Some of the areas with lower than average performance included patients bothered by noise at night.
- A number of recommendations from the survey analysis focused on: admission to hospital; the hospital and ward environment (including cleanliness, noise at night, food and support at meal times); doctors and nurses; care & treatment; and discharge arrangements.
- With regards to ratings for the overall experience, 74% of respondents scored their experience at 7 or above out of 10 (10 being very good). This compares with 80% nationally.
- Throughout our inspection, we observed patients being treated with compassion, dignity and respect. The patients and families we spoke with were generally pleased with the care provided. They told us doctors, nurses and other staff were caring, compassionate, and responded quickly to their needs.
- We observed that staff introduced themselves to patients and would draw the curtains or close the door if they needed to speak privately or undertake and examination.
- About 90% of the patients and families we spoke with were all positive about the care they had received, one patient told us, " All the nurses are very caring and have time for you, I never felt rushed". Another patient told us, "Staff check on me regularly and I could not fault this ward".
- About 10% of the patients we spoke with raised concerns about their care, the vast majority of these patients were on Victoria ward. One patient told us, "The staff just walk past you, they don't have the time to look after people properly". One relative said, " They haven't washed my mum properly and they left her uncovered and very cold".

Understanding and involvement of patients and those close to them

- Patients and families we spoke with told us they felt involved in their care. One patient told us, "Doctors have been very informative and kept me at ease with their plans".
- Results of the National Cancer Patient Experience Survey 2014 for the locality, the hospital had mixed results. Patients said they had confidence in the hospital staff but did not feel hospital and community staff shared information enough.
- We observed nurses, doctors and therapists introducing themselves to patients at all times, and explaining to patients and their families about the care and treatment options.

Emotional support

Medical care (including older people's care)

- We observed patients receiving emotional support from staff. However, when we asked staff what external or internal people they use to provide emotional support, such as counsellors, they were unable to tell us what was available other than the chaplaincy service.
- We spoke with a patient who told us that he had been feeling depressed. He said that the cheerfulness of the nurses on his ward and the time they had spent talking with him had helped him to feel much better. Another patient we spoke with said, " I had a couple of weepy days, but staff have been brilliant on both wards they have been super".
- We observed a singer from the 'Kissing it better' charity going from ward to ward singing songs requested by patients. This helped patients who were living with dementia to feel more comfortable and relaxed.

Are medical care services responsive?

Good

We rated the responsiveness of medical care as **good** because;

The medical division met the needs of its community. Elderly care pathways had been well designed to ensure that elderly patients were assessed and supported with all their medical and social needs.

The medical division was effective at managing inpatient admissions that either required emergency admission from ED or referral from a range of other sources, which included direct referral from GPs.

The hospital had designed pathways that, if possible, kept patients out of the ED department and keeps their stays in hospital to a minimum. The Ambulatory Care Unit, ED Department and MAU worked well together to ensure patients are placed on care pathways that meet their medical and social needs.

The trust did not put adequate arrangements in place for the patients of the Lower Urinary Tract Symptoms (LUTS) service, when that service had to be unexpectedly suspended.

Service planning and delivery to meet the needs of local people

- The medical division met the needs of its elderly community. 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. This meant that elderly patients spent less time in the ED and were either admitted to the ward or supported in going home.
- The hospital ran a consultant led lower urinary tract service (LUTS) service for about 900 patients. Concerns had been raised by clinical professionals and commissioners about the doses and durations of antibiotics that were being prescribed. The approach was not common in the field and was not approved by NICE. However, we spoke with four patients during our inspection and received evidence from other patients via e mail. All the evidence we received from patients was supportive of the treatment they had received with patients describing it as "life changing" and "my last hope".
- There was great concern about the suspension of the service at short notice, and about arrangements for the service in the longer term. The trust had held a public meeting where patients had been given the opportunity to express their concerns. Although the trust arranged to re-open the clinic after the unplanned suspension, patients remained concerned about the availability of future treatment. The patients were concerned that the trust did not have a clear plan in place for the longer term arrangements for the service.

Access and flow

- Referral to Treatment (RTT) performance has achieved all three standards for the last nine months although performance has deteriorated recently.
- In terms of cancer performance, over the past 6 months the trust had failed the 2 week wait for all cancers. This had been reviewed and attributed to a seasonal variation on skin cancer referrals in dermatology.
- The six week diagnostic wait had not been compliant since May 2015. However, unverified data reports that it

was back to compliance by the end of September. This had been due to an issue identified in May 2015 relating to endoscopy waiting times. This had been reported as a Serious Incident and the Trust had completed additional clinics to reduce the Endoscopy backlog.

- In May 2015, it was identified that there were a number of patients who had been incorrectly booked onto Patient Administration System (PAS) and were not offered an appointment for their procedure. This resulted in a back log of patients who were not seen within target timescales. A clinical harm review has been completed for all patients on cancer pathways which has not identified any incidents of harm as a result of the delays in undertaking their endoscopy investigation.
- There was a trust wide discharge planning and bed management team who were responsible for the co-ordination of capacity and bed availability. They liaised daily with individual wards to establish the numbers of patients on the ward and how many beds were available for new patients to be admitted into. Bed meetings are held at key time throughout the day.
- Staff we spoke with told us that the patient coordinator rings each person who has been discharged 24 hours after the discharge to ensure that they are still well and to receive feedback on their care and the discharge process.
- The average length of stay for most clinical area is in line with the England average. However, for geriatric medicine the average length of stay is much higher. For elective admission the average length of stay is 29.2 days compared to an England average of 20.7 days. For non-elective admissions the average length of stay is 10.7 days compared to an England average of 6.9 days.
- The trust is effective at managing the flow of patients through the hospital. The trust had developed effective pathways that reduce the need for patients to access services through the Emergency Department (ED). For example, they had established an ambulatory care unit (ACU) which was open on weekdays from 8am to 8pm and weekends from 9am to 5pm. The unit deals with a wide variety of complaints including low risk pulmonary embolism, blood transfusions, and cellulitis. GPs can directly access the unit and can telephone the units consultant directly.
- The trust had an acute medical unit which is open 24/7. This unit deals with patients who have been assessed by the ED department or the ACU and are still not well enough to go home.
- The trust had a facilitated early discharge service (FEDS). This was a small team of physiotherapists, occupational therapists and social workers who work with patients to ensure they spend as little time in hospital as necessary. The team was available to support discharges seven days a week from 8.30am to 7.30pm. Patients were given the FEDS telephone number should they have any problems after leaving the hospital.

Meeting people's individual needs

- The three largest nationality groups in the local area are Turkish, Spanish and Polish. The three language translations requested most often by patients are Turkish, Spanish and British Sign Language. Alongside face to face and telephone interpreting for non-English speakers, the trust provides British Sign language, Irish Sign Language, and lip speakers for those who have a sensory impairment.
- Interpreting provision is supported by two substantive Turkish interpreters and 80 sessional interpreters who work on an ad-hoc basis providing both face to face and telephone interpreting. For languages where the trust is not able to provide cover from our internal sessional pool, they use two external agencies.
- We observed staff speaking with patients who had difficulty in communicating in English. We observed that the staff took their time and used hand signals appropriately to facilitate communication.
- The pharmacy department had collated a list of languages spoken by their staff to assist with translation for patients whose first language was not English.
- The emergency and urgent care ICSU ran a 'virtual ward'. This meant that although patients were at home they were still under the responsibility of an acute medical consultant in the hospital. Patients

could be cared for this way for up to 14 days as long as they were medically stable. The service covered a range of conditions including; cellulitis, unstable diabetes, urinary tract infections and wound care. This approach not only helped patients to remain in their own homes but reduced the demand on in patient beds.

- Staff and patients expressed concerns about Victoria ward. Some staff described the ward as "chaotic" with an inappropriate patient mix, low morale and low levels of competency and capacity among nursing staff. Patients described it as an 'overflow' ward where nurses and doctors were too busy to provide good care.
- We observed a number of posters throughout the hospital advising staff how they could support patients who were living with a learning disability.
- A ward manger we spoke with told us that they us a 'forget me knot' symbol to identify patients who are living with dementia. This means they are able to provide greater support to these patients.
- The trust had a number of dementia champions. The trust used the 'This is Me' scheme to support communication of individual needs, and had introduced dementia identifiers and a dementia webpage on the intranet.
- The Trust had signed up to 'Johns Campaign', providing carers passports and allowing carers to stay with patients and support them. Patients and staff we spoke with were not aware that carers could stay with their families all day and night if they wanted to.
- There was an electronic flagging system in electronic patient record (EPR) which automatically generated an email to the learning disability nurse. The learning disability nurse was responsive and competent; however, staff were not clear what happened when she was not available.

Learning from complaints and concerns

- Staff told us that they did their best to deal with issues and complaints at a ward level. In the first instance, the ward manager would speak to the patient and their family and attempt to resolve the concern at an early stage. If the ward manager was unable to resolve the complaint then the Matron would usually arrange to have a meeting with the patient and their family.
- Between September 2014 and August 2015 there had been 44 formal complaints. Mary Seacole South and Mercers ward had received the largest number of complaints. We reviewed the complaints and found that there were no clear themes, however, many of the complaints referred to; poor clinical practice, poor communication with patients' families and patients believing they had been discharged too early.
- Staff we spoke with were able to describe what sort of complaints patients and their families were making. They told us that the two main areas of complaint were food and patients not feeling that they were kept informed about their treatment.
- On the wall in Acute Assessment Unit there was a 'You Said. We did' notice board setting out how the ward had responded to feedback. The board had a comment from a patient which read, " I was unable to see any clock, which meant I couldn't tell when my medicine was due". The ward response on the board was, " we have installed four new clocks to ensure that all beds on the ward have a clock in view". We observed that all the beds in the ward were able to view a wall mounted clock.
- Patients and family members we spoke with felt able to raise issues with staff. We observed that complaints leaflets were available in wards and public areas within the hospital.
- There was information about how to make a complaint in most of the wards. 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.

Are medical care services well-led?

Good

We rated the leadership of medical care as **good** because;

Medical care (including older people's care)

The Medicine, Frailty & Networked Service was well led; divisional senior managers had a clear understanding of the key risks and issues in their area. They were able to describe the complex health and social care landscape they were operating in, and how they worked within it.

Managers we spoke with were open and honest about where they needed to improve and had plans to make the necessary improvements. There was a clear drive and enthusiasm among managers to innovate services for patients.

Ward staff felt well supported by their ward sisters and matrons, and they told us they could raise concerns with them. Staff told us that they regularly saw divisional managers and clinical leads on the wards. Most ward managers and sisters we spoke with were passionate about improving services for patients and delivering a high quality service.

Senior managers were seen as visible and supportive by most of the staff we spoke to. Staff said that when things became difficult senior managers would be visible and if needed 'muck in'.

Vision and strategy for this service

- The leadership team of the Medicine, Frailty & Networked Service had a clear vision of the health and social care landscape in their area and how their services fitted into it. They had a clear vision of where the division needed to get to in the future.
- Staff generally unclear about the new ISCU structures
- No consultation about the trusts vision.
- ICARE; Innovation, Compassion, Accountability, Respect and Excellence.
- Most of the clinical leaders we spoke with also had a clear vision for how they would develop their specific services in the future. For example, the trust has plans to continues to integrate it care between the hospital and community services.

Governance, risk management and quality measurement

- We found that there was clear governance in place within the medical division. Regular patient safety meetings, monthly senior managers meetings and meetings of the risk board ensured key risks and performance issues were identified and acted upon.
- The risk register was regularly updated, with risks added to the register relating to patient care, technical issues, and recording failings. A manager took responsibility to monitor each risk, and they recorded regular updates, with mitigation plans put in place and action to eliminate risk when possible
- The managers of the Medicine, Frailty & Networked Service we spoke with told us that there was effective management of risk through a risk register supporting management meetings. We examined the risk register and found that the medical decision had fourteen risks on the corporate risk register. One of these was classified as 'extreme' and was described as 'Staffing levels to acute wards consistently running at or below 75% establishments'. There was evidence that the hospital had mitigations in place to reduce the impact of the risk.
- There were clear governance structures in the trust with adequate representation from trust pharmacists, local clinical commissioning groups and local provider organisations.
- Regular committee meetings were held, and new drugs applications as well as any issues concerning medicines in the trust were discussed.
- The trust was fully compliant with the directives from NICE that: all medicines with a positive NICE Technology Appraisal (which were relevant to the Trust clinical practice) must be available on the Trust Formulary, all Trusts must publish their formularies on their public website so it is transparent to all patients and the general public which drugs were available, a statement of compliance to the NICE TA guidance must be published on the site. The Medication Safety Officer highlighted any trends seen in medication incidents on the DATIX system.
- There was very little learning shared between departments about serious incidents
- Each clinical area held a monthly meeting attended by the managers, clinical lead, nursing lead and ward

managers. The board looked at risk, finance and key performance indicators on the medical 'Dashboard'. Ward boards are then held to disseminate information at ward level. We observed that there was a good focus on clinical risk and performance.

- The wards we visited had regular team meetings at which performance issues, concerns and complaints were discussed. Where staff were unable to attend ward meetings, steps were taken to communicate key messages to them.

Leadership of service

- Ward staff felt well supported by their ward sisters and matrons and told us they could raise concerns with them. 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. Nurse we spoke with said that the Head of nursing for the ICSU was very visible and supportive, she regularly attended ward meetings and provided updates on changes within the trust.
- We found that, throughout the medical division, clinical and non-clinical managers worked well together to identify risks and make improvements.
- Consultants are not all meeting their CDs regularly.
- We spoke with a number of divisional managers who had a good understanding of the issues in their clinical areas. For example, managers had identified that there was a need to further improve the delivery of endoscopy services.
- Junior and middle grade doctors felt well supported by their consultants and other senior colleagues. Medical staff felt supported by the medical leadership in the division and the trust.
- We observed good leadership skills during medical and nursing handovers. Senior staff were visible in leading these meetings and giving clear direction and support to junior colleagues.

Culture within the service

- Throughout our inspection it was clear that there was a patient centred culture within the hospital. In particular, the trust has a clear focus on meeting the needs of their patients. Staff we spoke with were proud to work at the trust and felt they gave patients good care.
- Financial concerns are worrying some staff, they don't know if they will have jobs or services will be cut.
- The trust had good levels of staff attendance with sickness absence being well below the England average for most wards. Outpatients nursing staff had high sickness levels at over 10%.

Public engagement

- Patients were engaged through feedback from the NHS Friends and Family test and complaints and concerns raised from PALS.Clinical governance meetings showed patient experience data was reviewed and monitored. However, there was no evidence of action plans to address issues raised by the public.

Staff engagement

- The trust performed within normal expectation in the General Medical Council (GMC) 2014 survey of doctors' opinion. With only one area being an outlier which was that doctors did not always feel they received feedback on their performance.
- The NHS Staff Survey for 2014 showed the Trust were in the top 20% of Trusts nationally for: colleagues feeling they had support from immediate line managers; few colleagues witnessing potential harmful incidents; few colleagues experiencing physical violence from patients or the public. The Trust was in the bottom 20% of Trusts for: appraisal; working extra hours; work related stress; bullying and harassment; career progression; and discrimination at work.
- Staff and managers we spoke with were not always aware that the trust had performed poorly in the last NHS staff survey but were not able to describe the details. None of the staff or managers we spoke with were aware of a plan to address the concerns raised in the staff survey.
- The trust undertook a friend and family test asking staff members; " How likely would you be to recommend Whittington Health to friend and family if

they needed care or treatment?". For the first quarter for 2015/16 77% would recommend the trust. However, only 60% of staff recommended Whittington Health as a place to work.

- The trust had low levels of turnover among many of its staff with some concerns around diabetes specialist nurses and administration staff.
- The Chief Executive Officer (CEO) held regular staff open meetings where staff were free to raise any issue they like. We spoke with many staff who had been to these meetings and they told us they felt able to raise issues and that the CEO had been open and transparent in his approach.

Innovation, improvement and sustainability

- Whittington Health worked well to avoid patients needing to attend hospital in the first place. As part of the drive to keep patients out of hospital, the integrate 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.
- Managers in the medical division expressed the view that the primary purpose was to do deliver existing good practice to a high standard rather than focus too much on being a national lead on improvement.

Surgery

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

Information about the service

Whittington Hospital provides a range of day case, elective and emergency surgical services to a mostly local population of patients from the boroughs of Islington and Harringey in North London. 10,987 surgical procedures were carried out in 2014 – towards the lower end of trust surgical activity nationally. Whittington Hospital is used mostly for day case and non-elective surgery, with 53% day case procedures, 18% elective procedures and 24% non-elective procedures in 2014.

There are six operating theatres at Whittington Hospital covering general surgery, orthopaedics, trauma and emergency and urology. They operate Monday to Friday, with additional availability for elective lists at weekends.There are four theatres in the Day Treatment Centre and a minor procedures room. The post-operative recovery facility has nine beds for inpatients and five for day cases. There are 66 inpatient surgical beds in three designated surgical wards.

Surgical activity at Whittington Hospital is managed by one directorate within the trust: Surgery and Cancer Integrated Care Service Unit (ICSU). Our inspection focused on the services provided by this ICSU only. During our inspection we visited all three surgery wards: Thorogood, Coyle and Mercers, the surgical admissions area, Day Treatment Centre, main operating theatres and the recovery area. We spoke with 20 patients and their family members. We observed care and treatment and looked at care records. We also spoke with more than 40 staff members, including allied healthcare professionals, nurses, doctors in training, consultants, ward managers and senior staff. In addition, we reviewed national data and performance information about the trust.

Surgery

Summary of findings

Overall we rated the surgery core service at Whittington Hospital as good because;

The surgery service had a good overall safety performance with low rates of serious incidents and few surgical site infections. We found good processes for reporting and escalation of incidents and good sharing of learning from incidents. All of the clinical areas we visited were clean and there were good infection control systems in place. However, there were significant staffing pressures across the service, particularly around recruitment and retention of nursing staff.

The surgery service at Whittington Hospital was effective. There were good patient outcomes across surgical specialties. The trust performed well in national clinical audits. There were short length of stay and low readmission rates. There was good multidisciplinary team (MDT) working. There were enhanced recovery processes for different patient groups. Good learning and development opportunities were available to staff.

Staff across the surgery service were friendly, caring and professional. Patients told us that nurses and doctors had a caring approach and they were treated with dignity. There was good family involvement and we found a very good approach to partnership care and keeping family members engaged at all stages of the surgery process.

There was good provision and systems in place to support patient's individual needs, including those with complex needs. Flow within the surgery system was well managed, particularly at the front end of the patient experience, from admissions through theatres and into recovery. However, flow was impacted by significant bed pressures on surgery wards. Surgery wards were used as overflow wards for medical patients.

We found a cohesive and supportive leadership team and there was a clearly defined strategic plan for the service. Leadership of the service was clinically led. Matrons were very visible on the ward and consultants provided clear clinical direction.

The escalation of risks was not robust. A number of identified risks were not addressed adequately or in a timely way. The service required investment by the trust to alleviate pressure and build capacity. There were some challenges with the organisation culture within the service, which impacted on staff morale.

Surgery

Are surgery services safe?

Good

We rated safe for surgery as good because;

The surgery service at Whittington Hospital had a good overall safety performance but there were some areas that needed developing.

Nurse staffing in theatres and on wards was adequate but there were significant staffing pressures across the service, particularly around recruitment and retention of nursing staff.

There were low rates of serious incidents, no never events, and good safety thermometer performance. We found good processes for reporting and escalation of incidents and good sharing of learning from incidents. All of the clinical areas we visited were visibly clean. There were good infection control systems in place. Equipment was clean and well maintained. Staffing in wards and theatres was based on acuity of patients. There was a good understanding of the trust's major incident policy amongst clinical staff. We found good completion of mandatory training and staff appraisals. The World Health Organisation (WHO) Surgical Safety Checklist was well-embedded in theatres.

We also found that the surgery service relied heavily on doctors in training during out of hours and weekends. Weekend emergencies were consultant supervised rather than consultant led. Infection prevention control was generally well managed but we found that equipment was not routinely labelled as clean and ready for use.

Incidents

- The surgery service reported no never events and two serious incidents in the year preceding our inspection. The surgery service had a very good overall safety performance for the period September 2014-September 2015, with a low rate of serious incidents including one grade three pressure ulcer, no falls with harm and no new catheter acquired urinary tract infections.
- The one fall in November 2015 resulted in a periprosthetic fracture, this was declared as a serious incident and an investigation was ongoing at the time of our inspection. The patient's family had been informed and a duty of candour letter was sent to them.
- Senior nurses told us that few patients in the surgery service experience falls while on the ward. We were told that falls occurred infrequently and most had not resulted in harm, but ward staff identifed elderly patients having orthopaedic procedures as a high risk group. We found that nurses mobilised patients quickly after their procedure to assist recovery, but the staff we spoke with recognised the risk of falls for some older patients. We were told of one instance of an elderly patient who deliberately threw themselves out of a chair because they did not want to go home. We saw falls prevention posters placed on walls around the wards, encouraging patients to wear shoes or non-slip socks to prevent the risk of slipping or falling while in hospital.
- The surgery service was represented at the trustwide falls group which met to account for all falls. However there was no falls lead within surgery.
- All of the staff we spoke to on wards and in theatres told us that they felt comfortable to report incidents. Student nurses and doctors in training were aware of how to report incidents using the trust's online reporting system. Junior staff were encouraged to escalate concerns directly to the appropriate matron and to the online reporting system.
- There was a trust-wide serious incident executive approval group, which was held weekly. The panel reviewed all incidents to determine if they can be classified as serious incidents. Investigation reports were presented by the appropriate manager within 72 hours.
- Recommendations following serious incidents were shared with leads of each department within the Surgery and Cancer ICSU board. Learning from serious incidents was shared on the trust intranet pages and in all staff emails so that all staff could access the information. Reports and recommendations following serious incidents were shared with leads of each department within the Surgery and Cancer ICSU. Learning points were also disseminated via email and at handover to all staff. Communication of learning from serious incidents was documented in ward meeting minutes, which were held every two to three months. Learning from incidents was also shared with clinical

and nursing staff at fortnightly audit meetings. The surgery and cancer clinical governance manager attended meetings with clinical and nursing staff in the surgery service each week to discuss reported incidents.

- The operating theatres at the Whittington Hospital clearly displayed a 'Big Four' notice board which included bullet points of learning from incidents and concerns. This was placed in theatres in recognition that some staff were not able to attend meetings to hear about learning from incidents.
- The surgery service used external investigators to ensure objectivity in root cause analysis investigations of never events and serious incidents. The external investigators were approved by the surgery clinical director.
- There was a patient safety week across the trust in November 2015 to improve understanding and engagement amongst staff. The trust had also developed refresher training for surgerystaff on reporting incidents. Senior nurses told us that the refresher training had helped to improve staff engagement in the process.
- The surgery service held monthly morbidity and mortality meetings where difficult surgical cases were discussed by consultants and doctors in training. All patient deaths and surgical complications were discussed at the morbidity and mortality meetings. Consultant surgeons reported a close knit group which fostered open and constructive dialogue in these meetings.

Duty of Candour

- We found that senior staff within the surgery service understood their responsibilities for duty of candour, and were able to describe giving feedback in an honesty and timely way when things have gone wrong. 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.
- Some junior staff were not aware of the term duty of candour, but when questioned were fully able to articulate how they would respond should a mistake happen. They appreciated the need for openness and honesty in the investigation of incidents.
- There was flowchart document which staff could refer to regarding duty of candour processes within the trust. The trust policy required that all incidents and supporting duty of candour processes were completed with 10 working days of the incident being reported.

Safety thermometer

- The NHS Safety Thermometer is an improvement tool to measure patient harm and harm free care. It provides a monthly snapshot audit of the prevalence of avoidable harms in relation to new pressure ulcers, patient falls, venous thromboembolism (VTE) and catheters and associated urinary tract infections (UTIs). The surgery service collected Safety Thermometer data on a monthly basis and the results were made available to wards managers.
- There was good Safety Thermometer performance of over 95% for harm free care across the surgery service for the two months prior to our inspection. In October and November there were no serious grade 2-4 pressure ulcers and no instances of CDiff, MRSA or MSSA infection. Across all surgery wards there were six falls, three medications errors and three complaints recorded.
- Safety Thermometer performance data were clearly displayed on information boards at the entrance to each of the surgery wards. This included accessible and easy to read charts and graphs to demonstrate performance in infection rates, pressure ulcers and patient falls.

Cleanliness, infection control and hygiene

- All of the clinical areas we visited were visibly clean. The environment across the surgery wards and theatres was clean, tidy, well organised and clutter-free. All floors in corridors were clean. Infection prevention and control was generally well managed.
- Dashboard reports for the surgery service reported 100% hand hygiene compliance across the service for the two months prior to our inspection. Compliance with infections control policies and processes was recorded at above 95%
- There were no cases of MRSA, MSSA or CDiff reported in the three months prior to our inspection.
- The Director of Operations and Head of Nursing for surgery conducted hygiene spot checks twice per week to help improve compliance.
- We reviewed cleaning schedules and policies which were held in a folder in the domestics room on each

ward. The policy included handwashing, work schedules, COSHH, confidentiality, security and safety. There was a detailed and comprehensive schedule of cleaning activity.

- There were three domestic staff allocated to each ward. Full time cleaning cover was between 7am and 5pm. Cleaning staff were visible on the wards and we saw them mopping floors and wiping surfaces.
- There were appropriate infection prevention and control processes on wards and in theatres. Thorogood ward was ring fenced for patients having orthopaedics procedures and cleaning protocols were in place to ensure appropriate infection control for at risk patients. We were told that other groups of patients, such as gynaecology patients and those having general surgery procedures were allocated to Thorogood ward and these patients were located in individual side rooms for infection control purposes. We were told that each room was given a deep clean after non-orthopaedic patients were discharged . Nurses told us that this occurred two to three times per week and that the allocation on non-orthopaedic patients was impacting on the workload of the ward domestic team.
- Side rooms were used to care for patients where a potential infection risk was identified. This was to protect other patients from the risk of infection. Signs were in place at the entrance to side rooms which were being used for isolating patients, giving clear information on the precautions to be taken when entering the room.
- All staff were given hand washing instruction during their induction and oritentation to the wards and theatres. Hand cleaning instructions were visible on wards and in theatres, with posters displaying information on the importance of hand washing. We observed clinicians, nurses and allied health professionals cleaning their hands and following hand hygiene procedures.
- There was easily accessible handwashing gel facilities located at the entrance to each ward, throughout wards, theatres and the day surgery unit.
- There was easily accessible personal protective clothing such as latex gloves and plastic gowns and we saw staff using this appropriately when delivering care. We noted that all staff adhered to bare below the elbows guidance in clinical areas.,
- We checked sluices on wards and in theatres and all were clean, tidy and well organised. In one sluice we found an overloaded clinical waste bin, but this was an isolated case.
- The toilets and shower facilities we inspected were clean and tidy.
- The equipment we reviewed was visible clean, but equipment was not routinely labelled as clean and ready for use.We did not find evidence of stickers to indicate when equipment had been cleaned and by whom. For examples, bed pans and wash bowls were not labelled so it was not clear if they had been cleaned. Other equipment like blood pressure monitors were also not labelled.
- All commodes were deep cleaned by the trust's sterilisation services to minimise risk of infection.
- We saw that clinical and domestic waste was appropriately segregated and that there were arrangements for the separation and handling of high risk used linen. We observed that staff complied with these arrangements. However, there were no posters or labels to identify what should be disposed in different bins.
- We observed that sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. We saw that sharps containers were used appropriately and that they were dated and signed when brought into use. There were adequate and well placed syringe disposal bins at the entrance to each bay on wards.
- There were low rates of surgical site infections at the trust. The surgery service undertook surgical site infection surveillance of selected procedures, which was coordinated by the Centre for Infections at Public Health England. The trust contributed data for repair of neck of femur and knee replacement site infection rates on a quartlerly basis. For the period January to March 2015 the trust was performing comparable to the national average, with 2.6% of knee replacements patients experiencing a surgical site infection compared to a national average of 1.6%, 0% of hip replacement compared to 0.6% nationally, and 0% for repair of neck of femur compared to 1.6% nationally.

Environment and equipment

- We checked medical equipment records which demonstrated that equipment was checked on a daily basis. The equipment we checked, such as blood

pressure machines, were all clean and in good operating order, but the surgery service did not use a labelling system to visibly display when equipment had been cleaned and by whom..

- In theatres, equipment was neatly organised, clean and available in marked trollies. Drawers were labelled for ease of use.
- We saw resuscitation equipment available in all clinical areas with security tabs present and intact on each. Systems were in place to check resuscitation equipment. We saw that checklists were completed daily and in full and audit and policy documents were present, signed and up to date for all resuscitation trolleys that we checked. All necessary trolley equipment was present and sealed as appropriate. There were daily logs for equipment in each bay, such as wall suction and emergency bells.
- There were dedicated sepsis trolleys on surgery ward with a clearly displayed pathway and algorithm for staff to use for unwell patients. This was introduced by the trust's critical care outreach team. On inspection, the sepsis trolleys contained all required equipment and medication for unwell patients.
- We were informed by staff in the day surgery unit that the unit needed new crutches for patients, but they had been instructed not to order them because there were too many being ordered. Staff told us that they had to borrow crutches from the A&E department.
- We observed that ward bays and corridors were generally kept clear of equipment therefore avoiding trip hazards so that people were kept safe.
- We saw that all electrical medical equipment had a registration label affixed and that it was maintained and serviced in accordance with manufacturer's recommendations. We also saw that Portable Appliance Testing (PAT) labels were attached to electrical systems showing that it had been inspected within the last 12 months and was safe to use.
- In theatres there were systems in place for staff to report broken equipment or theatre infrastructure that needed to be fixed by the trust facilities team. The facilities team provided confirmation via email to inform staff once a fix was completed.
- Staff in theatres told us the trust's equipment sterilisation service was understaffed and this had resulted in equipment placed in the wrong area of theatres. Staff told us that they spend up to 15 minutes searching for equipment which was impacting on theatre efficiency. We were told that this concern was reported to the theatre matron but errors were still occurring.
- The main theatres and day surgery unit were quiet and calm environments, despite being busy. The recovery area of the main theatres was refurbished in 2015 and theatres appeared well maintained. There was adequate and well organised storage space for equipment in theatres. The medical electrical equipment we checked was all charged and ready for use.
- All of the wards we visited were quiet and calm and provided for a peaceful atmosphere for patients. Patients told us that the wards were generally calm despite being busy. Most of the patients we spoke with said that the wards were quiet overnight and they managed to sleep.
- We found that some rooms within the surgery areas were very high temperature, particularly in the pre-operative assessment area and in treatment rooms.

Medicines

- Evidence seen during our inspection showed that medicines including controlled drugs (CDs) were stored and managed appropriately across the surgery service.
- Patient records included appropriate drug history and prescribing information. Allergy status was completed for each patient record that we looked at on the electronic prescribing and medicines administration (EPMA) system, and on the corresponding handwritten drug charts. Drug history was completed for each patient and this information was documented on the EPMA. A pharmacist reviewed each EPMA drug entry.
- In patient records we observed that some missed doses were recorded, but each instance clearly documented the reason why the dose was missed.
- Across the surgery service, the nurse in charge of a ward or clinical area was responsible for holding the keys for the drugs cupboard.
- In the recovery areas we witnessed a member of staff taking morphine from the controlled drugs cupboard but the controlled drugs log book was not available so the staff member left a paper note to record what drugs had been taken from the cupboard. This is not good practice.
- We conducted a thorough spot check of medicines management on Coyle ward during our inspection. An

inspection of the controlled drugs cupboard stock check record found that the quantities of controlled drugs recorded in the CD register and what was available in the cupboard was correct for most products.

- We checked a sample of drugs fridges on the surgery wards. All of the fridges we checked were locked appropriately and their temperatures were in line with the recommended range. Temperature records were up to date and signed appropriately. However, on Coyle ward we found that only the current fridge temperature was monitored; and no minimum or maximum temperatures were recorded. This meant that there was no assurance that the fridge temperatures had remained within the recommended range for the storage of medicines (2 – 8°c).
- Treatment rooms were clean and tidy, with medicines stored securely. The ambient room temperature of treatment rooms was monitored daily, however the rooms were very warm. On Coyle ward the temperature was recorded consistently above 25°c. Medicines and IV fluids were stored in the treatment rooms.
- Emergency boxes were available in treatment rooms with the expiry date clearly labelled.
- Medicines to take out (TTO) were stored securely and appropriately in the designated cupboard and patients' own drugs (POD) were stored securely in lockers next to the patient's bed. Keys to the drug cupboards and POD lockers were held by a registered nurse and the doors to the room housing medicines were locked.
- On surgery wards we found that drug trolleys were not seen chained to a wall or immobilised when not in use. However, the medicines inside were appropriately locked by an electronic keypad.
- In main theatres, drugs cupboards were well ventilated and locked appropriately, with appropriate labelling for different drugs on shelves. Controlled drugs cabinets were locked and the key held by the nurse in charge.

Records

- Most patient care was recorded in paper records. Electronic record systems were used for storing and viewing x-ray and scan images. We reviewed a sample of patient records on the surgery wards and found that they were mostly completed in a comprehensive, legible way. Nursing and medical notes in patient records were interspersed and not always logically organised, but all were up to date and fully completed.
- Patients' observations were recorded and national early warning scores (NEWS) were calculated in accordance with guidance. Nursing assessments were completed, including falls assessments, assessment for pressure areas and nutritional status. Care plans included all identified care needs. However, our review of patient notes found that venous thrombo-embolism (VTE) assessments were not completed for all patients or consistently available in notes if they had been completed.
- Fluid balance charts were completed in patient records, however nurses told us that they were not always completed properly across surgery wards as the morning observations was not always recorded in morning notes. Nurses told us this recording of fluid balanace observations was sporadic, very much nurse dependent and not always a complete or accurate reading. We were told that senior staff were aware of this and it was improving as ward managers were reiterating the importance and conducting checks on patients notes. The trust's critical outreach team and practice development nurses were also leading on work across the hospital to improve recording of fluid balance charts.
- On wards and in theatres, patients notes were stored in moveable trolleys which were securely locked with a digital lock. There were ward clerk who coordinated medical records. However, we observed some patient notes lying around in the day treatment centre and saw the notes trolley left open and unsupervised.
- In the main theatre recovery area we found a computer station left open and not locked which meant that identifiable sensitive patient information could be viewed and accessed.
- Staff on wards used whiteboards to record core patient information such as name, estimated date of discharge, allocated physiotherapist/occupational therapist, and imaging requests. Names of staff on duty were clearly documented, with their allocated patients. In theatres, a display board recorded the names of each patient, their allocated consultant and bay location.
- There was adequate availability of computer stations to record patient observations and results of investigations.

- In theatres, operating lists were printed out and clearly displayed. Alerts were visible and clearly labelled, for exampled patients' post-procedure requirements (such as high dependency bed) and allergies. Day case / inpatient status was also clearly marked.
- Data collection of photographs and video within theatres was recorded as a risk on the surgery risk register, as staff had to manually back up these data. We were told that theatre staff did weekly back ups and monthly audits. There were regular meetings between to theatre repsresentatives and the trust IT team to ensure that data were stored correctly. The surgery service completed audits of records to ensure that patients were aware and had consented to image recording and retention.

Safeguarding

- There was a trust wide policy for safeguarding vulnerable adults and children. The policy and protocol for safeguarding referrals was available for staff to access via the trust's intranet and in paper copies which were displayed on the walls within the ward managers' offices on the surgery wards. The trust's Deprivation of Liberties Safeguards policy and process was also available for staff to access on the trust intranet.
- The staff we spoke to were able to explain their understanding of safeguarding and the principles of safeguarding for children and adults. They were clear about the trust's safeguarding escalation process. Some student nurses we spoke with were not entirely certain about processes for escalating safeguarding concerns, but they explained that they would seek guidance and advice from a senior nurse if they needed it.
- The nurses we spoke with were aware of the policies and protocols for seeking a safeguarding referral and escalating safeguarding concerns. However, few of the staff we spoke with had had to liaise with the trust safeguarding team. This was particularly the case in Thorogood ward as most patients allocated to that ward were for elective procedures.
- Safeguarding vulernable adults and children was included as part of mandatory training for all staff.
- The trust had implemented guidance on female genital mutilation awareness and reporting.
- All clinical staff were required to complete level one adult safeguarding training on an annual basis. Senior nursing staff such as ward managers were required to complete level two training. Level three training was for senior staff who may instigate and carry out safeguarding investigations and proceedings. All clinical staff were required to complete level one adult safeguarding training upon joining the trust, and then every three years. All staff with patient contact must complete level 2 training, repeated every three years. The trust's intercollegiate document for adult safeguarding was still in draft form, and will be adopted once finalised. This will then allow the trust to develop a training programme for those staff requiring level 3 training. Data for surgical wards and theatres indicated that 62% staff had completed for level 1 and 85% for level 2.

Mandatory training

- The surgery service recorded and monitored completion rates of mandatory training for all staff groups. This was reported on a monthly basis.
- The trust's corporate induction for a new staff was part of mandatory training. It included infection preventation 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.
- Newly appointed permanent medical staff completed a two week local induction period, with tailored input by clinical specialists. Doctors in training told us that their induction was very good.
- Nurses and health care assistants completed a one week tailored local induction, with assessment by senior nurses.
- Temporary agency staff were required to complete a local induction checklist with the ward sister expected to take them through induction. Bank staff were also required to complete local induction.
- The trust provided an induction pack for all new staff. Surgery matrons had also developed a local induction pack which included business processes on the ward and contact details.
- The target set for the trust for completion of mandatory training was 90%. Across the surgical wards and theatres in the trust compliance figures averaged 80% for all surgical staff at the time of our inspection.

- Staff across nursing, allied health professional and medical groups had access to their training records on the trust's electronic staff record system. This informed staff of all completed mandatory training and renewal dates and sent email alerts when training was due.
- An information board in the theatres staff room had a list of staff with outstanding training for completion, which training was required and renewal date.
- Some nursing staff and health care assistants told us that they enjoyed group training sessions but they felt that most online mandatory training was repetitive. They felt that the trust's approach to mandatory training did not promote genuinely learning and was "a tick box exercise".
- Newly qualified nurses had a preceptorship pack which contained all of their competencies. They were required to develop competency over a two year period after qualification. Mentors were assigned to newly qualified nurses to help them through each of the competences.
- Newly qualified nurses were allocated half a day in the trust's plaster room to familiarise them with that aspect of trauma and orthopaedic care.
- We were told that orientation and induction for new staff was not managed centrally by the trust education department and as a result the first few days of the job can feel disjointed and impact on the first impressions of new members of staff. Ward managers were expected to organise induction for their new nurses and this took up a lot of time and detracted from managing the ward. It also meant that aspects of induction could be delayed such as booking new staff on the corporate induction.

Assessing and responding to patient risk

- Patients' clinical observations were monitored in line with NICE guidance CG50 'Acutely Ill-Patients in Hospital.' A scoring system known as a national early warning score (NEWS) system was used to identify patients whose condition was at risk of deteriorating.
- We saw that staff in surgical wards recorded the observations of patient safety parameters such as heart rate, respirations, blood pressure, temperature and pain. These were hand written in the patient notes. Patients were assessed for actual and potential risks related to their health and well-being and we saw evidence of these in patient's notes.
- Nurses were trained in NEWS competency, with a training programme delivered by senior practice development nurses in the hospital. The training was not part of mandatory training so it was provided to nurses across the trust to ensure all nurses were trained in the fundamentals of nursing care. Competency was signed off by the mentor of the individual.
- Nursing staff told us they would call the doctor if they were concerned about a patient but some staff we asked were unsure about when to make an emergency call.
- Senior nurses told us that the surgery service was working hard to improve awareness of deteriotating patient escalation protocols. There a drive to use a structured communication tools such as Situation, Background, Action, Result (SBAR) to escalate concerns.
- The surgery service had worked with external partners to develop a deteriorating patient dashboard with process and outcome measures to audit performance of vital signs recording, timeliness of referral and timely transfer to critical care.
- At the time of our inspection the trust had just appointed a new resuscitation lead, and there was a desire amongst senior surgery leaders to combine the outreach and seven day services. The service was available every day from 8AM-8PM and the surgery service was seeking for this to be extended to 10PM each day to obviate problems that might come up over night.

Use of the 'five steps to safer surgery' procedure

- 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. 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.
- Medical and nursing staff in theatres told us that the process was well embedded within the surgery service, including team briefings, but they highlighted that debriefings at the end of a theatre list needed to be more commonplace.
- There was a comprehensive integrated perioperative care document which incorporated the WHO checklist within patient notes so that the information followed the patient pathway automatically. This documentation

facilitated the completion of different stages of the checklist, however on further investigation we found that WHO checklist sign out sheets were missing in some patient records.

- A registered member of the perioperative team was responsible for ensuring that the use of surgical safety checklist was recorded in the patient clinical notes.
- Tailored safer surgery checklists for speciality such obstetrics and ophthalmology, were developed in line with the nationally produced guidance from respective Royal Colleges.
- There was provision within the staff induction for new member of theatre staff, including agency staff, bank staff and students in the department to be trained on the use of the five steps to surgical safety.
- The surgery service audited WHO checklist compliance in September 2015 over a period of 6-8 weeks covering main theatres and DTC, covering specialities of general surgery, trauma and orthopaedics, gynaecology and obstetrics and ophthalmology, using an audit tool validated by the Association for Perioperative Practice (AfPP) to bench mark against standards.
- The audit found good general compliance with completing the checklist across the service, for example, most specialities in theatres completed the team brief, sign in, time out and sign out appropriately. However, the audit found that one specialty completed the checklist in a hurry, probably due to the emergency nature of that theatre. Only one speciality was observed to undertake a debrief at the end of the day list.
- The key findings of the audit indicated that the service needed local champions to drive the agenda of the five step to safety in the department and to support consistency in practice. It also identified the need for regular audit to give reassurance that all the staff are compliant with good practice. It was noted that only one speciality had a local champion. The audit report recommended that the department implement local champions from both medical and nursing staff to promote good practice with the surgical safety checklist; to ensure that debrief take place at the end of the day list, so that lessons can be learnt; and implement a rolling audit calendar to ensure audit was undertaken every 2-3 months. There was an action plan in place to address each of the recommendations.

Nursing staffing

- Nurse staffing in theatres and on wards was adequate but there were significant staffing pressures across the service, particularly around recruitment and retention of nursing staff.
- Safe staffing levels were updated on a constant basis using a safe care e-system. The acuity tool used was the Safer Nursing Care Tool which measured the number of required nursing shifts based on acuity of patients and automatically risk rated the requirement. Full nurse staffing requirement was measured twice yearly using detailed patient acuity measure. These audits were completed by the ward manager or shift leader and validated by the Head of Nursing or delegated matron.
- The ward manager or shift leader made an assessment of the acuity of patients at 3pm each day. Each patient was graded dependent upon their care needs.
- There was an annual large scale review of establishments which takes into account acuity tool results, nursing hours per bed day, ratio of 1:8 and benchmarking against similar wards in other trusts. The last review recommended no change to the nursing establishments, but as a result of changes to the number of beds in one of the surgical wards, minimum staffing levels had been increased.
- Coyle ward had 24 beds, Mercers ward had 16 beds, and Thorogood ward 10 beds. Minimum nurse staffing for Coyle on the day shift during the week was five nurses and two HCAs, on Mercers was five nurses and one HCA, and on Thorogood was two nurses and one HCA. At night Coyle had three nurses and two HCAs, Mercers had three nurses and one HCA and Thorogood had two nurses and no HCAs.
- In main theatres there were staffing pressures and staff told us that theatres were not always well staffed. There were two members of staff off sick during our inspection who were not replaced, and no bank or agency staff were used. We were told that this was a common occurance and nurses and ODPs provided extra support where needed.
- Consultants, ODPs and theatre nurses told us that nurse staffing levels and the ratio of nurses to patients in the theatres recovery area was a cause for concern. Vacancies were not filled and there were times meant there was not one to one nursing care in recovery. We saw data that demonstrated theatres were running at usual capacity even though there were inadequate recovery staffing numbers.

- There were also staffing challenges in the pre-operative assessment unit, as a result of recently increased activity but no increase in establishment of nurses and a high number of vacancies which staff told us impacted on safe staffing levels.
- Nursing staff across the service told us that staff shortages were impacting on staff morale as the workload was increasing. Some nurses told us that the lack of staff left them feeling exhausted and crying. Some worked beyond their shifts and returned home late which impacted on their family life. Nurses had reported their concerns to senior staff within the service and felt that they had been listened to as managers had approved the recruitment of new nursing staff and these had been appointed within the past six months.
- At the time of our inspection there was a full establishment of nursing staff on Mercers ward and no reported staffing problems. Coyle ward had vacancies for one band 6 nurse and two HCAs at the time of our inspection. Ward managers told us that they had increased staffing establishment figures to reflect an increased number of patients on the ward. However, they reported that recruitment was challenging. There was a full establishment of nurses and one HCA on Thorogood ward. There was an identified need for an extra HCA on the night shift because the two night nurses were very busy.
- The service had recruited a number of new nursing staff to Coyle ward in the months preceding our inspection. This included a number of Portuguese and Filipino nurses and increased bank usage. We met a number of the new nurses and all had excellent English language skills. Ward managers told us that some new nurses required additional support to develop their clinical skills and training was being put in place. Some Filipino nurses experienced delays of up to six months with registering with the NHS and Nursing and Midwifery Council and were having to work as healthcare assistants as an interim measure.
- Ward managers told us that the service was recruiting new nurses on a monthly basis to cover winter pressures.
- There was frequent use of agency nursing staff to fill roster gaps and sickness absence. Ward managers told us that that internal bank staff were used as a preference, but agency staff were employed on average 4-5 times per week. Staff told us that the service tried to use known agency workers but the complex patient mix and heavy workload meant that few agency nurses returned for another shift.
- Safe staffing levels were discussed at trustwide daily morning meetings . Matrons and ward managers discussed establishment and actual staffing numbers and negotiated transferring nurses between ward to ensure there were safe staffing numbers. Surgery wards did not have partner wards, but ward managers and matrons flexed staff within surgery before seeking staff from other wards. Senior nurses reviewed required skill mix, experience and agency usage before flexing a nurse from another ward. However nurses told us that it happened 3-4 times per week on average and that they sometimes felt coerced into working on another ward.
- Health care assistants on wards told us that they were frequently asked to act up to complete nursing tasks and they felt expected to provide the same level of services as a qualified nurse.
- The number of nursing staff on duty was clearly displayed at the entrance to each ward.
- Nursing rosters were recorded on a spreadsheet, but the trust was introducing a web based e-roster for staff to access remotely. Nurse working patterns were 12 hour shifts, with four days on, three days off. Some nurses reported that the long shifts were very intense.
- There were effective nursing handover processes in place to ensure transfer of information between staff at the end of each shift. Handover was held 7:30am and 7:30pm, with an additional ward meeting at 1:30pm to review patient status. The trust had introduced a daily electronic handover sheet which all wards used. This included the name, age, diagnosis, mental health status, infection status, bed number, consultant, and estimated date of discharge of each patient. Staff told us this had improved consistency of handover between wards and that handover worked well. Ward clerks were included in handover so that logistical arrangements could be made for patients. Senior nurses told us that the next step was to introduce a structured communication tool such as SBAR to make handover more consice and focused. Student nurses reported that handover was robust and thorough and helped them to plan the day ahead.

Surgical staffing

Surgery

- Surgical treatment at Whittington Hospital was consultant led. There was a stable cohort of consultant surgeons and anaesthetists working in the surgery service and many doctors we spoke with had worked at the trust for many years.
- The surgery service had a lower percentage of consultant surgeons compared to the England average, with 35% of medical staff at consultant level compared to a national average of 41%. The surgery service relied more heavily on higher tier doctors in training (ST1-6 grades) with 48% compared to 37% nationally. There were nominally fewer foundation doctors in surgery posts at the trust, with 9% compared to 12% nationally.
- The medical rota was well staffed and well managed. The service had recently appointed a number of staff grade doctors to fill gaps. Consultant surgeons told that the service rarely used agency or locum consultants, with one locum consultant used in the four months prior to our inspection. There were two long term locum consultant surgeons in trauma and orthopaedics. All rotas for medical staff were managed by one rota coordinator.
- There were some challenges with weekend cover, and we found evidence that weekend operating lists were not always consultant led. Doctors in training told us that weekend emergencies were consultant supervised rather than consultant led and middle grade doctors managed the service on weekends.
- We also found that theatres roster was not well organised. There was no rolling programme of allocating staff in charge and no ongoing tally of hours worked. Theatres used a two week roster which made it difficult to plan operating lists. It was not clear what hours were being worked and by whom.
- The medical rota highlighted that a foundation doctor was resident every day until 7pm, with a higher tier doctor in training covering the night shift with access to an on call consultant surgeon. There was a resident higher tier doctor in training and an on call consultant surgeon available at weekends. Consultants in some surgical specialties were present on Saturdays for operating lists.
- Doctors in training told us they felt well supported by consultants and reported good access to supervision, teaching and advice Consultants reported positive feedback from doctors in training and locum doctors. The trust had seen a reduction in the number of surgical training posts allocated by Health Education England.

Major incident awareness and training

- The staff we spoke with in the surgery service had a good understanding of the trust's major incident policy and protocols. Nursing staff were able to refer to the major incident plan emergency box in the ward managers' offices.
- We saw the major incident plan emergency box which included action cards for major incidents and the contact telephone numbers of all staff. It also included a role description of emergency manager and a tabard for the emergency manager to wear. There were trustwide policies on terrorist attacks, hospital site lock down and dealing with suspect packages.
- There were protocols in place for deferring elective activity to prioritise unscheduled emergency surgery procedures.

Are surgery services effective?

Good

We rated the effectiveness of surgery services as Good because:

There were good patient outcomes across surgical specialties.

The trust performed well in national clinical audits.

There were short length of stay and low readmission rates.

All of the patients we spoke said they had effective and timely pain relief.

Doctors in training and student nurses felt well supported with good supervision and good training opportunities.

There was good multidisciplinary team (MDT) working between doctors, nurses and allied health professionals, including dedicated physiotherapists and occupational therapists on each ward. T

here were enhanced recovery processes for different patient groups.

Learning and development opportunities were available to staff, but some HCAs felt that their career development within the trust was limited.

Evidence-based care and treatment

Surgery

- Staff accessed policies and corporate information on the trust's intranet. There were protocols, policies and guidance for clinical and other patient interventions and care on the intranet.
- We reviewed a sample of trust policies for surgery and found appropriate reference to relevant National Institute for Health and Care Excellence (NICE) and Royal College guidelines.
- The trust's policy for recognition of and response to acute illness in adults in surgery services was provided in line with NICE CG50 guidance (see assessing and responding to patient risk in safe section) and post-operative rehabilitation services were provided in line with NICE CG83 guidance on rehabilitation after critical illness in adults, with good enhanced recovery processes for patients after colorectal and orthopaedic procedures.
- Implementation of new guidelines and regulations was managed by clinical leads with support from the quality and risk manager for surgery. There was a central risk management team within the trust which disseminated new guidelines to heads of nursing. This information was then cascaded to staff via ward and theatre managers. New policies and guidelines were also printed and sent to post pigeon holes for all staff to read.
- Printed copies of trust policies and guidance were available in 'communications books' on each ward and in theatres. The folder also contained audit information. There was also a 'good stuff to read folder' in ward managers office which contained other useful information for nurses and HCAs.
- There was a clinical audit programme for 2015/16 document which highlighted the surgery service's involvement in local and national audits. The surgery service participated and performed well in national clinical audits. The trust performed higher than the England average for five indicators in the national hip fracture audit. In the bowel cancer audit the trust scored better than the England average and was 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.
- However, 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.
- In main theatres, ODPs conducted monthly infection and hygiene, health and safety and fire safety audits.
- Audit outcomes and performance was presented at the trust patient safety committee.
- Consultant surgeons were engaged in clinical research. There was a programme of surgery service evaluation projects, which included research on stenting interventions for post-gastric bypass patients, joint diabetes urology clinic evaluations, patient surveys for service improvement, and clinical trials of high flow nasal oxygen, amongst others.
- The surgery service published locally benchmarked analysis of performance data for each consultant surgeon.

Pain relief

- There were effective processes in place to ensure that patients' pain relief needs were met and pain was well managed in the surgery service.
- We witnessed nursing staff regularly asking patients whether their pain was being effectively managed and if they were comfortable. Patients told us that nurses were very responsive to pain relief needs. All of the patients we spoke with were aware that they could use the call bell to request additional pain relief.
- Pharmacists met with patients in their pre-operative appointments to discuss medication needs. Consultants recorded post-operative pain relief requirements during pre-operative assessments.
- There was a dedicated acute pain service at the hospital, with a chronic pain consultant and a pain nurse. This was a seven day service available on weekdays from 8am-5pm, with on call arrangements on weekends and out of hours. Doctors in training reported that the pain team was very supportive and collegiate in its approach.
- Nurses told us there was scope to develop the pain service using more nurse-led pain management activity.

- The service allowed patients to self-medicate where appropriate so they could maintain control of their medication and pain levels. Nurses were conscious that patients' own medications were stored in the locker next to their bed and not left out.
- Nurses were educated to make sure medications were delivered on time but there was recognition amongst nurses that it was difficult to ensure all patients received their medication in a timely way.
- We found that drug rounds were not protected time and nurses did not wear a tabard when administering drugs which meant they were at risk of being frequently interrupted.

Nutrition and hydration

- There were regular protected meal times on surgical wards and we saw that these were respected by staff and visitors. This meant that all non-urgent activities on the ward would stop and patients would be positioned safely and comfortably for their meal and staff would assist patients with their meals as necessary.
- An extensive menu was available for patients and displayed on information boards on the ward corridors. The menu was coded with meals for different dietary requirements and specific needs. A selection of food choices was available for patients, including options for high protein, low fat and religious/cultural specific diet.
- Patients gave us mixed feedback about the quality of food while in hospital. Some patients felt that meals were good quality with adequate portion sizes. Other patients told us that the food was cold and not very good, and some were eating their own food.
- The trust used the Malnutrition Universal Screening Tool (MUST) to monitor patients who were at risk of malnutrition. The accredited screening tool also screened patients at risk of obesity. Where patients were identified as at medium or high risk of malnutrition, food intake was to be recorded, and the patient was to be encouraged and given assistance with meals. The meal hostess was also alerted on the menu card. Patients identified as at risk of dehydration also had fluid balance charts to monitor fluid intake and output.
- There was a hospital dietician which nurses were able to contact for nutrition advice and guidance.
- There were weekly weigh-ins for patients to monitor body weight and tailor food provision accordingly.
- The trust used a 'red tray' system where patients who needed help with eating were given food on a red tray so that nurses and health assistants could easily identify them.

Patient outcomes

- 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.
- The trust had a higher relative risk of readmission for General Surgery (elective) and Trauma and Orthopaedic (non elective) than the England average. Urology (both elective and non-elective), Trauma and Orthopaedic (elective) and General Surgery (non elective) show a lower relative risk of readmission than the England average.
- There were enhanced recovery pathways for patients after colorectal and orthopaedic (fractured neck of femur and knees) procedures. The programmes were well-established and used patient feedback to help provide targeted support for these patient groups. Interventions included information booklets, joint and knee schools, input from the pain team to help patients manage their pain, and physiotherapy input for rehabilitation exercises. There were good outcomes for patients and the enhanced recovery programmes were contribution to reduced length of stay in hospital. However, some nurses told us that the pathways needed to be embedded into the nursing work programme instead of being an add on. There was also a sense from senior staff that the pathways required redeveloping.
- There was good provision of literature and documentation given to patients on discharge to help them prepare for when they go home.
- Nurses told us that they ensure all patients are encouraged to get up from bed on the first day after their procedure to help reinforce and encourage patients' mobility and recovery.

- The director of operations for the ICSU was responsible for reporting patient outcomes. There were leads within each department within the ICSU responsible for benchmarking and providing performance statistics.
- The trust was not accredited as part of the Anaesthesia Clinical Services Accreditation Scheme.

Competent staff

- Information provided by the trust for the whole surgery and cancer ICSU, showed that 67% of staff in the ICSU had received an annual appraisal in 2015 (up to the time of our inspection) against an annual target figure of 90% for the directorate. Surgery matrons reported that completion of appraisals and objective setting required improvement.
- We were told that appraisals were well structured and incorporated the trust values.
- Nurses told us that the service was proactive in its support and funding for learning and development opportunities such as masters degrees, accredited courses, and more informal learning such as shadowing and coaching.
- Individual developmental needs were identified and recorded during annual appraisals. Service leaders told us that they were seeking to introduce more training for all staff on communication skills and end of life care. Funding was available for training in support patients with cancer, which was distributed amongst HCAs and nurses to improve care for patients with cancer.
- Some HCAs told us that there were limited opportunities for them to progress and that they would value more development opportunities.
- Surgeons and anaesthetists in the hospital participated in the GMC revalidation initiative for all UK licensed doctors to demonstrate they were competent and fit to practice.
- The trust participated in the NMC nursing revalidation scheme for all UK registered nurses. Senior staff told that they were aware of the implementation date and conducting ongoing work to prepare for revalidation. Matrons had a printed list of the dates for each member of staffs' revalidation date and were aware of the need to help nurses develop their portfolio evidence.
- Some junior ward nurses told us that there was not always sufficient training for operating new equipment and they are expected to know how to operate the equipment.
- Ward staff told us that new clerical staff would benefit from additional training, particularly in retrieving and storing patients notes. We were told that there was very limited induction and training for clerical staff and no longer any handover between established and newer staff, which did not provide a clear transition period.
- Specialty doctors in training told us that the Whittington Hospital was a very good place to work with approachable and supportive consultants, good supervision and good access to teaching opportunities. They told us that it was easy to get study leave and there was a small training budget available. Foundation doctors told us that they enjoyed working at the trust and that appropriate supervision and learning opportunities were available.
- ODPs in theatres told us that efficiency could be improved if anaesthetic assistants were trained in cannulation.

Multidisciplinary working

- There was an effective multidisciplinary team (MDT) working environment within the surgery service at Whittington Hospital. We found evidence of good multidisciplinary relationships supporting patients' health and wellbeing. We observed multidisciplinary input in caring for and interacting with patients on the wards.
- Occupational therapists and physiotherapists told us that there was a strong MDT culture within the surgery service. There were adequate AHP staff on wards and they did not overrun their shifts.
- Physiotherapists provided advice on exercises to improve mobility before and after surgery. Occupational therapists gave advice on aids and strategies to maximise independence and liaised with social services on behalf of patients and provided advice on any support patients may be entitled to.
- Patient records demonstrated input from therapists including physiotherapy, dieticians, speech and language therapists, occupational therapists, pharmacists as well as the nursing and medical teams.

- There were dedicated orthopaedics physiotherapists, occupational therapists and enhanced recovery nurses who worked across the surgery wards and were present every weekday.
- Patients reported good levels of support from physiotherapists and told us that their input had helped with recovery after their procedure.
- There was a daily ward MDT handover meeting at 9am for nurses, physiotherapists and occupational therapists. We were told that these meetings were not formalised but were used as an opportunity to share patient information and develop care plans.
- Consultant surgeons and doctors in training were very positive about the trust's orthogeriatricians, who looked after vulnerable patients aged 65 years and above to improve their medical health before and after surgery. They did this by assessing patients before surgery, following their care while in hospital and supporting consultants and ward staff. Support was tailored to patients' individual needs.

Seven-day services

- Arrangements were in place to ensure adequate out of hours medical cover on surgical wards. Consultant surgeons were on call, rather than resident within the hospital.
- The hospital delivered a full service on six days, with on call availability seven day per week. Operating theatres were used on Saturdays for elective and priority list patients. The surgery service delivered an elective orthopaedic list on Saturdays. Theatres were set up for emergency cases only on Sundays.
- Consultants were not resident on weekends. They were available for telephone advice rather than coming into the hospital.
- The medical rota highlighted that a foundation doctor was resident every day until 7pm, with a higher tier doctor in training covering the night shift with access to an on call consultant surgeon. There was a resident higher tier doctor in training and an on call consultant surgeon available at weekends. Consultants in some surgical specialties were present on Saturdays for operating lists.
- There were some challenges with weekend cover, and we found evidence that weekend operating lists were not always consultant led. Doctors in training told us that weekend emergencies were consultant supervised rather than consultant led and middle grade doctors managed the service on weekends.
- There was a seven day acute pain service at the hospital available on weekdays from 8am-5pm, with on call arrangements on weekends and out of hours.
- Pharmacy and radiology were available on weekdays and then on call during nights and weekends.
- Physiotherapy and occupational therapy provision for surgery patients was on week days only, with limited physiotherapy cover at the weekend.

Access to information

- There were Information boards for visitors in each of the wards we visited, which included information such as visiting times and protected meal times. In each ward we visited there were information boards displaying information about the wards performance on patient safety and satisfaction measures. There were posters on the boards with information on treating people with dignity and respect; and safeguarding against abuse and neglect.
- On surgical wards all authorised nursing staff and medical staff were able to access patient notes from a locked notes trolley to read and add relevant information. There were also risk assessments, and fluid charts in patient's bedside folders.
- Staff with access to computer workstations were able to access test results electronically. Access to patients' diagnostic and screening results was good.Computer stations with intranet and internet access were available on the surgical wards for staff to use.
- Staff in theatres reported an effective theatre sessions planner which was a spreadsheet developed in-house by theatre staff. It allowed staff to manage beds effectively and identify trends in peak usage and patient throughput. This allowed staff to predict times of high demand and plan theatre lists accordingly.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Surgery

- Patients told us staff explained treatment and care and sought consent before proceeding. All patients we spoke with said they had been given information about the benefits and risks of their surgery before they signed the consent form. We saw evidence of consent forms with risks recorded by the doctor.
- 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.
- There was mandatory training for all staff in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). It was also included in the trust's corporate induction. Staff told us they knew who to contact for advice in cases where a patient may require safeguarding support.
- There was a trust policy for Consent to Examination or Treatment and Records Management. The trust audited ICSU compliance with the policy on an annual basis to ensure that when a patient has undertaken a procedure requiring written consent, the consent form is scribed in accordance with national standards and the local policy.
- The most recent consent audit in March 2015 found a number of areas requiring improvement including the recording of the patient's NHS number, gender, any special requirements, job title of responsible health professional and use of abbreviations. The patient printing their name on consent forms reduced from being recorded on 81% of occasions in 2013/14 to 68% in 2014/15. The documenting of oral consent was a new requirement for each procedure and the audit found that a full explanation or the giving of written information was not documented in the patient record in all cases. There were recommendations and associated action plans for each of the areas for improvement.

Are surgery services caring?

Good

We rated caring in surgery as Good because;

Overall we found that staff across the surgery service were friendly, caring and professional. Patients told us that nurses and doctors had a caring approach despite being very busy. We saw staff communicating with patients in a polite and caring way. Patients were treated with dignity.

Friends and Family Test results were consistently very good across surgery wards with a good response rate. However the survey was not embedded in the pre-operative assessment unit.

There was good family involvement and sharing of information. We found a very good approach to partnership care and keeping family members engaged at all stages of the surgery process.

Compassionate care

- The majority of patients we spoke with were very happy with the care and treatment they had received while in hospital. Direct comments from patients, which were representative of this feedback included: "nurses are very kind, very respectful and answered all questions I had", "doctors have very good bedside manner, the care has been amazing", "nurses are caring and have a sense of humour. Even the porters and chef are caring with the time they have with you", and "nurses are very visible and look in control. Everyone is very busy and overworked but they are still caring and understanding". This was a common theme in all the feedback we received.
- Friends and Family Test (FFT) results were consistently very good across surgery areas. For the period September 2014 – August 2015, the surgery service received an average response rate of 43%, comparing favourably to an England average of 35%. Thorogood ward received consistently the most responses by patients with a 67% response rate averaging 91% recommendations. Coyle ward had a response rate of 41% and 86.5% recommendations. While Mercer ward had a response rate of 36% and 79% recommendations.
- The surgery wards displayed FFT scores on information boards at the entrance to each ward. Data from October 2015 was available and this demonstrated the overall

performance of the surgery service as a whole, with a 40% response rate and 94% recommendation. Only 2.7% of respondents said that they would not recommend the service.
- The trust used computer tablets for patients to record their feedback electronically. In November 2015 the trust implemented a new reporting system called Meridian which facilitated live reporting and access of FFT feedback. Matrons and ward managers were able to access the data and shared feedback with their staff.
- Senior nurses and matrons were proud of the quality and compassion of the care delivered by their staff. We saw evidence of many thank you cards and letters displayed around the nurses' stations on wards. We were told that the Head of Nursing for Surgery writes to each of the nurses who are named in thank you cards. The general theme within the cards and letters was that staff worked hard, but always smile and were caring and professional.
- Patients on wards appeared relaxed and comfortable.
- In theatres we observed a recovery nurses giving oxygen to a patient after a procedure. The nurse explained what they were doing, why, and how they were going to do it. This was communicated slowly and clearly to the patient. We saw staff ensuring that curtains were pulled around patients and blankets and gowns covered patients to preserve their dignity.

Understanding and involvement of patients and those close to them

- Patients on surgery wards and in the day surgery unit told us that pre-assessment by consultant surgeons fully explained the risks and benefits of the procedure and provided information about after care and home support. One patients told us that the surgeon had provided "full disclosure and an honest appraisal of the situation" which they found reassuring. We spoke with patients' family members and the overall impression we gathered was that family members and carers felt involved and that information was shared appropriately at all stages of the surgery process.
- A day room was available on each of the surgery wards. The rooms were bright and comfortable with chairs and tables and a television. Paper leaflets of patient literature was placed in holders on the walls of the day rooms so that family members and carers had access to this information.
- Information boards for patients, family members and carers were located at the entrance to each ward. These included a guide to staff uniforms, a photograph of the responsible matron and contact details.
- In theatres there was a waiting room available for family members and carers. Relatives and carers of patients with learning difficulties or specific needs were allowed into the admissions lounge to keep them company and help them feel more secure.
- We were told of some communication challenges on surgery wards, particularly around explaining things to patients and managing their expectations. For example, some elderly patients having orthopaedic procedures were anxious that they were being sent home early. The surgery service was working with orthopaedic surgerons and local GPs to better manage these patients' expectations about the length of time they would spend in hospital.

Emotional support

- 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, including emotional support such as non-clinical chats before patients started chemotherapy and providing telephone support for reassurance out of hours. 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 motiviational speakers including talks on personal wellbeing, nutrition and recovery care. Emotional support for families was also available through events, for example a carers conference funded by a cancer charity.
- All of the nursing staff we spoke with on surgery wards demonstrated a very compassionate approach and we observed nurses carefully listening to patients and providing reassurance.

Surgery

Are surgery services responsive?

Good

We rated responsiveness of surgery services as Good because:

There was good provision and systems in place to support patient's individual needs, including those with complex needs such as patients with dementia and those with learning disabilities.

The flow within the surgery system was well managed, particularly at the front end of the patient experience, from admissions through theatres and into recovery.

However;

There were significant bed pressures on surgery wards. 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. The mix of patients on ward was impacting on discharge because of the need for many different consultants to review many different patients across the hospital.

Service planning and delivery to meet the needs of local people

- The trust was working to meet the needs of local service users and improve health outcomes for local people.
- There were Saturday operating lists for elective procedures in some surgical specialties. Day treatment Saturday lists were held every two weeks.
- We were informed that the orthopaedic service would open an extra theatre during busy periods to avoid patients being deferred to the next day. However there was only one laminar flow theatre in the hospital which limited the number of orthopaedic procedures. This resulted in some inpatient cases being transferred to day case operating lists to ensure they were treated within standard timeframes. Orthopaedic consultants told us that there were sufficient demand to warrant an additional laminar flow theatre set up.
- The trauma operating theatre list was a hybrid list of elective and emergency surgery which improved theatre utilisation; however this presented potential risks for infection control.
- The Day Treatment Centre (DTC) was purpose built and well thought out with a logical and seamless flow. The DTC was open from 7am-10pm on weekdays. The surgery service had investigated opening the DTC for 24 hours but found that there was insufficient demand. There was a very high patient throughput and during our inspection it was very busy and chaotic with pre-operative and post-operative patients mixed together in one bay.
- Staff in the DTC admissions lounge told us that the workload of the unit had increased significantly from 50 patients per day to up to 120 patients per day.
- The service had identified unmet demand in bariatric and colorectal surgery. The surgery service planned to increase theatre activity for more bariatric and colorectal procedures to reduce waiting lists.
- There were high rates of 'did not attend' (DNA) patients in urology, outpatients and the day treatment centre. The surgery service did not identify any discernible trends but had set up outreach clinics within the local community to help to reduce the prevalence of DNA rates.
- There was no evidence of engagement with lifestyles teams in tertiary, secondary or primary care to help patients with smoking cessation, weight loss or exercise programmes to improve local health outcomes.

Access and flow

- The flow within the surgery system was well managed, particularly at the front end of the patient experience, from admissions through theatres and into recovery. On arrival to the admissions area, patients were admitted into private bays (on a trolley or chair) and were given time to dress in theatre gowns.
- However, post-procedure flow from the recovery area onto surgical wards was impacted by the limited availability of beds in surgical ward. This was a trust wide problem that was not isolated to the surgery service.

Surgery

- We were informed by many staff across staff groups that bed availability was a major problem for the surgery service. There was a recognised risk amongst surgery staff across all staff groups about bed shortages in wards across the hospital. We found that medical patients were frequently placed on surgical wards due to increasing demand for beds on medical wards. This had a knock on impact on availability of surgery beds, and subsequent impact on flow through theatres. Surgical patients were frequently held in the recovery area of theatres because they could not be moved to a suitable ward bed. The service was frequently required used the recovery area as the backup for placing surgery patients.
- We were informed of two instances in 2015 of patients remaining in the recovery area overnight due to unavailable ward beds. We were told that this occurred as a last resort and the patients were allocated a ward bed as a priority.
- Although recovery staff told us they were coping, there were insufficient plans to alleviate the pressure on the recovery area. There was no strategic long term plan to ring fence or protect surgery beds from being used for medical patients. The surgery service was focused on reducing length of stay for surgery patients by using enhanced recovery pathways. Service leaders had submitted a proposal to the trust board to cross-charge the medicine ICSU for use of surgery beds. There was also recognition of the need for a step down facility to enable the transfer of patients out of the hospital and into the community with full allied health support.
- The service had increased the number of beds per bay on surgery wards, which was a reversal of trust policy to meet bed demands. Bays were set up for four beds and in winter months this increased to five or six beds to cope with demand. Nurses told us that the increased bed density increased their workload and impacted on the quality of patient care. They told us that it was difficult to speak with patients confidentially because beds were so close together and the limited room made it difficult to do dressings.
- Matrons and ward managers told us that surgery wards were set up for single specialty allocations, but a broad variety of non-surgical patients were located across all surgery ward. At the time of our inspection there were three to four medical outlier patients each day on the surgery wards.
- Nursing staff on surgery wards told us that they experienced no problems in seeking input and review of medical patients by physicians. We were told that physicians attend surgery wards regularly throughout the day.
- Staff on wards felt that discharge arrangements were impacted by the sheer mix of different patients on the wards and the need for different consultants to see patients at different times.
- There were daily bed management meetings, and during winter months this was increased to three daily meetings to review the bed capacity.
- There was a designated flow nurse, with an agreed escalation protocol to consultants, the director of operations, head of nursing and silver and gold command managers when there were concerns regarding a trust wide deficit of available beds.
- Senior nurses told us that patients in for day cases sometimes stay overnight if there were complications after their procedure. These patients were allocated to a surgery ward.
- There was a reserved emergency operating theatre, as recommended by the NCEPOD report (1990). This theatre was available 24 per day seven days a week for emergency and trauma cases.
- There was no dedicated recovery bay for paediatric patients in main theatres.
- Overall theatre utilisation, across all surgical specialties was at 81.4% for the period March - August 2015. The trust's stretch standard for theatre utilisation was set at 95%. There was a theatre utilisation group, with a formal agenda which included utilisation statistic for each specialty and any clinical incidents. Urology, breast surgery and otolaryngology had the lowest theatre utilisation rates within the surgery service. A urology theatre improvement plan was in place. Breast surgery utilisation was not viewed as a concern as operating

lists were left open for urgent cancer treatment cases. Otolaryngology surgery was undertaken by visiting consultants from another trust and they had been challenged to use lists more productively.

- The surgery service had a low rate of cancelled procedures. Data from the trust demonstrated that only one patient who had their operation cancelled was not treated within 28 days between April 2014 and April 2015.
- The surgery service's Referral to treatment (RTT) performance was lower than the NHS England standard and the England average. The trust missed the standard for four out of five specialty groupings, with only Urology being at 98%. General Surgery was particularly low. There was an action plan in place to improve RTT performance across the surgery service, but senior staff highlighted that it was impacted by a number of general surgeons leaving the trust in the past year and lists not yet taken over by other surgeons.
- The average length of stay for both elective and non-elective procedures was lower than the England average at 2.9 and 4.3 days respectively. This compared to England averages of 3.1 and 5.2 days. There were no length of stay major outliers across surgical specialties.

Meeting people's individual needs

- The surgery service proactively considered and responded to specific individual needs, including complex needs and cultural and religious requirements. Pre-assessment and admissions screened for learning disability and dementia which was then recorded in the patient records. Most specific needs were identified in advance during pre-admission clinics which established dietary or isolation requirements. Patients' specific needs were also confirmed by nurses during handover.
- Staff were able to access discrete dementia awareness training and there was a dementia champion matron within the trust. The trust had introduced new colour schemes on wards to improve the patient experience for patients with dementia. Ward managers liaised with the trust bed management team to ensure patients with dementia were allocated to an appropriate ward and bay.
- Nurses conducted comprehensive risk and needs assessments for patients with dementia, including deprivation of liberty safeguards and mental capacity structured assessments.
- There were discrete visual indicators above beds to signify those patients at risk of falls and those with dementia.
- The surgery service involved patients' relatives and carers as partners in their care. Nurses liaised with family members and carers to understand the specific needs and preferences of patients with dementia. There was also provision for carers to stay with patients overnight. Nurses told us that this helped some patients with their recovery. Where appropriate, relatives and carers were able to consent on behalf of a patient.
- The trust used a 'red tray and cup' system to indicate those patients requiring nutritional assistance. We observed HCAs helping patients with their food.
- There was a clinical nurse specialist for learning disability within the trust. The needs of vulnerable patients with learning disabilities were discussed by the MDT and specific support requirements were recorded in patient records. In theatres, there were cot side safety barriers to provide additional safety measures for patients with learning disabilities.
- There were also nurse leads for vulnerable adults and domestic violence within the trust, and a mental health liaison team. Staff told us that the trust had focused on raising awareness of vulnerable adults and they felt confident to seek advice and support from the named leads. Specific needs and concerns for vulnerable adults were also recorded in patients' notes.
- Ward managers reported good access and support from community nurses for patients with complex social needs and there was good liaison with social work teams in the local area to ensure that appropriate support was in place for patients on discharge from hospital.
- The surgery service worked with NHS England to improve its support and provision for patients having bariatric procedures. The trust had updated local policy the redefine the criteria for high risk bariatric patients to improve management of conditions and strengthen the

unit. This included the recruitment two dedicated bariatric specialist nurses working across the trust to provide support. This service was available from 9am-5pm on weekdays.

- Translation services were available and staff were familiar with the process for booking an interpreter. Translation services were provided via a telephone interpreter and also by face-to-face interpreters. There was a dedicated full time Turkish translator working within the trust. There were no reported problems with accessing the translation service. Trust policy stated that patients' family members should not be used to translate, but we found that nurses relied heavily on family members to provide translation services. Nurses told us that they often encouraged family members to translate on behalf of patients on wards. They recognised this was not the best course of action.
- The patients we spoke with were not very aware that translation services were available and some patients were relying on internet-based translation services on their smartphones to communicate with staff.
- Cultural and religious specific dietary requirements were catered for, including vegetarian, kosher and halal meals.

Learning from complaints and concerns

- The trust complaints process and contacted details were clearly displayed on posters on wards.
- The surgery service received 46 formal complaints between August 2014 and August 2015.
- We were told that most complaints were dealt with informally as they arose, with a matron or ward manager speaking with patients and their relatives or carers to find a solution to a problem or apologise if things went wrong.
- Senior nurses and service leaders reported difficulty in responding to complaints in a timely way. The head of nursing and director of operations told us that there was a backlog of complaints that required a response. At the time of our inspection there were 14 open complaints open, and eight that were overdue. Responsibility for responding to complaints was allocated to service managers, with oversight by the head of nursing.
- Senior staff told us that it was sometimes difficult to get consultant surgeon input to complaint responses, and most responses were delayed by consultants not imputing in a timely way.
- We were told that formal responses to complaints were signed off by the trust chief executive before they were sent out.
- Matrons told us that they shared learning from complaints with individual staff and groups of staff on wards and in theatres. Matrons had developed action plans to respond to complaints and prevent them from happening again.
- There were no overarching themes from complaints about the surgery service, but senior staff had identified concerns with staff communication, clinical decisions, the appointment booking process, and wrong appointment information.
- There was evidence of learning and changes in response to complaints. The trust provided staff training on communication and was working to streamline the triage process to improve the outpatients experience. Some patients had previously received incorrect appointment letters. In response the trust introduced new processes for booking appointments and follow ups. In November the trust implemented a system for patients to book their first and second appointments at the same time.

Are surgery services well-led?

Good

We rated the leadership of the surgery service as Good because;

We found a cohesive and supportive leadership team, with well established members of staff. There was a clearly defined strategic plan for the service. Leadership of the service was clinically led. Matrons were very visible on the ward and the consultant body within the service provided clear clinical direction.

However:

There were clinical governance and risk management systems in place, but we found that there was scope to

make them more interlinked and robust. Senior staff reported a culture of quality improvement but it needed to be embedded and establish further in more robust governance structures.

A number of identified risks remained on corporate risk registers for a long time and were not addressed adequately or in a timely way. There was a lack of formal opportunities for consultants to meet regularly. Management support in theatres required investment by the trust to alleviate pressure and build capacity.

Some nurses told us about unprofessional behaviours by matrons. Consultant surgeons also reported a disconnect between the consultant body and trust and service management. This was impacting on staff morale.

Vision and strategy for this service

- There was a comprehensive local strategy plan for the surgery service which was aligned with the trust's five year plan and six strategic goals. Key areas for surgery were identified: ensure that patient pathways are evidence based and tailored for the patient; patients and their families are key decision makers in their care, demonstrated by improved clinical outcomes and high patient experience; reduce length of stay by undertaking more procedures as out-patient procedures or day cases; maximise theatre capacity; develop models for community based surgical care; and to be the provider of choice across North London for spinal surgery, bariatrics and urology.
- Service leaders were clear on the direction for the surgery service and were able to articulate a vision of doing the right thing, first time. However, they recognised that staff in wards and in theatres may not be clear on the service level strategic plan because it was only recently put in place after a period of uncertainty and instability at a trust executive level. Service leaders told us that the trust, and the surgery service had become more stable.
- We asked nursing and medical staff on wards about their understanding of the service vision. All were aware of the trust vision but not that of the surgery service.
- There was a sense of anxiety amongst the some of the clinical staff we spoke with around trust and service finances and the future direction of the trust. Senior staff recognised that Whittington Hospital was a relatively small trust with many bigger competitors nearby. There was a clear message from staff that they felt better off as a small trust without being subsumed into a bigger organisation.

Governance, risk management and quality measurement

- There were clinical governance and risk management systems in place, but we found that there was scope to make them more interlinked and robust. Senior staff reported a culture of quality improvement but it needed to be embedded and establish further in more robust governance structures.
- The surgery service used a performance quality dashboard, which was a spreadsheet containing key performance indicators. Matrons reported quality indicators from their respective areas on a monthly basis. This included safety performance, infection prevention, training completion, staffing and vacancies, patient experience and reported incidents. All ICSUs within the trust used the same format document for consistency. The risk and quality manager for surgery worked with the Head of Nursing to create a synopsis of performance data for the surgery service as a whole which was submitted to the Surgery and Cancer ICSU board and fed into the trust patient safety board.
- There were weekly meetings between surgery matrons and the Head of Nursing to discuss performance data.
- There were monthly team meetings for wards and theatres. These meetings were used to discuss serious incidents, including root cause analysis investigations and action plans.
- Each service within the Surgery and Cancer ICSU had its own dedicated governance meetings such as morbidity and mortality meetings, bi-monthly audit meetings and departmental meetings. This was emulated across each service but there were differences in the timing, duration and attendance of these meetings. Doctors in training were allocated protected time to attend these meetings.
- Risk registers were reported on a monthly basis and reviewed by the clinical director, director of operations, head of nursing and risk and quality manager at the monthly directorate management team meeting. Service leads updated the risk register on a monthly basis but responsibility for completing the risk register was not clear as we were told that many individuals will update the document.

- Ward and theatre staff were aware of processes for reporting risks. Staff were required to discussed the risk with their line or service manager for review and investigation. A risk assessment form was then completed and reviewed by the ward or theatre manager and escalated to the appropriate matron and risk and quality manager. Verified risks were discussed at directorate management meetings to determine if a concern needed to be put on the risk register.
- Senior staff were able to explain the top rated risks on the risk register. These included records and data back up systems in theatres; doctor in training rotas; and bed demand and management, including medical outliers on surgery wards. We were told that this had remained on the risk register since 2011/12, with a high impact and likelihood score.
- A regular risk update email was sent to all heads (service managers, HoN and matrons) in the directorate, however, we were told that there was a reliance on clinical leads to disseminate risk information to more junior staff.
- There were joint meetings between the anaesthetics, ITU and general surgery service lines which covered serious incidents and high risk cases, so that learning could be shared across specialties. These meetings were predominantly attended by medical staff with some limited MDT input. Consultants told us that these meetings had been used to develop the deteriorating patient pathway, including MEWS scoring and escalation of care, and outreach services.
- There was a lack of formal forums for consultants to meet regularly. A consultants meeting with the senior surgery leadership team was held every two months. We were told that a separate quality and safety committee was no longer held, as this had been integrated into the Surgery and Cancer ICSU board to reduce the number of meetings staff were required to attend.
- The surgery service had one risk and quality manager with no administration support, which meant that the role was very operational and data driven, rather than strategic. The risk and quality manager for surgery highlighted a need to be invited to team meetings to incorporate risk management into team meetings and to provide opportunities for staff to report risks.

Leadership of service

- There was a stable and cohesive surgery service leadership team which comprised a Clinical Director, Director of Operations and Head of Nursing triumvirate. The second tier of leadership included clinical leads for each of the specialties within the directorate, matrons and three shared service managers. We found evidence that the senior team led the directorate effectively. Nurses and clinicians told us that senior staff were visible and accessible and receptive to staff feedback and evaluation.
- Some nurses told us that while senior leaders were visible and approachable, they felt that there was scope for the leadership to inspire staff and drive forward the service. This related to the lack of a communicated vision and strategic plan for the service.
- Service leaders told us that matrons provided clear leadership as a result of clinical experience and operational competence. When we spoke with the matrons they clealy understood their operational performance, were able to articulate the challenges within the service and had identified solutions to address them. However, some nurses and theatre staff felt that matrons were sometimes too involved in the daily management of wards and theatres, and that they interferred in small operational matters rather than focus on leading. They sensed of a lack of trust which they felt resulted in centralised control and lack of delegation.
- Senior leaders within the service had clear job descriptions and objectives to ensure they were held to account. However, the trust did not provide formal leadership training for consultants. At the time of our inspection the service had not introduced job planning for consultants to manage their clinical and leadership responsibilities.
- Some of the consultant surgeons we met told us that there was a disconnect between the consultant body, middle management and the trust leadership team. They reported a “them and us atmosphere”. They did not feel appreciated or listened to, and considered the consultant body was an undervalued intellectual resource. They told us that individual units within surgery were self-sufficient and autonomous, with “light touch” management. However, they felt that communication between consultants and the trust board needed to improve. There was enuine desire amongst consultants that they wanted to support and sustain the trust in what they saw as a threatening external environment.

- We were told consistently by staff across groups and grades that leadership in theatres required additional support. There was recognition that the theatre matron position had a big remit, covering both main theatres and the day treatment centre. We were told that frequent turn around of staffing within theatres which had impacted on perceptions of stability amongst theatre staff. Senior leaders were aware of this and told us about plans to appoint a general manager and a dedicated matron to manage main theatres. The trust was also working with an external management consultancy to improve efficiencies in theatres, but some staff felt that this was taking away resources from the front line.

Culture within the service

- We found, for the most part, an inclusive and constructive working culture within the surgery service. Staff we spoke with felt that the Whittington Hospital was a good place to work. Nurses and doctors reported approachable and supportive colleagues. Senior staff were proud of their teams and the support staff provided to each other across wards and theatres.
- 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. The surgery service was viewed by staff as small enough to facilitate good relationships between all staff and visibility and continuity for patients.
- Doctors in training told us that many trainees wish to return to Whittington Hospital, and they attritubed this to the supportive and open culture of the surgery service. Service leaders reported that many newly appointed staff had worked at the trust previously. Student nurses told us that staff were supportive, particularly the ward sisters. They felt that they were progressing well and they told us that they would like to apply for a job at Whittington Hospital.
- The staff we spoke with were aware of the trust's values: ICARE, however there was limited understanding about how they were applied. Senior staff told us that the values were being integrated into the annual appraisal framework.
- Some staff reported that the communication style of individual matrons was not always professional and could feel intimidating and aggressive. We were told of instances of shouting which had been overheard by patients. Some of the nurses we spoke with felt that they were not able to challenge matrons and told us that this impacted on staff morale as they felt their concerns during times of pressure were being dismissed rather than listened to.

Public and staff engagement

- In addition to the Friends and Family Test, individual surgical specialties at the trust conducted patient satisfaction surveys to measure patient satisfication against indicators such as: being treated in a sensitive and caring way, provision of information and overall satisfaction.
- Surgery wards and theatres conducted compassionate care audits which measured performance against indicators such as: listening, communicating, caring, advocating, empathising and supporting patients.
- The trust distributed a Whittington Hospital Bulletin newsletter and chief executive team brief email to all staff within the trust.
- Staff on Mercers wards were recognised at the trust Excellence awards in 2015 for demonstrationg courage in their work.

Innovation, improvement and sustainability

- The surgery service introduced a number of innovations in the 12 months preceding our inspection.
- The surgery service had established a one-stop pathway for patients with colorectal conditions. This facilitated virtual clinics, investigations, diagnostics and treatment in one appointment. Senior staff within the service told us that the service was working well.
- The surgery service did not have access to 'step down' beds in the community – where patients could be cared for outside of the hospital environment. To reduce length of stay, the surgery service was actively using the trust ambulatory care unit to treat patients who did not require inpatient treatment.
- The trust had appointed two emergency surgeons to provide additional support and roster capacity to consultant surgeons. Consultant surgeons and service leaders told us that this had reduced anti-social rosters, reduced pay expenditure and improved throughput of patients in theatres.
- The urology department had developed day surgery stone work and was in the process of introducing day

case minimally invasive percutaneous nephrolithotomy for removal of kidney stones. The urology department was also planning to commence focal therapy day surgery cases for patients with prostate cancer.

- The trauma and orthopaedics department had introduced minimally invasive spinal surgery procedures.
- The surgery department had introduced single incision laparoscopic surgery.
- In bariatric surgery, the team had introduced 'vanguard lists' in theatres where a higher number of patients than normal are booked onto a list so that they are all seen and operated on as the team is co-ordinated and prepared in advance for these lists and there is high productivity. The surgery service was investigating whether this approach could be adopted for other specialties.

Critical care

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

Information about the service

The Kanitz Critical Care Unit is a 15-bedded critical care facility which accommodates level two and level three patients. A maximum of 11 level three patients can be admitted at any one time. Critical care sits within the surgery integrated clinical service unit (ICSU) and is primarily managed by the surgery ICSU Matron and a Critical Care Clinical Lead Consultant. Between May and October 2015, 355 patients were admitted to the critical care unit.

Most patients admitted to critical care are unplanned medical admissions and post-operative patients. A critical care outreach team is available from 8am to 8.30pm to assess and support the care of deteriorating patients prior to their transfer to critical care and also to follow up patients discharged from the unit.

We visited the critical care unit for four announced inspection days. During our inspection, we spoke with 38 members of staff including doctors, nurses, allied health professionals and ancillary staff. We also spoke with the critical care leadership team, six patients and four relatives. We used a Short Observational Framework for Inspections (SOFI) to evaluate care interactions. We checked 10 patient records and more than 30 pieces of equipment.

Summary of findings

We rated critical care overall as requires improvement because;

There were significant issues with the flow of patients from 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. There was little evidence the critical care leadership team were pushing to address these issues and some senior staff failed to acknowledge the problems. The departmental risk register was sparse and did not contain matters identified during our inspection. We were concerned at an apparent under-reporting culture relating to incidents and near misses and senior staff on the unit did not recognise this.

We observed some occasions where patient privacy and dignity was not maintained. Staff were not fully aware how to support people with specific needs such as those with a hearing impairment and staff knowledge of Deprivation of Liberty Safeguards (DoLS) was variable. Staff did not challenge visitors entering the unit and we were concerned patients could be at risk if the unit was accessed inappropriately.

The critical care unit contributed data to national and regional monitoring bodies, allowing outcomes to

Critical care

benchmarked. Patient outcomes were in line with or better than other similar critical care units and use of evidence-based practice was embedded throughout the unit. Safety thermometer results were good and we saw evidence demonstrating staff knowledge and understanding of safeguarding principles. Patient and visitor feedback about critical care was complimentary and staff routinely provided emotional support to patients and their relatives. There was a positive culture on the unit and staff spoke highly of the approachable and supportive leadership team.

Are critical care services safe?

Requires improvement

We rated safety in critical care as Requires Improvement because;

A robust and proactive safety culture was not embedded on the unit. We were concerned that incidents were under-reported as only a small number (69) were recorded over a twelve-month period. We identified two out of date items on the resuscitation trolleys, indicating equipment checks were not always thorough and we were concerned that visitors could access emergency medicines on one resuscitation trolley due to its quiet location on the unit. We were also concerned that patients could be placed at risk because visitors could access the unit inappropriately when the door was not secured. Staff did not challenge people walking around the unit or looking in bed spaces for their relative.

Some areas of the unit were not visibly clean and we noted three disposable curtains that had not been dated when they were put up and so it was unclear how long they had been in place. We noted used cutlery and crockery piled up in the pantry, along with a mop and bucket containing dirty water. All of these items remained in place for over two hours without being cleaned.

We saw old critical care records inappropriately stored in plastic containers within a store cupboard and some ventilated patients receiving oxygen without a prescription. A Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order was in place for one patient however no review date had been documented and there were no notes entries to suggest this decision had been reviewed within the previous 14 days. This is not appropriate practice when a DNACPR is in place, as these decisions should be reviewed at regular intervals.

However:

Staff hand hygiene was mostly good and we observed correct use and disposal of personal protective equipment. There were suitable facilities for barrier-nursed patients including decontamination lobbies and 'Intensive Care National Audit and Research Centre' (©ICNARC) data

demonstrated no concerns with unit-acquired infections. Staff had good knowledge of safeguarding principles and we saw evidence of safeguarding referrals made by critical care staff.

Incidents

- Incidents were reported via online forms which could be accessed by all staff and completed on any trust computer. Data provided by the hospital showed there were 69 incidents reported between October 2014 and September 2015 which related to the critical care unit. There was one serious incident and no never events reported during the reporting period. Serious incidents known as 'Never Events' are largely preventable patient safety incidents which should not occur if the available preventative measures had been implemented.
- Staff on the critical care unit were able to identify how to report incidents and describe examples where an incident form would be necessary. Most staff told us they would speak to the nurse in charge before submitting an incident form. Some staff we spoke with had worked on the unit for a long time (Between two and four years) yet had never completed an incident form.
- We were concerned 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). For example, recommendations from the Faculty of Intensive Care Medicine (FICM) state patients discharged from critical care out of hours should be recorded as incidents. There were ten patients discharged out of hours between July and September 2015 yet only four out of hours discharges in total were recorded as incidents between October 2014 and September 2015 showing there were omissions in incident reporting.
- We saw evidence incidents were investigated fully and all relevant people were involved in the investigation. Learning and action points were identified and senior staff told us they were disseminated to ward staff without delay. Staff told us they sometimes received feedback and learning points from incidents during handovers but mainly in staff meetings. They told us the practice development nurse emailed key information about incidents and we saw evidence of this.
- Most staff were aware of duty of candour principles and told us patients and their next of kin had to be informed when incidents or near misses occurred which involved their care. Junior staff told us they would seek guidance from a more senior colleague to support this type of discussion. We saw written evidence patients were informed when incidents occurred and they received apologies from senior staff on the unit.

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 (CUTI and UTIs), falls with harm to patients over 70 and Venous Thromboembolism (VTE) incidence. Safety thermometer data for the November and December 2015 were displayed at the ward entrance. Safety thermometer data detailed below covered the period December 2014 to November 2015.
- Safety thermometer data showed there had been one unit-acquired pressure ulcer in the reporting period and a poster at the ward entrance showed it had been 235 days since a unit-acquired pressure ulcer had occurred. The 'Waterlow Pressure Ulcer Prevention Score' was used to identify patients' risk of developing a pressure ulcer. A staff nurse was identified as the tissue viability link nurse on the unit.
- Catheter care bundles were used on the critical care unit and there had been no instances of CUTIs during the data period specified.
- There were no falls with harm to patients on the critical care unit during the reporting period. We saw evidence of patient mobility assessment by physiotherapists and falls risk assessments completed for patients considered to be at risk.
- VTE assessments were recorded on daily care charts and completed at regular intervals. There were no new VTEs within intensive care during the reporting period. Hospital audit data demonstrated consistently more than 90% of patients were assessed for VTE risk between August and October 2015; which met the 90% hospital target.

Mandatory training

Critical care

- Mandatory training was delivered via a combination of face to face learning and e-learning sessions. Staff told us mandatory training was easily accessible and it was not difficult to book time out in the unit diary to complete training.
- Staff were complimentary about the quality of mandatory training they received and told us the sessions were useful because they were usually directly applicable to their day to day work. They told us senior staff told them if the mandatory training uptake was too low and if they were out of date on their training.
- Staff told us the target for departmental mandatory training completion within the trust was 90% for each topic. The 90% target was met for safeguarding adults level two (90%), infection prevention and control (93%), moving and handling (95%) and information governance (90%).
- The 90% target was not met for child protection level two (87%), health and safety (88%) or risk management and duty of candour (83%). It was unclear what actions were in place to improve training uptake in these areas.
- Uptake of conflict avoidance training (82%) also did not meet the 90% target. This training was listed as "not required" for two administrative staff on the unit; one of whom worked on the reception desk and was at risk of being exposed to conflict situations.

Cleanliness, infection control and hygiene

- Domestic staff covered three shifts each day (7am-3pm, 3pm-11pm and 11pm-7am) with two members of staff working during each shift. There was also an additional housekeeper dedicated to the critical care unit between 8am and 4pm Monday to Friday.
- Cleaning audits were completed on critical care sporadically by senior domestics staff. The most recent audit was completed in September and the result showed 97.78% compliance with expected cleaning standards; this was slightly lower than previous results which were consistently above 99% compliance. We saw evidence of actions to address areas where non-compliance had been identified.
- Throughout our inspection, we noted the critical care unit was mainly clean although we observed a thick layer of dust on the shelving at the nursing station and on some pieces of equipment. We observed the same spots of dried blood on the arterial blood gas analyser on each day of our inspection suggesting it was not cleaned daily.
- In the pantry we observed many items of used cutlery, plates, water jugs and cups piled up in the sink. The same items were still in the sink two hours later and had not been cleaned. We also saw a mop and bucket that had been used and contained dirty water left in the corner of the pantry. These were still in in the same place two hours later.
- A lavatory brush was available within the patient bathroom on critical care. This posed an infection risk and was not in line with infection control best practice.
- Fabric curtains were used to separate patient bed spaces and staff told us these were replaced on a quarterly basis or sooner if they became soiled. Staff told us the curtains were also changed if a barrier-nursed patient was cared for within the bed space. We observed most curtains were labelled with the date they were put up, however we found three curtains had not been labelled which meant staff could not be sure how long these curtains had been in place.
- Alcohol gel was available at the entrance to the critical care unit, at regular intervals throughout the unit and within each patient bed space. There were no handwashing facilities available for visitors immediately at the entrance to the ward. We saw hand hygiene reminder posters on the walls and printed on the floor.
- The infection control link nurse completed hand hygiene audits on the critical care unit on a monthly basis. Results for October, November and December 2015 showed 100% compliance with hand cleaning. We observed the majority of staff were compliant with hand hygiene principles during our inspection, however we observed some staff failing to clean their hands at times when this should have been completed. For example, we observed a member of nursing staff sneeze into her hands then continue rearranging the patient's medicine lines without cleaning her hands.
- Basic personal protective equipment (PPE) was available throughout the critical care unit including gloves and aprons. Housekeeping staff refilled PPE holders throughout the unit on a regular basis. More advanced equipment for example face shields and

masks were found in storerooms on the unit. We observed staff using PPE at appropriate times during our inspection and we noted the PPE items were disposed of correctly in clinical waste bins.

- Barrier nursed patients were accommodated in the side rooms if possible or were nursed within the main critical care unit with "source isolation" warning signs at the foot of the bed if no side rooms were available. Staff told us patients who required barrier nursing would be risk assessed and accommodated accordingly. Senior staff were able to explain the rationale behind the placement of patients we saw on the unit who required critical care nursing and explained the liaison with the infection control team which took place.
- ICNARC data showed there were no cases of unit-acquired infections such as methicillin-resistant staphylococcus aureusis (MRSA) or Colostrum Difficile (C. Difficile) between July and September 2015.

Environment and equipment

- The critical care unit was rebuilt in 2006 via a private finance initiative (PFI) and information provided by the hospital showed the unit was compliant with 2013 NHS Estate guidance HBN57. This was the recommendation for critical care unit design within Wales and was slightly different to the recommendations for units within England.
- There was an access card entry system at the entrance to the unit which was secured outside of visiting hours. Staff and visitors without an access card used a buzzer entry system to obtain permission for entry when the door was locked. This meant staff could control who accessed critical care when the door was secured. When the door was open, we observed relatives walking into the main ward area and looking into bed spaces for their relatives without challenge from staff which could place patients at risk if people accessed the unit inappropriately.
- We noted the fire door to the room containing the arterial blood gas analyser was propped open with a clinical waste bin throughout our inspection which was incorrect.
- There were four single patient side rooms which all had individual decontamination lobbies. Each side room had negative pressure capabilities and the decontamination lobbies ensured an 'air-lock' (where the door to the ward area could not be open at the same time as the door to the patients' room) to maintain appropriate airflow for infection control. It was possible to override the 'air-lock' in the event of an emergency or if accessing the side room with a bed or other large piece of equipment.
- Two resuscitation trolleys were available on the unit; one within the main ward area and one outside the four individual cubicles. We saw evidence the trolley contents were checked on a daily basis and there were no gaps on the checking documentation. A patient transfer bag was available in the main critical care area, however there was no documentary evidence the contents of the bag were checked. We noted the sterilised forceps were past their expiry date (9 July 2015) on one resuscitation trolley and in the patient transfer bad. This was raised with a senior member of staff who rectified the issue immediately.
- We were concerned the quiet location of the resuscitation trolley by the individual cubicles meant visitors to the unit would be able to access the emergency medicines stored within the unsecured bottom drawer without staff noticing. We raised our concerns with a senior nurse who liaised with the resuscitation officer and placed a plastic snap lock on the drawer to prevent inappropriate access.
- A difficult airway trolley was available within theatres which was located approximately one minute away and was checked by staff within the theatres department.
- Patient beds had a maximum safe working load of 267kg, which meant they were appropriate for accommodating bariatric patients. Bariatrics is the branch of medicine that deals with the control and treatment of obesity. Chairs designed for bariatric patients were available on the unit and staff told us it was possible to order more if required.
- Regular maintenance checks were completed on the trust maintained areas within critical care and we saw evidence of a weekly job plan highlighting which areas would be inspected each week. We saw evidence demonstrating equipment purchased via the PFI was regularly serviced and maintained and external estates staff inspected areas not maintained by the trust according to their weekly job plan.

Critical care

- Medical devices were categorised as low, medium or high-risk equipment. High-risk equipment had to be signed off by a "trainer" in that specific item of equipment. Study days were held for high-risk or specialist equipment. Training for medium risk devices could be given by a peer and low risk items by any member of staff already deemed competent. Records demonstrated training for high-risk equipment was 80% complete.
- Equipment we checked was in good working and labelled with stickers indicating the last service date. We also saw evidence of portable appliance testing (PAT) for equipment within the critical care unit, including ventilators and computers.
- Staff felt there was sufficient medical equipment available on the unit and told us there were no problems accessing consumables or other items. One member of therapy staff told us there were not enough suitable chairs for patients with complex needs and we observed a nurse searching for a suitable patient chair for almost ten minutes.
- Staff told us there was a shortage of mop heads throughout the hospital which led to delays in accessing appropriate equipment for cleaning. This had been reported as an incident within critical care on one occasion however there was no action as a result of this. Staff in other areas of the hospital corroborated this equipment shortage.
- We observed spare consumables and other equipment were appropriately stored in labelled units or in cardboard boxes stacked on top of pallets. Staff told us medical items such as non-invasive ventilation masks and disposable scissors were labelled with their cost price to raise awareness with staff and try to reduce wastage.

Medicines

- There was a critical care specialist pharmacist allocated to the unit from 9am to 5:30pm from Monday to Friday. An on-site clinical pharmacist was available at weekends from 9am to 5:30pm. Out of hours, an on-call pharmacist was available to provide advice. Pharmacists were responsible for reviewing medicine charts to check prescriptions were correct and for drug interactions.
- Pharmacy support staff visited the critical care unit to top up medicine supplies three times per week. Pharmacy and nursing staff told us this support was sufficient and there were no problems with medicine stocks.
- Trust-wide antibiotic guidelines were in use on the critical care unit and we saw doctors referring to these when prescribing medicines for patients. Doctors also referred to the British National Formulary to ensure correct choice and dosage of medicines.
- The antimicrobial performance dashboard for critical care between January and March 2015 showed antibiotics were correctly selected when prescribed however documentation related to review dates and indications for antibiotic choice were not fully completed with adherence lower than the 90% target (67% and 75% respectively).
- Medicines were prescribed and managed electronically. Medicines charts we reviewed were fully completed and there was evidence medicines were checked by two nurses when administered. We observed no omissions in the electronic medicines charts we checked.
- Access to the medicine chart that has material change to the medication e.g. prescribing or administration is restricted to one person at a time but more than one staff member can view a prescription at a time. Staff provided an example where a staff member had not closed down a patient record appropriately which meant no one else could access the record for over two hours while the record remained open. They told us this meant the patient involved received medicines later than prescribed.
- Medicines were stored in individual secured lockers at the patient bedsides. One key opened all but two medicines lockers on the unit and these two had their own allocated keys. A general key was held by each nurse on duty. Stock medicines not allocated to an individual patient were stored in the pharmacy room that was secured with a keypad access lock.
- The temperature of the storage room for intra-venous fluids and the pharmacy room were checked daily. Documentation showed the temperature of each room was consistently within the desired range; however there were six gaps in temperature checks over a three week period from November to December 2015.

- Staff had to complete a series of competencies to be able to prepare and administer intra-venous medicines. We saw evidence these competencies were completed with permanent and temporary staff prior to them managing medicines on the unit. Temporary staff working their first shift overnight (and so could not have their competencies checked by senior staff on the ward) worked with a permanent "buddy" nurse who would be responsible for medicines for the temporary staff member's patient.
- Controlled drugs (CDs) were stored in a lockable, wall-mounted unit within the secured pharmacy room which was in line with best practice. The cupboard was well organised and contained a range of CDs and concentrated potassium, as well as benzodiazepines in line with trust policy.
- The CD book was also stored within the CD cupboard. The book was neatly and accurately completed, and there were no missing entries or signatures. We saw evidence of daily CD stock checks.
- Pharmacy staff completed CD audits on a quarterly basis. Audit results from October 2015 demonstrated 83% compliance with CD management due to incorrect documentation of CDs in the stock book. This was not as good as the result from the audit in July 2015 (100%). Pharmacy staff rectified mistakes and identified actions to correct non-compliance which were communicated to the critical care charge nurse for dissemination to ward staff.
- We observed nursing staff preparing and administering oral, intra-venous and controlled medicines correctly on the unit, including checking the patients' name and date of birth prior to giving the medicine.
- Oxygen cylinders were appropriately stored in racks throughout the storage areas of the unit. All cylinders checked were seen to be in date. We saw evidence oxygen was prescribed for most patients, with the exception of some ventilated patients. When this was raised with staff, they agreed this was an omission and sought to rectify this.

Records

- Patient notes relating to their current critical care admission were maintained in their paper medical records which were kept at their bedside. These notes contained entries from all members of the multidisciplinary team. Some records we reviewed were not fully legible throughout and name of who had written each set of notes was unclear in many cases.
- Blood transfusion records were maintained for patients on the critical care unit. We noted these were in use during our inspection and were fully completed.
- A Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order was in place for one patient on the unit and we saw evidence this form had been completed by a critical care consultant. We saw evidence the decision to put a DNACPR in place was made alongside the patient and their family. The DNACPR had been in place for 14 days and there was no evidence within the patient's notes that this decision had been reviewed in the 14 day period. Additionally, no date for reviewing the DNACPR had been identified on the form. This is not appropriate practice when a DNACPR is in place, as these decisions should be reviewed at regular intervals.
- ITU charts dating back to June 2015 were found in plastic containers in an unlocked storeroom located on the main critical care unit corridor, which is inappropriate storage for confidential information. The charts were stored according to the month patients were discharged and not by patient name or hospital number, which would make retrieving the information contained within the charts difficult. Staff told us the charts were moved to a "shed" on site at the hospital, before being transferred to specialist storage offsite. The timescales for each stage of the move were not clearly identified. The charts were not filed in the main patient records, which is not compliant with good information governance principles.

Safeguarding

- Mandatory safeguarding adults level two training had been completed by 90% of critical care staff. Administrative staff were required to complete level one safeguarding adults training and 100% had completed this.
- The critical care unit had access to the hospital safeguarding team on a bleep referral basis. There was a trust-wide safeguarding policy in place which was

accessible to all staff via the intranet. Staff were aware they could access additional safeguarding information on the safeguarding team's intranet page and told us this was a useful resource.

- Staff throughout critical care were able to describe what would constitute as a safeguarding concern and what actions should be taken as a result of this. Most staff had not completed safeguarding referrals personally but told us thy discussed any worries with the nurse in charge who would instigate the referral if appropriate.
- We saw evidence of safeguarding referrals completed by staff on the critical care unit. We also saw evidence of significant safeguarding discussions relating to a complex case during our inspection. This discussion involved medial staff, senior nursing staff, the patient's legal representative and family.

Assessing and responding to patient risk

- The 'Bloomsbury Sedation Scale' was used to assess the level of sedation for each patient every two hours. Staff told us over-sedation is associated with a higher incidence of delirium and so it was important to regularly assess patients to try and limit the number of patients who experience delirium. Staff also dimmed the lights at night and provided patients with earplugs and an eye mask to help them sleep to assist with this.
- The CAM-ICU delirium scoring system was used to identify patients experiencing delirium on the critical care unit. The medical team led these assessments and completed them at regular intervals to ensure delirious or potentially delirious patients were suitable monitored.
- Throughout the hospital a traffic light warning system was used whenever patient observations were taken; this was in line with guidance from the Royal College of Physicians and compliant with the NICE 50 guideline. The purpose of the warning system was to enable early identification of patient deterioration, as indicated by their observations. Patients with three ambers or one red observation were referred to the critical care outreach team for review to consider transition to or escalation of critical care. The night nurse practitioner was also contacted when patients triggered an outreach referral overnight.
- In addition to the traffic light observations warning system, other scoring systems such as the Acute Kidney Injury (level three or above), the Nottingham Hip Fracture Score (score of five or above) and the Glasgow Pancreatitis Score (score of three or above) triggered a referral to the critical care outreach team.
- The critical care outreach team was available from 8am to 8:30pm each day. There were usually two outreach nurses on duty during the week and one nurse at weekends. Out of hours the outreach bleep was held by the critical care senior house officer, who reviewed new outreach patients and followed up any patients identified by the outreach nurses from the daytime shift. Staff told us the critical care outreach team followed up some patients who had been stepped down from the unit but not all.
- The critical care outreach team aimed to review all referrals within one hour and audit data for November 2015 showed 80% of referrals achieved this target. Staff told us the remaining 20% of patients were seen after one hour but this was based upon a clinical decision for the delay; for example a patient who required a scan would have their scan prior to being reviewed by the outreach team if they were stable enough to do so.
- Between May and October 2015 there were 397 patients referred and 1342 reviews completed by the outreach team. This did not include multiple reviews of a patient on the same day.

Nursing staffing

- Nursing staff worked shifts from 8am to 8:30pm and nightshifts from 8pm to 8:30am, with handovers at the start of each shift. During handovers, staff were told which patient had been allocated to them and then received a general overview of all patients on the unit, before receiving a more detailed bedside handover about their allocated patient/s.
- An acuity tool was used to determine safe staffing levels across critical care. The Faculty of Intensive Care Medicine Core Standards for Intensive Care Units states that all level three (patients requiring advanced respiratory support alone or basic respiratory support with support of two other organ systems) patients are required to have a registered nurse to patient ratio of a minimum of 1:1 to deliver direct care. For level two (patients requiring more detailed observation and

higher levels of care such as those receiving basic respiratory support or with single organ failure) patients a ratio of 1:2 is required. We reviewed patient allocation records and staffing during our inspection which showed the critical care unit complied with the required staffing levels.

- A supernumerary charge nurse was allocated to each shift and was responsible for overseeing the day-to-day management of the unit. This was in line with recommendations from the FICM Core Standards for Intensive Care Units. Staff told us there was almost always an additional "runner" member of staff who was present to cover staff break times and to assist with fetching equipment for staff with allocated patients.
- Hospital policy advised there should always be one empty critical care bed available for an emergency admission and this bed should be staffed at all times to allow patient transfer to critical care within one hour. Critical care staffing and allocation records demonstrated there was consistently an additional member of staff rostered for this reason.
- The hospitals' 'bed management and transfer policy' stated critical care nurses must not be redeployed to other wards in the hospital even in the event of severe staff shortages. Staff told us this was to ensure a responsive critical care service with safe staffing levels at all times however sometimes nurses were required to work elsewhere despite this.
- The establishment of registered nursing staff was for seven band 7 nurses, 20 band 6 nurses and 41 band 5 nurses to cover the required staffing for the critical care unit. Hospital data from August 2015 showed there were seven band 6 vacancies and 10.5 band 5 vacancies. Information provided by the hospital identified the establishment of registered nurses was only sufficient to staff 11 critical care beds and vacant shifts went out to bank or agency staff.
- The FICM Core Standards for Intensive Care Units recommends no more than 20% agency staff usage per shift. Documentation we reviewed demonstrated use of agency staff on the critical care unit was compliant with this standard as agency nurses made up between 5-10% of registered nursing staff on duty.
- New starters began work as a supernumerary member of staff while receiving a local induction and signing off essential competencies. They were allocated a mentor who was responsible for providing support through the induction process and assisting in teaching and signing off competencies when appropriate.
- The critical care outreach team was staffed by 4.5 whole time equivalent (WTE) band 7 critical care nurses. One member of staff had recently been on maternity leave and cover for the shift gaps caused by this was provided by a band 7 who was usually based on the critical care unit.
- To address the development needs of staff on the unit there was a band 8a lecturer practitioner and a band 7 practice development nurse (PDN) allocated to the unit and both of these posts had substantive staff members in post.
- To support the administrative needs of staff and patients on the unit there was a band 3 administrator in post. Staff were enthusiastic about the support provided by the administrator and told us they wouldn't be up to date with all the necessary paperwork without this support.

Medical staffing

- There were six substantive and one regular locum critical care consultants rostered to cover the unit. One consultant was on duty at once, working periods of 24 or 48 hours on call, during which they worked day shifts between 8:30am and approximately 7pm. Consultants had no other commitments while responsible for the critical care unit. The provision of consultant cover on the unit was compliant with recommendations from the FICM Core Standards for Intensive Care Units.
- The consultant to patient ratio was 1:15 when the critical care unit was at full capacity. This was sufficient to meet the ratio recommended by the FICM Core Standards for Intensive Care Units.
- Medical handover meetings took place twice each day during which staff finishing their shift would handover patient details and any relevant updates to doctors starting work.
- Doctors completed a formal ward round twice each day and decided upon a management plan for each patient; this was in line with recommendations by the FICM Core Standards for Intensive Care Units.

- A registrar, two senior house officers and a foundation year one doctor supported the critical care consultant on duty during daytime shifts. Overnight, a registrar and a senior house officer were responsible for the unit, with the on call critical care consultant available for telephone advice or to come into the unit to review patients if needed. The consultants' required response time overnight was 30 minutes which was in line with recommendations from FICM Core Standards for Intensive Care Units.

Major incident awareness and training

- A major incident folder was available at the nursing station that contained the hospital policy, definitions of various types of major incidents and action cards. It was not clear what staff on the critical care unit were expected to do in the event of a major incident, where to contact for guidance or where patients could be moved to in order to create critical care capacity.
- Staff on the unit were not aware where to locate the major incident policy however they were able to tell us patients could be decanted or admitted directly to theatres in the event of a major incident.
- Staff told us they had not received any specific major incident training or taken part in a simulation exercise relating to this.

Are critical care services effective?

Good

We rated effectiveness in critical care as good because;

The unit was involved in the local critical care network and submitted data to ICNARC so patient outcomes could be benchmarked against other units. Patient outcomes were consistently in line with or better than other similar units. Evidence-based care including enhanced recovery programmes and care bundles were used and there was an audit programme in place to measure and monitor various elements of patient treatment.

There was a comprehensive competency and development programme in place for nursing staff and good access to information on the unit. Staff knowledge of mental capacity and consent issues was good throughout critical care however understanding of DoLS was variable.

We saw evidence of good multidisciplinary working, although there was no presence from the physiotherapy team on the daily ward round which is not compliant with recommended practice. It was not possible to instigate parenteral nutrition during weekends due to a lack of specialist dietetic support, which was not in line with best practice guidance.

Evidence-based care and treatment

- The critical care unit participated in the North Central London Critical Care Network and was involved in developing a set of standards to be used during unit self-assessments throughout London which were based on the FICM Core Standards for Intensive Care Units. A self-assessment for the unit was completed in May 2015 and demonstrated compliance with 94% of standards identified, which was better performance than most other units within the region.
- The critical care unit admissions policy and discharge policy were based upon current evidence of best practice as well as recommendations from the FICM Core Standards for Intensive Care Units and Department of Health guidelines.
- We observed medical ward rounds on the unit and saw regular references to best practice guidance and current research when discussing and deciding upon a treatment plan for patients in critical care.
- We saw evidence certain policies and procedures were updated at regular intervals to reflect current best practice and guidance. For example a new analgosedation policy was created to reflect best practice in pain and sedation management. This policy also included information relating to the assessment and management of patients with delirium, including the use of the 'CAM-ICU Delirium Assessment Method'.
- A new dedicated guideline relating to the management of patients requiring non-invasive ventilation was recently introduced. This guideline adhered to recommendations from the British Thoracic Society and used a multidisciplinary approach to management.
- The critical care unit was working towards a trial of citrate anticoagulation for haemofiltration in response to new guidelines from 'Kidney Disease: Improving Global Outcomes' (KDIGO).

- Specific care bundles were in use for the insertion and management of central venous catheters (CVC). Information provided by the Director of Infection Prevention and Control (DIPC) explained performance in compliance with CVC care bundles was poor for a period (audit results of 50-80%) leading up to 2012. An education programme and change of clinical guidelines were introduced as a result of this and audit results were then consistently 100% for both the insertion and maintenance of CVCs until the end of 2014. There had been no audits of CVC care bundle compliance in 2015; instead an insertion sticker and maintenance check list were used on a daily basis to ensure appropriate care. We saw evidence of these systems in use with all patients who had a CVC line in place during our inspection.
- Peripheral intra-venous lines were inserted and cared for under a specific evidence-based care bundle and audit data from 5 December 2015 showed 100% adherence with the care bundle.
- A ventilator-acquired pneumonia (VAP) care bundle was in use on the critical care unit. Hospital audit data from October 2014 demonstrated 97-100% compliance with individual aspects of the care bundle, which was marginally below the 100% target for all areas. Suitable recommendations for improvement were made such an increase in staff training relating to VAP care bundles and we saw evidence these had been implemented. Senior staff told us a re-audit of this information was due.
- Evidence-based enhanced recovery programmes were used with certain patient cohorts, such as patients who had a laparotomy. This meant evidence-based interventions such as mobilisation were used to optimise their recovery post procedure. Staff told us this type of programme ensured the care of high risk patients were targeted appropriately after their operation.

Pain relief

- Pain was assessed at hourly intervals or more frequently for patients with pain control issues. We saw evidence patients who were able were asked to rate their level of pain and pain relief was given quickly when required. A scale specifically for patients unable to communicate their pain was used for unconscious patients.
- Patients could receive pain relief in various formats; patient controlled analgesia (PCA), epidural, intra-venous or orally. Staff told us pain relief medicines were reviewed frequently to ensure pain control was optimised and patients were weaned from analgesia when they were ready.
- A team of allocated critical care nurses made up the unit's pain link team. These nurses liaised closely with the hospital-wide pain team and produced a reference folder for ward staff to access up to date information regarding pain management readily. The pain link team distributed bulletins outlining any developments or news in pain management. The link team also led extended teachings on pain management equipment, such as epidural pump set up.
- Patients told us their pain was well controlled and staff provided pain relief quickly when requested. One patient told us a pain relief medicine had made them "feel funny" and the team changed the prescription to a different type of pain relief immediately

Nutrition and hydration

- Specialist dietetic support was available from 8:30am to 4:30pm Monday to Friday on the critical care unit. This support was provided by 0.8 WTE band 7 specialist dietician allocated to the critical care unit. At the time of our inspection, 0.3 WTE was vacant.
- During weekends, non-specialist dietetic cover was available via bleep to address any urgent enquiries. Staff told us this meant critical care patients admitted over the weekend who required parenteral nutrition (PN) had to wait until Monday morning to start this. Dietetics staff we spoke to told us starting parenteral nutrition was not a priority. This was not in line with recommendations from the European Society for Clinical Nutrition and Metabolism (ESPEN).
- A nutrition link nurse was identified who completed specific training with new band 5 nurses regarding nutrition best practice. The link nurse also monitored adherence to the nutrition-monitoring tool and we saw evidence this adherence had improved over the last 12 months.

- Posters highlighting the risks of food allergies were on the walls in the pantry and housekeeping staff told us they always checked patient food allergies with nursing staff to make sure patients got appropriate food.
- Patients who were able to eat and drink could choose their meals from a selection of menus. The menus accommodated specific patient needs such as pureed meals, gluten free, halal and kosher, as well as preferences for certain genres of food for example African Caribbean and Asian.
- Patient meals were temperature checked before they were served; any meals not at 75 degrees Celsius or above were reheated on the unit. We saw documentation demonstrating these checks took place at each mealtime and for every meal served.

Patient outcomes

- The critical care unit contributed data to the ICNARC database for England, Wales and Northern Ireland. This meant care delivered and patient outcomes were benchmarked against similar units nationally. ICNARC data quoted relates specifically to patients on the critical care unit and to the period from July to September 2015. The unit also contributed to the local critical care network which enabled further outcome and quality benchmarking, specifically against other local critical care units.
- The critical care unit had an audit programme in place to ensure audits of key performance criteria were completed at appropriate intervals, which was in line with recommendations from the FICM Core Standards for Intensive Care Units. Other teams on the unit such as the microbiologists and physiotherapists completed additional audits.
- A 0.8 WTE audit clerk was in post to complete data entry for audit information such as the critical care minimum data set and ICNARC database. The clerk received a recognition of achievement award in 2014 from ICNARC for submitting the most accurate information with the fewest gaps in comparison with other contributors nationwide.
- Staff told us ICNARC results were reviewed quarterly and action plans were created to address any areas for improvement. We saw evidence of actions identified in response to ICNARC results, such as a change in discharge policy to discourage out of hours discharges from happening.
- There were 36 patient deaths on the critical care unit between May and October 2015, showing a 10% mortality rate. ICNARC data showed the unit mortality and acute hospital mortality for ventilated patients was better than in other similar units. These outcomes were also better for elective surgical patients and emergency surgical patients. Mortality outcomes for patients with severe sepsis, pneumonia and trauma, perforation or rupture were in line with other similar units nationally.
- ICNARC data showed readmission to critical care within 48 hours of discharge occurred less often than in other similar units; affecting less than 0.5% of patients. Readmissions after 48 hours occurred more frequently than in other similar units; affecting almost 3% of patients. The hospital target aimed for less than 5% of patients to be readmitted to critical care and data showed this target was consistently met between October 2014 and September 2015.
- ICNARC data demonstrated most patients discharged from critical care left hospital with the same or better independence than on admission. Most patients returned to their pre-admission residence.

Competent staff

Nursing Staff:

- All nurses new to critical care worked as supernumerary members of staff for six weeks and a weekly study day was allocated to these staff members for independent professional development during this period. Staff were allocated mentors who supported them during their induction and whilst settling into their roles. All band 7 nurses and 20 band 6 critical care nurses had completed mentorship training.
- We saw evidence basic competencies were completed with new nursing staff, including key areas of care such as mouth care and documentation. More complex topics for example haemodynamic monitoring and shock were completed as the staff member's knowledge and confidence developed.
- Junior nurses attended tissue viability, pain and tracheostomy study days within their first year of

employment. Updates on these topics were provided on a 2-3 yearly basis. Critical care staff could access additional hospital wide study days if the topic was considered relevant to their work on the unit. For example, staff attended a diabetes study day and an end of life study day.

- Ad hoc training sessions were written in the unit communication book and staff were encouraged to attend if possible. These sessions were short and which took place at the patient bed side or close by on the unit. A range of topics were covered such as the Optiflow respiratory support system and nutrition assessment. These sessions were often held on more than one occasion to ensure as many staff as possible could attend.
- Staff were encouraged to complete the introduction to critical care course after working on the unit for approximately six months. Senior staff told us this ensured the nurses had sufficient background knowledge, understanding and experience to gain as much as possible from attending the course. An additional study day was introduced for staff undertaking the course and took place approximately six months after starting the award. This study day recapped subjects covered in the initial six-week period of intensive care work.
- The critical care unit had an allocation of eight places on the annual advanced life support course held by the hospital. Staff were able to access this course when they had sufficient experience and additional development in this area had been identified during their annual appraisal. Staff were complimentary about the course and told us it had improved their confidence in dealing with life support scenarios.
- Link nurses acted as critical care "champions" for certain topics for example pain and tissue viability. These staff members attended annual study days for updates and further training in their allocated area of expertise. Staff on critical care told us the link nurse system worked very well and their link nurse colleagues were knowledgeable and helpful.
- Nurses with a special interest or those acting as link nurses were encouraged to run their own study sessions for unit staff. Staff told us these sessions had been recently held by the pain link nurse as well as the end of life and organ donation link nurse.
- Attendance at external study events was encouraged and funding for these days was provided for staff when possible. For example we saw evidence of staff attendance at the State of the Art conference which was run by the Intensive Care Society.
- We saw evidence the PDN disseminated information from study days and conferences to critical care staff via email. One staff member told us they valued accessing information in this way as staff could read the information when it fitted in with their workload rather than having to attend a scheduled session.
- Senior nurses had opportunities to develop their management knowledge and experience by shadowing the shift coordinator and leading a shift with support from a senior colleague. They could also shadow staff from the critical care outreach team for a team to gain experience in a more specialist role.
- All but one of the critical care outreach nurses had completed nurse prescribing qualifications which meant they were able to prescribe certain medicines and treatments without delay for patients they reviewed.
- Medical devices training passports were used to document the completed and required training relating to medical equipment for all critical care staff. This passport covered a range of basic equipment such as patient beds and more advanced equipment like ventilators. Key assessment criteria were identified for example the ability to demonstrate safe operation of the device and identify how to report faulty medical devices.
- According to hospital data, 81% of critical care staff had an up to date appraisal. Senior staff told us this was lower than their 90% target due to difficulties booking in sessions when both staff were on duty but told us they were on track to have 100% completed by the end of March 2016.

Medical Staff:

- New doctors on the unit received an induction to the unit from a senior colleague and were provided with a

17-page information leaflet providing an overview of the service provided by critical care. Timetables of activities such as meetings and ward rounds as well as contact details for relevant teams were included.

- Training for junior doctors was held on a weekly basis until July 2015 when the rota was changed to less frequent but longer afternoon blocks in response to feedback from the trainees. The teaching programme demonstrated a range of topics covered and attendance lists showed good attendance from medical trainees. Trainees were positive about the teaching they received and told us there was plenty of ad hoc teaching from senior colleagues that took place at patient bedsides.
- Five of the substantive critical care consultants had FICM accreditation and the sixth consultant had a certificate of completion of training (CCT) in intensive care medicine. These qualifications met recommendations from the FICM Core Standards for Intensive Care Units.
- Monitoring data provided by the hospital showed up to date appraisals had been completed for 75% of medical staff on critical care.
- Medical staff completed self-assessments relating to their training needs on items of medical equipment for example patient ventilators and dialysis machines. Members of the critical care team would then provide training as required.

Multidisciplinary working

- There were weekly multidisciplinary meetings attended by the medical staff on duty, senior nurses and senior physiotherapist. Patient progress and goals were discussed and a plan was made for the following week. This plan was discussed with patients and their visitors the following day during the medical ward round.
- The morning daily ward round was attended by the on duty consultant, junior doctors, nurse in charge and pharmacist. There was no daily involvement of the physiotherapy team during the ward round, which is not compliant with recommendations from FICM Core Standards for Intensive Care Units.
- Each patient discharged from critical care, including those who die on the unit, had a discharge summary written by the medical team. This summary was passed to the receiving ward, if appropriate, as well as to the patient's GP. If the patient had died on the unit staff would usually accompany the discharge summary with a courtesy telephone call to the GP.
- Some patients discharged from critical care were followed up on the wards by the outreach team. We observed excellent collaborative working from the outreach team who liaised closely with the medical and nursing teams on the hospital wards to ensure patients received optimised treatment.
- Physiotherapy was provided by 0.25 WTE band 8a, 0.64 band 7, 1.6 WTE band 6 and 0.25 WTE band 5 therapists. Patients discharged from critical care had a prescription in place for continuation of their rehabilitation once stepped down. This was in line with NICE 83 guidance.
- Speech and language therapy (SALT) was provided by a 0.5 WTE therapist, who worked in other areas of the hospital for the other 0.5 WTE. Information provided by the hospital indicated the work completed on the critical care unit took more time than the 0.5 WTE could provide and so had a knock on effect for patients in other areas of the hospital.
- There was no designated occupational therapy support allocated for critical care patients. Staff told us they used the experience of the physiotherapy team to try and "bridge the gap" and accessed additional support from the neurological physiotherapy team who could assist with specialist tasks such as splinting.

Seven-day services

- Consultants completed daily ward rounds, including weekends, which was in line with recommendations from FICM Core Standards for Intensive Care Units.
- Physiotherapy ward cover was available between 8:30am and 4:45pm Monday to Friday. Out of hours emergency respiratory support was provided by an on call therapist via a bleep referral system with a response time of 45 minutes. During weekends an allocated respiratory physiotherapy team would review critical care patients requiring ongoing support and a designated mobility team would review patient rehabilitation.

- There was no availability of speech and language therapy support during weekends. Staff told us nursing staff could lead on some assessments and physiotherapists could assist with respiratory needs of SALT patients particularly relating to tracheostomies.

Access to information

- The main patient notes were obtained from medical records as quickly as possible once a patient was admitted to critical care. The ward administrator was usually responsible for this and staff told us notes were usually on the unit within 48 hours. We were told delays in getting hold of notes were infrequent.
- Patient information such as blood test results and x-rays were available on computer systems accessible from all computers on the unit. This meant staff did not have to leave the patient's bedside to review their most recent investigation results.
- Critical care policies and procedures, including clinical guidelines, were available on every bedside computer. This meant staff were able to access the most up to date versions of these documents at all times.
- Reference folders were available for staff to access on the unit, such as the pain folder and tissue viability folder. Staff were allocated to specific folders to keep the information contained in these folders up to date.

Consent, Mental Capacity Act and DoLS

- Mental capacity and DoLS training was completed alongside the training for adult safeguarding level two. 90% of critical care staff had completed this training.
- Doctors completed mental capacity assessments with patients whose capacity to make decisions was in question. We saw evidence these were completed twice per day with patients who had fluctuating states of capacity.
- Specific capacity assessments were completed when key decisions about the patients' care were needed and best interests decisions were made when the patient was unable to consent. Most staff understood next of kin were not able to consent on behalf of patients. We observed appropriate consent forms were in use for patients who were unable to consent.
- Senior staff had some experience of caring for patients with advance healthcare directives and could describe how this affected the care given to these patients. More junior critical care staff told us they would speak to senior nurses for guidance with patients where an advance directive was in place.
- Knowledge regarding DoLS was variable on the unit. Some staff were able to clearly explain the principles of DoLS and identify the relevance of this within a critical care setting whereas others were not familiar with the term or could not correctly describe what DoLS entails.
- Senior staff initiated DoLS applications and we saw evidence of completed DoLS applications on the critical care unit when indicated. For example for patients who required use of 'mittens' to stop them from pulling intravenous lines and ventilator tube. We saw an approved DoLS application and extension in place on the unit at the time of our inspection.

Are critical care services caring?

Good

We rated caring in the critical care service as good because;

Patients were complimentary about the approach staff took when caring for them and results from the Friends and Family Test (FFT) showed 100% of patients would recommend the unit. Copious numbers of thank you cards and letters were on display, all praising the care given on the unit and expressing gratitude for everything the staff had done.

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. Staff routinely provided emotional support to patients and visitors and accessed the hospital chaplaincy service when appropriate.

Patients felt their privacy and dignity was well maintained however we witnessed some occasions when this was not the case, for example staff entering closed curtains without asking permission and curtains being fully opened when patients were not suitably covered up. We also noted staff did not always place the needs of patients first during some interactions on the unit.

Critical care

Compassionate care

- Patients and their relatives provided feedback to the critical care unit via the FFT. Results from November 2015 showed a response rate of 45% and 100% of respondents reported they would recommend the critical care unit.
- Our Short Observational Framework for Inspections (SOFI) demonstrated mainly neutral interactions between staff and patients, including offering patients drinks and exchanges of information such as telling the patient the time when they asked. One staff member was noted as having all positives interactions with patients as they always chatted to the patient and asked questions to put the patient at ease.
- We observed many thank you cards and letters on display that were sent to the unit by patients and their relatives. Praise for the critical care staff was evident throughout all cards. For example, "incredible care and professionalism" and "the care you gave her…was outstanding") and one letter stated "your unit is exemplary". There were many expressions of gratitude for the care provided by the critical care unit; "I'll be forever grateful", "we cannot thank you enough".
- Some nursing staff chatted to patients as they worked, asking about their lives and families. Patients appreciated the effort staff made to get to know them and told us it helped them feel more relaxed on the unit.
- We observed staff did not always put patients at the forefront of the interactions on the ward. For example we observed a nurse speaking to a confused patient kindly to help settle him however another member of staff, who spoke immediately to the nurse without any acknowledgement to the patient, interrupted her.
- Patients told us staff maintained their comfort at all times and offered help with repositioning or additional pillows when needed. One patient told us "they are always worried whether I'm comfortable enough".We observed staff carefully using pillows to support patients' limbs and adding extra blankets when they were concerned about patient temperature.
- Patients told us the staff "knew what they [were] doing" and that they felt safe. One thank you card described how the patient "always thought [they] were in safe hands".
- Patients felt their privacy and dignity was maintained throughout their stay on critical care. Patients told us staff took care to keep them covered up and offered blankets when they were sitting in a chair.
- Signs reminding staff to respect patient privacy and dignity were used when patient bed side curtains were closed. However, we observed several occasions where nursing and medical staff entered closed curtained areas without asking for permission from those inside, which could compromise patient privacy and dignity. We also saw a nurse fully open a patient's bedside curtains when the patient was sat on the edge of the bed with his gown open at the back, exposing him to the ward.
- We saw a nurse carefully selecting the correct type of chair for a patient but overheard the nurse comment "[the patient was] already up in the hoist". This meant the patient was left raised up in a hoist sling while the nurse found a chair. This did not maintain the patient's privacy or dignity and exposed the patient to risk of pressure sores from the hoist equipment.

Understanding and involvement of patients and those close to them

- Patients told us they felt well informed about their progress and expected care pathway. They told us staff offered them opportunities to ask questions and took their time to answer questions clearly and fully.
- We observed good interactions between staff on the ward round and patients on the unit. Patients were involved in discussions with the ward round and were involved in making decisions about their care.
- Visitors to critical care told us staff were happy to update them on the progress of their relatives and told us staff checked who they were first. One relative told us staff asked the visitor to liaise with the next of kin for medical updates so patient confidentiality was maintained.
- Relatives told us they felt involved in the care of their loved one and were included in discussions about their care, including when doctors asked a relative whether the patient had any pre-existing wishes about their

medical care. One relative told us they "cannot fault anything" about the care and support provided on the critical care unit and their involvement in the care of their loved one.

- Family meetings were not routinely held for critical care patients but staff told us these would be arranged if the patient's care was particularly complex or if end of life discussions were taking place.
- Patient diaries were used with patients who were ventilated for 24 hours or more. Visitors were encouraged to fill in these diaries with information about who had visited and what they had talked to the patient about. Staff were also see to be filling in the patient diaries with details about medical activities that had happened, such as going for a scan.
- We saw evidence showing patients who attended the follow up clinic found the experience useful. Emails thanking the staff involved described how the clinic helped patients make sense of things that happened to them during their critical care stay.

Emotional support

- Patients told us they felt well supported by staff on the unit. They told us staff were always willing to listen to anything that was upsetting them and to provide reassurance when needed. One patient told us staff were encouraging and helped them to achieve their goals when the patient had not thought it would be possible.
- Visitors to the critical care unit told us they felt well supported by staff on the critical care unit. One visitor told us they had built up a good relationship with several members of the team and felt supported by them all in different ways. Another visitor described the nursing staff providing support when a patient was readmitted to the unit and the visitor found this particularly worrying and upsetting.
- We observed staff on the critical care unit holding patients hands and providing support when patients were upset or unsettled. We saw a confused patient becoming upset and the nurse caring for the patient took time to sit with them and calm them down by providing reassurance.
- Spiritual and pastoral support was provided by the hospital chaplaincy service. There were chaplains of different faith traditions available to reflect the range of beliefs in the local community. Patients and their relatives could access this service via critical care staff or by attending the chapel or multi-faith room within the hospital.
- Relatives of patients who were approaching end of life on the critical care unit were supported by end of care link nurses on the unit if appropriate. These nurses would assist the relatives in making hand prints or obtaining locks of hair from the patient if relatives found this comforting as the patient approached their end of life.

Are critical care services responsive?

Requires improvement

We rated the responsiveness of the critical care service as requiring improvement because;

Difficulties with accessing step down beds within the hospital for critical care patients meant approximately 20% of patient bed days were occupied by level 0 and level 1 patients who should be cared for in a ward environment. This meant mixed sex accommodation breaches were frequent. This also meant 79% of patients had discharge delays of more than four hours which was much worse than on other similar units. However average length of stay and out of hours transfers were in line with other units. Some patients were discharged home directly from critical care because of the issues accessing ward beds. Critical care staff had developed discharge processes and community links to ensure discharges were successful.

However:

Staff were unaware of support processes for patients with a hearing impairment, learning disability, psychiatric needs or those living with dementia. Patient and relative literature was available in English or Turkish but it was unclear how information in other languages would be obtained.

There were clear admission pathways for patients to access critical care and a low occupancy rate meant almost all patients were admitted within an hour of the decision to admit being made. There was consistently one critical care

bed staffed and kept free to ensure an emergency admission could be accommodated. The needs of young people were met flexibly and patients could access an informal follow up clinic.

Service planning and delivery to meet the needs of local people

- The critical care consultant on call was responsible for deciding whether patients should be admitted to the unit or managed in a different way, such as on the ward with outreach support. Staff told us in practice it was the critical care registrar who would physically assess patients being considered for critical care and this would then be discussed with the consultant. The consultant on call was also responsible for identifying patients ready to be discharged from the unit and those to be transferred to other hospitals.
- Patients who required planned postoperative admissions to critical care were identified during their preoperative assessment clinic and highlighted to the critical care unit once a date for surgery was identified. Planned admissions were listed in the critical care communications diary and this was cross-referenced with the clinical bed manager to ensure bed availability and adherence to infection control protocols. Patients who had not been booked in for a postoperative critical care bed with sufficient notice (at least 24 hours) would only be admitted to critical care if staffing levels allowed and one free critical care bed remained for an emergency admission. No elective procedures had been cancelled due to a lack of critical care bed availability in 12 months.
- Patients who required admission to critical care from the emergency department or from other wards within the hospital were referred to the unit's registrar doctor and shift coordinator. The critical care outreach team were also contacted during daytime working hours. Hospital policy stated unplanned critical care admissions took priority over planned postoperative admissions and procedures were cancelled if insufficient critical care beds were available.
- When patients who live out of area were admitted to critical care, a transfer to the patient's local ITU was requested at the earliest appropriate time. Staff told us this ensured the critical care service was responsive to the needs of local patients.
- Anticipated bed needs in critical care were assessed by the critical care consultant and shift coordinator on a shift by shift basis. When sufficient critical care beds to meet internal requirements plus one emergency bed were available, additional beds were declared to the emergency bed service (EBS) who coordinated critical care beds across the region. Critical care beds occupied by ward level patients were also declared as available. Hospital policy stated elective procedures with critical care bed bookings and maintaining a spare bed for an emergency admission would take priority over declaring beds to EBS.
- Patients who were ventilated on the critical care unit were invited to a follow up clinic one month after their discharge from hospital. The practice development team along with one of the critical care consultants led the clinic, which was not a funded activity however there were hopes to obtain funding for this service in the future. Patients were invited to return to the unit and speak to staff who had cared for them.

Meeting people's individual needs

- Hospital data showed there were five admissions of young people under the age of 18 between December 2014 and November 2015. The youngest patient admitted during this period was 15 years old. Staff told us young people were admitted to critical care if they were unwell enough to need more complex care than that provided on the hospital wards and they would be stabilised before being moved to a more appropriate place of care, for example a paediatric critical care unit at another hospital. Critical care staff told us paediatric nurses would support the critical care admissions of young people under the age of 16 if needed, however we were unable to corroborate this.
- Various leaflets were available for patients and their visitors such as information about what to expect on the critical care unit, how to raise concerns or make a complaint, organ donation and smoking cessation. Staff were unsure how to access information in languages other than English and Turkish.
- Critical care patients and their visitors could access a translation service if required. Staff told us translators were preferably booked for telephone consultations but

could also be booked for face-to-face meetings. Staff told us other members of staff were sometimes used to translate at short notice but patients' relatives would never be used to translate sensitive information.

- Staff were not aware how they would support a patient admitted to the critical care unit who had a hearing impairment. They did not know if sign language support was available or how they might access this. One staff member suggested they would try using written information or picture boards if they struggled to communicate with the patient.
- Staff told us there was a policy in place entitled Whittington Strategy for Dementia however, the document we were shown was seen to be past the date of review, which suggested it was not the most up to date version or had not been reviewed/updated recently. A more up to date document was awaiting review by the Dementia subgroup therefore was unavailable to staff at the time of our inspection. Staff told us there was no specific guidance for caring for a patient living with dementia on the critical care unit but that they would be likely to use 1:1 nursing to ensure the patient was supervised at all times.There was also some specialist dementia staff working within the hospital who could provide support however staff we spoke with were unaware of this.
- There was no formal strategy or guidance in place for managing patients with a learning disability in the critical care setting. Staff told us there was a learning disability specialist nurse within the trust and critical care staff were complimentary about the support provided by this post. However this staff member covered all areas of the trust which meant they were extremely busy and there was no cover when the nurse was on leave. Staff told us they would use the experience of the patients' family or carer to help them care for a patient with a learning disability on the unit.
- An integrated liaison team was available within the hospital between 9am and 9pm daily and could be contacted to review critical care patients with psychiatric needs. Not all staff on the unit were aware this team was in place.
- Sensitive family discussions were held in a quiet room which was available within the critical care unit. Staff told us the room was sometimes used as a separate waiting area for visitors of dying patients but otherwise was not used. An 'in use' sign was available on the door to ensure people using the room were not disturbed. Seating for four people was available, along with a coffee table.
- There was a large relatives' waiting area located opposite the entrance to the critical care unit. Cold water and cups were available but hot drinks were accessed via staff on the unit. There was also a relatives' bedroom and en suite bathroom that could accommodate one overnight visitor, although this was not in use due to refurbishment at the time of our inspection.

Access and flow

- Critical care bed occupancy averaged 66% between May and October 2015, which was consistently below the national average. This was in line with the Royal College of Anaesthetists recommendation of 70% critical care occupancy. The recommended occupancy rates allow for units to be able to take in more patients should there be an emergency. If a unit is at a higher occupancy it is unable to respond to emergency admissions and may find they are required to step-down patients too early or transfer patients to other hospitals out of their locality.
- 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. FICM Core Standards for Intensive Care Units recommend patients should be transferred to ITU within four hours and the unit met this standard with all patients audited.
- Hospital data demonstrated there were 20 patients ventilated outside of the critical care unit between October 2014 and August 2015 which is not appropriate for this type of patient. The audit clerk told us any patient who was admitted already ventilated would be recorded within this dataset and so it was unclear how long each patient had been ventilated for before being transferred to the unit.

Critical care

- An intensive care consultant should review patients within 12 hours of admission to intensive care according to FICM Core Standards for Intensive Care Units recommendations. This standard was not routinely audited however a snapshot audit of critical care patients was completed on 30 November 2015. Results showed the 12 hour target was met for 15% of patients; 23% of patients were reviewed after 12 hours and times were not documented for the remaining 62% so it was not possible to establish when they were reviewed. No action plan was identified to improve this performance.
- ICNARC data showed patients who were ventilated during their critical care admission had a slightly longer length of stay than on other similar units (8.5 days in comparison with eight days). This was also the case for patient with severe sepsis (10 days in comparison with eight days), patients with pneumonia (nine days in comparison with eight days). Elective and emergency surgical patients as well as patients admitted with trauma, perforation or rupture experienced a length of stay in line with other similar units.
- There were 23 patients transferred to other hospitals for clinical reasons and specialist care between May and October 2015. Although ICNARC data demonstrates this was worse performance than in other similar units, this was expected due to the nature of critical care provided within a district general hospital and the lack of specialist services. There had been no non-clinical transfers from critical care in more than two years which ICNARC data showed was better than the national average.
- Out of 314 patients discharged from critical care between May and October 2015 248 patients (79%) experienced a delayed discharge of four hours or more from the critical care unit. This was not in line with hospital policy or recommendations from FICM that advise all patients should be discharged from critical care within four hours. According to ICNARC data, the number of delayed discharges was much higher than on other similar units. Staff attributed the frequency of delayed discharges to the lack of availability of step down beds within the hospital wards.
- Patients discharged from critical care 'out of hours' between 10pm and 7am are nationally associated with worse outcomes and ICNARC data showed a similar number of patients were affected by this in critical care in comparison with other similar units across the country.Hospital data showed approximately 5.5% of patients were discharged out of hours.
- Hospital data showed approximately 20% of all critical care bed days between May and October 2015 were used by level 1 (patients at risk of their health deteriorating or whose needs can be met with advice and support from the outreach team) or level 0 patients who should be cared for within a ward environment (with or without critical care outreach team involvement) and not on a critical care unit. Level 1 and level 0 patients should be cared for within same sex accommodation and critical care was a mixed sex environment, which was not appropriate. Mixed sex accommodation breaches were not recorded or reported as incidents.
- Documentation we reviewed showed ten patients were discharged home between 7 October 2015 and 7 December 2015. Staff told us some patients waited for a ward bed for so long, they were ready to go home directly from critical care. When staff identified this was a possibility they began discharge planning as soon as possible to ensure a smooth transition home. We saw evidence of community support referrals made by critical care staff for these patients where appropriate. All patients discharged home directly from critical care received a follow up call within 24 hours to ensure there were no problems. Staff told us they did not use the hospital discharge lounge although this would be considered if there was pressure to make a critical care bed available.
- Staff told us there was always one empty bed available to admit emergency patients, unless there were 15 genuine critical care patients on the unit. When the critical care unit was full step down patients were prioritised for ward beds within the hospital over any other patients, including those who required admission from the emergency department. This was in line with hospital policy and we reviewed critical care activity data which supported this information.
- Patients being transferred into critical care from other hospitals were discussed by the critical care and referring consultants. A plan for repatriation was then agreed along with the shift coordinator who would ensure bed and staff availability at the agree time. Staff

told us there were sometimes delays when repatriating patients to the unit as most transferred patients needed a side room for infection prevention and control reasons.

- Patients with a tracheostomy were stepped down from critical care to one of three medical wards (Nightingale, Mary Seacoles and Montuschi). An intensive care consultant was the lead tracheostomy physician and completed weekly ward rounds of all patients with a tracheostomy alongside the critical care outreach team. The outreach team also reviewed these patients on a daily basis.
- Hospital policy advised actions to be taken in the case of a full critical care unit with no patients suitable for step down. Actions included caring for patients within the emergency department resuscitation area or theatres recovery until a critical care bed was available. The policy acknowledges caring for this type of patient outside of the critical care environment was suboptimal however accessing critical care support quickly was of paramount importance. The major incident procedure would be adhered to if more than once critical care patient was being cared for outside of the critical care environment.

Learning from complaints and concerns

- There was one complaint on the critical care unit between January and October 2015. We saw evidence there was a thorough investigation into the complaint and the complainant received a suitable response.
- Leaflets outlining the informal and formal complaints procedures were available on the critical care unit. Informal guidance suggested passing comments onto unit staff in the first instance and progressing to making a formal complaint via the Patients Advice and Liaison Service (PALS) where the complainant felt an unsatisfactory response was received at ward level.
- The critical care unit used a "you said, we did" poster to demonstrate their responses to feedback from patients and their visitors. During our inspection, we noted the poster showed the unit's response as being "we may improve our communication with you and your family". This did not offer specific actions to the concern raised.

Are critical care services well-led?

Requires improvement

We rated the leadership of the critical care service as requires improvement because:

Patient flow through critical care was a significant issue and we saw little evidence the critical care leadership team were pushing to improve this, despite the problem being acknowledged by several of the management team. Some of the leadership team failed to acknowledge the problem at all or did not believe it was the responsibility of the critical care team to correct.

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 and the importance of proactive incident reporting was not recognised. We were told learning from incidents was mainly shared during staff meetings however we saw evidence suggesting these meetings occurred infrequently and were poorly attended.

However:

Staff felt the leadership team were visible and approachable, which contributed to the positive and friendly culture on the critical care unit.

We saw evidence of some innovation and improvement on the unit, such as participation in research and developing new services.

Vision and strategy for this service

- Senior staff anticipated a growing need for critical care beds within the hospital due to an aging population and patient acuity getting worse. They told us they anticipated increasing the threshold for critical care admission and improving the support for patients at ward level, including additional support from the critical care outreach team and maintaining skills of staff on the wards through teaching and experience.
- Senior staff described a "hub and spoke" critical care network within the region; this meant patients with specific critical care needs such as following a trauma were sent to specialist centres and returned to the general critical care units when the specialist care was

no longer needed. Senior staff felt this structure would develop further within the area, leaving the Whittington Hospital unit to continue with basic critical care patients and more of a weaning and rehabilitation role.

- The strategy of the unit aimed to deliver a patient-focused critical care service which met the needs of local critical care patients to a high standard, even during periods of high demand. The service also aimed for early intervention with deteriorating patients to prevent critical care admission.
- Staff within the critical care unit were mainly aware of the goals of the service and told us the aim was to continue providing high quality critical care to patients admitted to the unit. They recognised that the needs of local people were put first when planning service provision and told us this was why a bed was kept free for emergency admissions.

Governance, risk management and quality measurement

- Staff told us departmental meetings were held on a monthly basis however we saw evidence demonstrating there were no meetings between May and September 2015. Prior to May 2015 there was also an eight month gap between meetings. Minutes from these meetings suggested this was due to the busy workload of senior staff members. Topics for departmental meetings included FFT results, a review of incidents and overview of safety thermometer results.
- Minutes from departmental meetings which took place showed poor attendance, for example eight staff members attended in September 2015. Staff told us it had now been made compulsory to attend four departmental meetings each calendar year and we saw posters corroborating this.
- Departmental clinical governance meetings were held quarterly and included an overview of mortality and morbidity, journal club and presentation of audits or structured literature reviews. Patient stories were also presented where the critical care management of a patient was presented using the trust values as a basis for discussion.
- Monthly mortality and morbidity meetings were held on the unit, attended by critical care consultants, junior doctors and outreach nurses. No other critical care representatives or colleagues from other specialties attended. Outcome report forms were completed for each patient who was discussed in the meeting and a scale was used to determine whether any suboptimal care had occurred. Where suboptimal care was identified, learning and action points were identified. It was unclear how this learning was disseminated to the wider hospital audience; staff told us the ITU consultants personally feedback to consultants within surgical and medical specialities but this was done informally and not recorded.
- We saw evidence of collaboration with the North East and North Central London Critical Care Networks in relation to shared learning from incidents. Minutes from a network meeting demonstrated reviews of serious incidents across the network and learning point dissemination.
- Senior staff including the matron, clinical lead and director of the surgery ICSU oversaw the risk management for the critical care unit. The risk register contained all items for specialties that fell under the surgery ICSU. One item was documented on the risk register for critical care; “a lack of an electronic critical care system which includes all notes”. Senior staff told us the risk register was kept brief to make oversight and tracking of issues easier. We identified other risks during our inspection which should have been recorded, such as the difficulties with patient flow out of the unit. When we raised this with senior staff they acknowledged it was potentially an omission but told us “everyone knows about the problem” and “it doesn’t need to be written down to be discussed”.
- We raised our concerns regarding potential underreporting of incidents on critical care with senior staff who told us they were confident all incidents which required investigation or acknowledgment would be reported by staff on the ward. A senior member of staff told us “we can report more if you want us to” which indicated lack of appreciation with regards to the purpose of incident reporting and another told us “it’s good when staff feel they don’t need to report things as incidents”.
- The unit had completed self-assessment of the critical care service specification standards (D16) 2015. This meant a gap analysis had been completed, allowing identification of any areas where the unit was not

meeting current recommendations. The unit demonstrated full compliance with 73% and partial compliance with 21% of the standards measured. Senior staff told us parts of the unit incompliance were due to the external provision of certain specialist services such as plastic surgery.

- A deteriorating patient group was held on a monthly basis and included representatives from critical care, the critical care outreach team, the end of life team and senior staff from medical and surgical wards. This group discussed the quality of response to deteriorating patients throughout the hospital and identified action points for improvement. For example the critical care outreach team were asked to deliver training on deteriorating patients on a certain ward where there were concerns deteriorating patients were not referred to the outreach team in a timely manner.

Leadership of service

- Clinical leadership was the responsibility of the clinical lead who worked with other consultants on the unit to provide high quality and consistent leadership for patient care. The matron of the surgery ICSU was responsible for overseeing the nursing management on critical care.
- Staff felt the senior critical care leadership team maintained a strong presence on the unit; the clinical director worked as the on call intensivist on a 'one in 12' basis and the unit matron was reported as being seen on the ward daily.Staff told us they felt confident raising concerns, problems and ideas with these senior members of staff.
- Seven band 7 nurses were responsible for overseeing the day-to-day management of the critical care unit and were allocated as the supernumerary nurse in charge of each daytime shift. Staff told us the nurse in charge was always experienced, knowledgeable and approachable. They felt comfortable raising any issues with the staff in charge and were confident they would be supported.
- Some senior critical care staff acknowledged more needed to be done to address the issues with patient flow and the high numbers of level 0 and level 1 patient days. They told us "it might be time to have another push [at improving the patient flow]" and that they "haven't placed enough emphasis on getting the right patients onto the unit, especially in comparison with other more acute critical care units". Other senior staff felt it was not a significant problem or that they had raised the issues with patient flow plenty of times before and the responsibility to improve this issue lay outside of the critical care leadership team.
- Some senior critical care staff told us trust management did not recognise the critical care unit as being as an area within the hospital that required development because it did not require "high levels of work" and the unit leadership team "get on with it without making a fuss".

Culture within the service

- There was a positive and friendly culture within the critical care unit and staff valued the knowledge and expertise of their colleagues. Staff told us their peers were keen to assist with teaching and sharing knowledge which was "an effective way of learning on the job". Staff felt comfortable asking questions and were confident constructively challenging each other regarding best practice and patient care; we observed this in practice during ward rounds.
- Staff on the unit told us they felt valued by the senior staff within the service and by the wider trust. They felt the value of the work they did was recognised and acknowledged sufficiently throughout the hospital.
- Staff throughout the hospital, as well as on the critical care unit, highly valued the support provided by the critical care outreach team. A senior critical care manager described the outreach team as "a jewel in the crown of critical care".

Public and staff engagement

- Patient feedback forms encouraged comments from patients and their visitors. Staff told us it was important to find out what they were doing right and what aspects of the service need to be improved.
- A coffee morning entitled "Involving Carers" was held in November 2015. Previous patients and their relatives were invited to attend and provide feedback about their experiences of the critical care unit. Staff told us the aim was to identify ways of improving engagement and involvement with patients' next of kin. No action plans had been identified from the morning as other clinical work had been prioritised however staff told us of their plans to review the feedback in the new year.

Critical care

- The critical care nursing staff were split into seven teams, each led by a different charge nurse and group of senior nurses. Team away days were held annually and updated staff on recent changes to critical care practice as well as specific training. Staff told us they valued opportunities to give feedback about their work and developments on the unit during these days however would like more frequent chances to be involved in the development of the unit.

Innovation, improvement and sustainability

- Staff on the critical care unit developed a wrist to elbow measurement to predict ideal body weight for patients. This meant optimum tidal volumes for ventilators could be calculated for each individual patient, reducing the risk of lung injury caused by overventilation.
- The ITU doctors developed a rapid sequence induction check list and video to improve intubation in the critical care unit. Staff we spoke with told us this had helped their knowledge and understanding regarding intubations, including for patients with difficult airways.
- One of the consultants was leading the trial of a high flow nasal oxygen service within the critical care unit. Staff told us the aim was for early intervention with patients who required additional support with their breathing and to maintain their oxygen levels, without the need for non-invasive ventilation. This service was provided on the critical care unit but it was hoped responsibility for managing patients on high flow oxygen would fall to staff on the respiratory wards, with support from the critical care outreach team.
- The SALT team introduced an iPad-based communication tool for patients unable to communicate verbally, for example those who are intubated or with a tracheostomy. The iPad could be clipped onto the patients' beds for easy access.
- Critical care was involved in various research studies such as the VANISH study, Halt It trial and a study comparing continuous and intermittent enteral feeding. There was evidence of good research infrastructure and governance.
- Cost improvements had been made through a revision of the number of permanent nursing staff and additional recruitment, therefore reducing the use of agency staff on the unit. Staff told us this also improved safety and patient experience as staff were more familiar with the unit and ways of working.
- Additional cost improvements were made by revising stock levels of consumables including fluids and medicines. This meant fewer items reached their expiry date and were disposed of, therefore wasting money. Staff told us there had been no problems with the availability of items since modifying the stock system.
- There were no additional cost improvement plans in place or planned at the time of our inspection and senior staff told us critical care consistently finished the financial year within budget.

Maternity and gynaecology

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

Information about the service

The Women's Health Integrated Clinical; Service Unit. (ICSU) at Whittington Hospital NHS Trust provide in-patient and outpatient gynaecology and all services relating to pregnancy. There were approximately 3,500 deliveries in 2014/2015.

The community midwifery service sees women for antenatal and postnatal appointments, close to women's homes in GP's surgeries or children's centres. At the hospital, the maternity day unit provides emergency and follow-up antenatal care for women with specific pregnancy-related problems. There were three beds on the specialist antenatal ward, Cearns, for women with medical needs. The triage unit saw over 600 women a month for women over 18 weeks pregnant up to 6 weeks post natally. There was also a fertility unit.

The birth centre, which is midwifery-led for low-risk births, has five delivery rooms and there are approximately 65 births a month.

The labour ward has eight delivery rooms. There is a dedicated obstetric operating theatre on labour ward for emergencies; elective caesarean sections are carried out in the main hospital theatre. The recovery area has three high dependency beds for patients with level 2 needs.

There are 23 beds on the postnatal ward, Cellier with 8 side rooms and a seating area for women and babies. Neonates with transitional care needs are cared for on Cellier ward and there were facilities for level 2 neonatal intensive care on site. There is also a home birth service used by, on average, 1% of women.

The gynaecology service provides inpatient, outpatient and emergency services. There is an Early Pregnancy and Gynaecology Unit on Betty Mansell ward, which is open seven days a week. There is no dedicated gynaecology inpatient ward. The hospital is registered for termination of pregnancy services.

We spoke with 23 women, 2 relatives and 38 staff who included consultants, doctors, midwives, nurses, physiotherapists, pharmacists and support staff. We observed care and looked at the care records and patient notes of mothers in the postnatal ward. We reviewed other documentation, which included performance information provided by the trust. We received comments from patients and those close to them, and from people who contacted us to tell us about their experiences.

We attended two community midwifery clinics unannounced on Wednesday 16th December 2015.

Maternity and gynaecology

Summary of findings

We rated the maternity and gynaecology service overall as Good because;

Patient risk assessments were undertaken in a timely and comprehensive manner. Across both services medical, midwifery and nursing staff provided safe care; staffing levels were in line with national averages and were regularly reviewed.

Staff delivered evidence-based care and treatment and followed NHS England and the National Institute for Health and Care Excellence (NICE) national guidelines and policies and procedures were accessible to staff. Staff were competent and understood the guidelines they were required to follow,

There was multidisciplinary working that promoted integrated care. The audit programme monitored whether staff followed guidelines and good practice standards.

Staff were caring and thoughtful, and treated women with respect. Patients' confidentiality and privacy were protected. All the patients and relatives we spoke with gave positive feedback about their care and how staff treated them. Women and their partners felt involved with their care and appropriate explanations were given to them.

Referral to Treatment Times (RTT) for gynaecology patients were routinely above 90%. Appropriate arrangements were in place for patients who could not make informed decisions about their care. Systems were in place to support patients who had a learning disability. Complaints were dealt with effectively and improvements made, where necessary.

However;

Whilst there were established local governance and risk management arrangements, safety risks we identified in our inspection had not been addressed. The leadership team was not yet fully established and the vision and strategy of the service was not formal and plans to expand the service had not been fully communicated to staff

There was limited assurance about safety of women undergoing elective procedures in the second obstetric theatre. Safety information, including staffing levels, was not displayed in any public area. Incidents were reviewed and learnt from, though there were some gaps in ensuring all actions listed on serious incident investigations were completed.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Requires improvement

We rated safety as requiring improvement because;

There was limited assurance about safety of women undergoing elective procedures in the second obstetric theatre. There were routinely insufficient staff numbers when cases were conducted. There was a failure to formally agree plans for adequate nursing cover, which meant that pregnant women and their families were left with a limited staff presence following surgery.

Safety information was not displayed in any public area. Incidents were reviewed and learnt from, though some gaps in ensuing all actions listed on serious incident investigations completed. Equipment was not readily available in the community.

Mandatory training rates were, in some areas, well below the trust's levels of expected compliance.

However;

Use of maternity early warning scores were embedded across the service. Systems were in place to safeguard women and babies. Medicines were stored, managed and administered appropriately.

Staffing arrangements ensured there were enough skilled and knowledgeable staff to meet patients' needs and cope with peaks in service demands.

Staff reported and recorded incidents and managers investigated them. This enabled teams to understand the causes and to improve the safety of services. Infection control procedures were evident in practice and there was regular screening and auditing of infection rates.

Incidents

- 15 serious incidents were reported in 2014 and 8 serious incidents were reported at the time of our inspection in 2015. Repeated occurrences included unexpected admissions to ITU. We also noted one maternal death and when raised with senior managers in the service we were told this was inaccurately recorded as there had been no maternal deaths in the service at the time of the inspection.
- In the July 2015 perinatal death report to the executive board it was stated there were four recommendations that had yet to be actioned including the guideline 'unbooked admissions/late bookers: antenatal and intrapartum management', 'review process of antenatal risk assessment with regards to place of birth, to ensure that all women have clearly documented plans for place of birth from 36 weeks onwards, changing the oxygen cylinder when advanced resuscitation is required and an external review of the SI investigation should be arranged as requested by the parents. It was not clear which SI reports these recommendations referred to.
- Maternity services carried out investigations of serious incidents promptly and undertook root cause analysis (RCA) investigations. Support for staff involved in incidents was available from supervisors of midwives (SoMs) and educational supervisors. RCA's were carried out by a wide range of senior staff including supervisors of midwives, obstetrics and gynaecology consultants, seniors midwives, matrons and neonatologists. The service did not provide evidence to demonstrate that these staff had received root cause analysis investigation training.
- We saw from the incidents recorded, and midwifery and nursing staff confirmed, that incidents were reported, action taken and learning shared. For example, systems for sharing information were reviewed following a confidential information breach . Some items were escalated to the risk midwife and entered onto the risk register. We were told Women's Services were encouraging staff to report staffing incidents and we saw examples of these reports. The midwife in charge of the ward attended the postnatal risk meeting regularly and the staff received the risk newsletter.
- Some staff lacked clarity regarding circumstances that would trigger an incident report other than a significant bleed immediately after birth (post partum haemorrhage or PPH). NHS England updated reporting guidelines in May 2015 and removed triggers. The service had not refreshed guidelines since then, which caused some confusion.
- The practice development team were involved in disseminating lessons learned through incident

reporting through case examples in statutory and mandatory training and back to basics training. We witnessed the Maternity Risk Manager reviewing lessons learned from incidents using the weekly newsletter.

- There was mixed evidence of fulfilling the duty of candour. The requirement was listed on the action log of each serious incident report since November 2014 but there was not always evidence to show this was completed.
- Neonatal and maternal morbidity and mortality was reviewed at the ICSU directorate level by senior staff on the maternity scorecard.

Safety thermometer

- The Maternity Safety Thermometer measures harm from perineal and/or abdominal trauma, post partum haemorrhage (PPH), infection, mother and baby separation and women's perception of safety.
- The service collected information on these areas but did not use the safety thermometer tool.
- Data on the areas was not made visible on ward area. A labour ward coordinator told us they were responsible for updating the scoreboard in the staff room on labour ward only with percentages of 3rd and 4th degree tears, PPH's and unplanned admissions to intensive care from November 2015. Other staff and women we spoke with were not familiar any of the safety thermometer or scoreboard information.
- The Safety Thermometer report to the Board from the Women's Health ICSU did not feature maternity specific data.

Cleanliness, infection control and hygiene

- In the past 12 months there were no reported Clostridium difficile (c.diff) infection and no meticillin-resistant Staphylococcus aureus (MRSA) Bacteraemia incidents.
- Between 75% and 86% of women were screen for MRSA in the service between January 2015 and June 2015.
- There was no routine screening for c.diff or MRSA on admission, but was undertaken when women were transferred from another unit.
- Puerperal sepsis rates were not measured or audited.
- Cleaning schedules in place and kept up to date. Staff complied with the trust's infection control polices and protocols. Staff practiced good hand hygiene, used personal protective equipment appropriately, and wore their uniforms above their elbows. However, a women told us that saw blood on the toilet seat on the second day of our inspection.
- Inpatient areas had a monthly hand hygiene audit and all areas scored over 90% for compliance in 2015.

Environment and equipment

- Each inpatient area had a buzzer entry system. Visitors had to use the intercom and identify themselves upon arrival. Staff had swipe card access. Measures to secure the maternity unit were in place. Entrance doors across the unit were locked and we saw staff routinely challenge visitors before allowing them to enter. Babies were security tagged and monitored.
- Most areas we visited were clear of clutter, though staff highlighted the need to upgrade the estate, which the trust recognised as not fit for purpose. Senior managers had long term plans to refurbish and expand labour ward and the post-natal ward. Some areas had been recently renovated including the birthing centre which was bright and women told us 'felt spacious'.
- Ventilation was assessed annually on the labour ward and in the birthing suite.
- The service kept a maintenance schedule which demonstrated that beds in inpatient were reviewed, repaired and, if necessary, replaced.
- Some equipment was not adequately maintained and had not been serviced. We noted there were no CTG's in empty rooms on the labour ward, which staff said were reported to medical physics but there was no log to confirm this was the case. In community clinics we identified two resuscitation trolleys that were not routinely checked, three foetal heart dopplers in two community clinics had not been serviced since 2011 and 2013 respectively, as well as a blood pressure machine and a set of weighing scales. Senior midwives did not know why and told us to check with the medical physics department. Staff in medical physics confirmed the equipment was not on the hospital inventory and therefore was not checked.

Medicines

- Medicines were stored securely across the service. We checked fridge temperatures and saw they were monitored appropriately.
- We observed safe prescription and administration of medicines. Staff kept up to date medicine records and completed them accurately.
- An electronic prescribing and administration programme was in place. The computer and drug cabinet was combined for bedside administration. However, we saw the trolley was chained to the wall and staff accessing medicines and taking them to the beside without the computer
- We reviewed 10 drug charts and they contained relevant information.
- Safe storage and checking was undertaken twice per shift by senior midwives using JAC
- The pharmacy team collected data that demonstrated that the introduction of electronic prescribing in maternity had resulted in a decrease of medication related problems, a decrease in the number of non-formulary drugs prescribed, and a decrease in the total number of drugs discovered missing during medication reconciliation.
- Records confirmed that staff regularly checked controlled drugs. A controlled drugs administration audit was completed monthly.

Records

- In maternity services, the majority of women's risk assessments for necessary areas including venous thromboembolism, pressure ulcers and the Maternal Early Obstetric Warning Score (MEOWS) staff completed accurately. This was evidenced by fifteen maternity records we reviewed across inpatient services and within the community.
- Whilst we noted records were stored and maintained in most areas, this was not the case in recovery. Women's notes were kept in an unlocked pigeon hole and were visible.
- There was a reportable confidential information breach, and learning from this incident was disseminated and staff we spoke with were aware.
- Senior managers told us of considerable issues in recording episodes of care and clinical coding, which led to inconsistencies in the maternity scorecard and other externally reportable measures. Senior managers and staff told us that an electronic system, Medway, was introduced in 2015 to allow for more accurate recording.
- There was appropriate consistent use of catheter risk assessments and care plans on labour and post-natal ward, though we noted this was not consistent for elective and emergency theatre cases as three of five records reviewed were not fully completed. These assessments were audited by administrative staff and collated as part of the integrated care pathway audit, and overall data was reported to and monitored at midwifery meetings.
- We reviewed five records in the gynaecology service we found that patients' risk assessments were completed in care records.

Safeguarding

- Safeguarding policies and procedures incorporated relevant guidance and legislation and staff we spoke with were knowledgeable as to what constituted a safeguarding concern, and knew how to raise matters appropriately. Doctors and midwives we spoke with gave us examples of where they had appropriately escalated and managed specific safeguarding incidents to the trust safeguarding lead midwife.
- Midwives we spoke with demonstrated with confidence how they could access safeguarding information. An alert icon was made visible on the electronic record system to any staff member accessing records of women and babies who were at risk of abuse or harm. Staff reported safeguarding information was sometimes not available in maternity if the mother was from outside the three adjacent local authorities.
- Although almost all staff across the Women's Health ICSU told us they had completed the relevant, mandatory, safeguarding training, levels of compliance across staff groups were below the trust's benchmark of 90%. Of particular concern, only 28% and 38% of medical staff had completed level 2 and level 3 child protection training.
- Between January and December 2014 278 safeguarding alerts were raised, most of these did not require social

service referral but raised the need for additional support for patients, which was provided. We felt confident that staff raised safeguarding alerts appropriately.

- Maternity services worked with local domestic violence advisors and ran a specific clinic for women at risk of who had suffered female genital mutilation.
- Safeguarding meetings were held monthly and were well attended by nurses, midwives and paediatric leads.

Mandatory training

- Mandatory training levels were considerably below the trust's benchmark of 90% compliance across a number of subject areas. These were subject areas the trust deemed as a basic requirement to ensure safe working practice.
- Amongst midwives 67% completed child protection level 2; 74% completed child protection at level 3; 62% had completed risk management and duty of candour; 73% completed safeguarding adults level 2, and 74% completed Mental Capacity Act 2005 and Deprivation of Liberty Safeguards training.
- Of medical staff, 75% completed child protection level 1, 75%; 28% completed child protection level 2; 38% completed child protection level 3, and all other areas including resuscitation, MCA and DOLS, information governance, infection prevention and control, health and safety were between 54-67% compliance.
- Amongst administrative staff only 29% had completed risk management and duty of candour training, 44% fire safety 44% and rates of compliance for all other rates were around 60% compliance.
- Maternity staff received additional annual mandatory training which included obstetric emergencies, domestic abuse, breastfeeding, PROMPT and CTG training. Records confirmed that 90% of relevant staff had completed this training within the past 12 months.
- Staff told and records showed 91% of nurses who worked with gynaecology patients had completed their mandatory training.

Assessing and responding to patient risk

- There was limited assurance about safety of women undergoing elective procedures in the second obstetric theatre. There were routinely insufficient staff numbers when cases were conducted. There was a failure to formally agree plans for adequate nursing cover, which meant that pregnant women and their families were left with a limited staff presence following surgery. We raised the issue of the lack of staff presence with a senior manager and asked them to take immediate action.
- Maternity obstetric warning scores (MEOWS) were used in the acute observation and high dependency unit. Four of ten MEOWS charts we checked were not fully completed, for instance total scores and reflexes.
- Records showed the WHO maternity surgical safety checklist in use for women who had planned operative deliveries. Use of the checklist was routinely audited.
- Following an investigation into an unexpected neonatal death in 2014, an agreed recommendation was to introduce use of a specific customised growth chart to assessment, NEWTT, across maternity services in 2015. We were concerned that there as some delay; senior managers told us training was underway for roll out in January 2016 and that midwives in the community were had been trained to use the NEWTT. Most midwives we spoke with in the antenatal and postnatal wards were unaware of the roll out.
- Observations and documentation we reviewed confirmed that a regular hourly systematic review occurred. 'Fresh eyes' checks, whereby another midwife, usually the labour ward lead, reviews CTG traces hourly, were undertaken, throughout a women's labour by senior midwives.
- For inpatient gynaecology patients, the National Early Warning Score (NEWS) system was in place and we found staff accurately completed patient observations and scores.

Midwifery staffing

- The ratio of all midwifery staff to births is better than the England average. The midwife to birth ratio was in line with the nationally recommended workforce figure of 1:28. The Royal College of Obstetricians "Safer Childbirth; Minimum Standards for organisation and delivery of care in labour, 2007" standards state that, "The minimum midwife-to-woman ratio is 1:28 for safe

level of service to ensure the capacity to achieve one-to-one care in labour". All staff we spoke with across the services raised no concerns about staffing levels during our inspection.

- Overall planned establishment was 202.27 WTE, compared to 164.92 planned WTE in post since August 2015. This was confirmed in the data submitted to us by the trust prior to the inspection and the birth rate plus report.
- Budgeted compared to actual establishment was not reported for Cellier ward, labour ward and labour theatre, maternity day assessment or the post natal ward.
- Some data the trust shared with us prior to the inspection on agency and bank use was contradictory across the Women's Health ICSU Some data stated there was zero agency use across all areas since November 2014, which contradicted reports provided regarding budgeted and actual staffing use. Other data in the same submission indicated agency use as less than 1% across all areas since April 2014.
- The supervisor of midwife (SOM) ratio was 1:17 as two SOMs had left in 2015. Recruitment to fill these vacancies had taken place.
- The service followed and met recommendations for 1:1 care in labour and skill mix for staff as outlined in Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour (RCOG and the RCM 01/10/2007) for over 90% of women. Staff told us this sometimes meant midwives had to be reallocated from other areas to ensure this occurred.
- Staffing levels reported for August 2015 showed there were two vacancies at band 7, 11.5 vacancies at Band 6, seven vacancies at Band 5 and four vacancies at Band 2.
- Two midwives or one midwife and a nurse staffed recovery. Nurses were dedicated to recovery though two staff members had recently left and posts were advertised in early December 2015.
- The birth centre had two midwives on duty at all times.
- The triage unit was staffed by two midwives and one support worker at all times.
- The maternity day unit was staffed 9 am to 5 pm by two midwives and an obstetric and gynaecology registrar. A sonography trained midwife and a multiple birth specialist midwife was also available.
- On Cellier ward, there were one band 5, two band 6 or one band 7, one health care assistant, one nursery nurse on shift at all times and in addition, one neonatal nurse Monday to Friday.
- Three supernumerary band 7 midwives covered Cellier and Murray ward.
- Band 7 midwives we spoke with were unaware of use of agency staff and told us the finan qce department kept details of usage and spend. Uncovered shifts could not go out to agency without senior sign off from the head of midwifery and operations director.
- If there were more than 3 agency staff across the maternity inpatient unit this was risk rated as a 'red day', and we were told this occurred twice in October 2015.
- Maternity dashboards in 2015 showed there were no instances when staffing was less than 1:1 for women in labour.
- Labour ward was staffed by six midwives and a band 7 coordinator who was supernumerary
- The service had adequate midwifery staffing levels, managed available resources and understood their vacancy and staff absence rates. There was evidence of bank and agency use and rota management, particularly at night, which meant that maternity units were staffed. The service undertook its own analysis of acuity, the individual maternity unit's population and out of area workload using the Birthrate Plus® tool. Staffing rates for a midwifery to birth ratio was 1:28, which met recommendations. This showed a larger proportion of postnatal care than would be expected from the number of births they undertake due to women going to a maternity unit out of their area.
- Supernumerary shift co-ordinators were rostered on labour ward. They were not included in establishment figures and did not carry a caseload.

- There was evidence of staff working in other areas (ante-natal clinic or ante/post-natal wards) and community midwives to provide labour ward cover which were managed by a rotational programme to ensure that midwives skills were up-to-date.
- There was one WTE infant feeding specialist midwives and the proportion of babies born before 33 weeks gestation who received their mother's milk was better than the national benchmark.
- Maternity services did not use agency staff at all. They used bank staff regularly where possible who were appropriately inducted to the area. Agency usage consistently under 0.5% in 2015.
- In gynaecology, on Betty Mansell ward budgeted establishment was 13 WTE staff since April 2015, and actual establishment was higher than 10 WTE throughout this period, with bank or agency staff used to fill gaps.

Medical staffing

- The service was compliant with "The Royal College of Obstetricians: Safer Childbirth; Minimum Standards for organisation and delivery of care in labour, 2007" standards which state that, any unit with more than 5000 deliveries per year requires 98 hours of consultant presence per week. The unit had approximately 3,500 deliveries in the previous year and 80 hours of consultant presence was provided per week. Therefore the trust met this standard.
- There were 17 consultants in the maternity and gynaecology service, and 43 whole time equivalents across the department. There was a higher than the national average consultant workforce at 39% compared to 35%.
- Staff told us there enough medical staff available when an opinion was required and that there were rarely gaps in the junior and middle grade medical rota.
- An anaesthetic registrar was available at all times on labour ward who was not required to assist with elective cases.
- Some staff told us that there was a high sickness absence rate amongst the consultant workforce. The reported sickness absence rates for all doctors in the service which included maternity and gynaecology was reported at 6%. Senior managers told us all staff who were on sickness absence underwent a review and from this analysis, they noted no trends.
- Locum doctor usage was reported to be low from April 2014, at consistently less than 1% and in usage was consistently under 0.2% in 2015.
- There were twice daily consultant led ward rounds on labour ward including an evening labour ward consultant ward round.

Major incident awareness and training

- The service had adopted the pan London approach to escalation and divert when demand for exceeded capacity, as required by the ambulance service. The service closed once in 2014 to delivering women and was reported by the trust to commissioners and recorded as an incident. The unit did not close in 2015. The maternity escalation plan was in place with clear protocol and escalation for closure.

Are maternity and gynaecology services effective?

Good

We rated the effectiveness of the service as good because;

Policies and procedures were up to date, known and accessible to staff and evidence-based. Audit at both local and national level occurred regularly, and embedded into practice.

Staff were competent in their roles. Multi-disciplinary team work across disciplines was standardised. Consent to care and treatment was obtained in line with relevant legislation and guidance.

Evidence-based care and treatment

- There was evidenced based care and treatment provided with use of Royal College of Obstetrics and Gynaecologists embedded in policies, protocols and seen in practice. Staff showed us guidelines were easy to access on the trust intranet.
- In maternity services, obstetric emergency practice was in line with guidance issued by the "National Institute for Health and Care Excellence" (NICE) and was reviewed

at quarterly maternity clinical audit and guideline meeting. A clinical governance specialist midwife disseminated new research and best practice at governance meetings as part of a multidisciplinary team discussion.

- The gynaecology service had started to enter data to the British Society for Urogynaecology (BSUGs) national database in December 2015 so there was no audit data or conclusions of results at the time of our inspection.
- There were processes in place for deciding audit topics across the specialties, which included areas of risk. A specialist public health midwife undertook a number of small surveys and audits including triage attendances, use of the acupuncture service, women's birth choices and introducing complementary therapies. A business case was successful in 2015 to provide outpatient hysteroscopy treatment following recommendations for an audit
- However some audits conducted by trainee doctors and midwives were not completed or used to improve practice. We reviewed the trust's "reducing caesarean sections" audit which was carried out in April 2014. There was a clear conclusion including recommendations such as improving data input on Medway and reviewing vaginal birth after caesarean section (VBAC) rates monthly, though the trust could not assure us that the actions had been achieved. In gynaecology a 2015 audit of community gynaecology return rates showed the 'did not attend' clinic (DNA) rates remained high at 20.8%. Audit conclusions showed reasons for the high rates were multi-factorial, though there were no specific recommendations stated to improve rates.

Pain relief

- Women told us that staff assessed their pain regularly offered them and administered the choice of pain relief when required.
- Pain assessments were used in maternity services.
- Staff confirmed that anaesthetists responded promptly to staff requests for specialist pain relief, such as epidurals.
- The early supported discharge plan for elective caesarean sections and leaflets on the post-natal ward were available and explained pre and post-natal analgesia.
- Staff did not undertake pain relief audits. Satisfaction surveys of epidural use were started but not presented, or used to audit the service were undertaken in 2014.
- The Whittington maternity acupuncture service was available to all woman who were booked in to use the hospitals services. Women were able to self-refer for musculo- skeletal pain during their pregnancy.

Nutrition and hydration

- There were regular meal times on Cellier ward with a variety of food choices, including options for range of dietary and religious needs.
- Antenatal records confirmed that staff discussed infant feeding choices with women prior to birth and after. Formula milk was not provided by the service, and this was explained to women in antenatal clinics.
- The service had achieved Level 2 in the UNICEF Baby Friendly initiative accreditation in 2014. A WTE breastfeeding specialist midwife supported and counselled women and new parents on Cellier ward.
- Over 95% of women who used Whittington maternity services initiated breastfeeding within 12 hours of delivering. We asked for further information regarding rates of women who continued to breastfeed at 10 days and 6-8 weeks after delivery; however the trust did not provide us with this data.
- We saw that expressed breast milk was stored correctly and safely in refrigerators.

Patient outcomes

- Clinical outcomes across the services were similar to the national averages. We did not identify any outliers, or indications of poor care from statistics of episode of care for puerperal sepsis rates, maternal readmissions or neonatal readmissions, relating to maternity and gynaecology care. The service monitored outcomes in maternity on the monthly maternity scorecard.
- In 2015 there had been three unplanned maternity admissions to intensive care from Cellier ward. and four readmissions from home to the maternity unit. However, this was not monitored in the service and we noted the section was left blank on the on the maternity scorecard.
- The rate of readmissions from women who presented post-natally at maternity triage was between 13 – 16% in 2015.
- The stated total number of deliveries in 2014 varied between approximately 3,350 and 3,500 in different data

sources. Of those provided directly to us prior to our inspection, 98.3% were single deliveries, similar to the national average at 98.5%. 93% of neonates were born at term, higher than the national average of 91%. The number of women giving birth aged 35 to 39 was 25.4% and aged 40 and over was 6.2%, both higher the national averages at 16.3% and 3.9% respectively.

- The proportion of delivery methods was monitored on the monthly maternity scorecard. In 2014. the proportion of delivery rates were: elective caesarean section (13%); emergency caesarean section (17%); normal vaginal delivery (52%); overall instrumental rate, ventouse or forceps (18%);
- Although the caesarean section (CS) rate was similar to expected accordingly to national figures adjusted for the profile of women served by the hospital in 2014, the CS rate in 2015 was higher than expected since June 2015, at consistently over 31%. The service had taken some actions address this rate, regular reviews by midwives at the monthly normalising births meetings and an audit of the caesarean section rates.
- The maternity scorecard showed on average 5% women having a first time baby experienced a bleed or post-partum haemorrhage over 1.5 litres since March 2015. The rate of women having a first time baby having an unassisted vaginal delivery experienced a 3rd or 4th degree tear had increased to over 7% between January and August 2015, though this had since reduced to approximately 2.5%. The still birth rate was less than 0.6% in 2015. The peripartum hysterectomy rate was zero, and therefore considerably lower than the UK Obstetric Surveillance System national average.
- The proportion of women seen within the 18 week referral to treatment time target for gynaecology was 98%, community gynaecology was 97.6% and colposcopy was 100%
- There were low numbers of breaches of the two week wait target for women with suspected cancer, with six reported in November 2015.

Competent staff

- Records confirmed that over 90% of staff had completed an appraisal in the past 12 months.
- 93% of nurses who worked in the gynaecology department completed an annual competency and appraisal workbook
- The annual supervisors of midwives (SOM) report for 2013/14 showed that the ratio for SOMs to midwives was 1:16. Senior managers told us this was because two midwives had left the service and recruitment to these roles was due to be completed in January 2016.
- Staff told us that they were encouraged to gain additional qualifications and to maintain their continual professional development.
- There was a 12-month preceptorship programme for all new starters, with buddy support who could not progress if they did not pass the assessment criteria at the end of the period.
- Maternity support workers a role specific competency programme within 6 months of commencing their role. Records showed that over 80% were on target to complete their training within the agreed time frames.

Multidisciplinary working

- There were good working relationships with the medical and surgical teams which facilitated safe transfers of care of women and babies when required between the hospital and the community.
- There were detailed multidisciplinary (MDT) team meetings and discussions where required which ensured effective care and treatment plans and handover of patient care.
- Care and treatment plans were documented and communicated to relevant health care professionals, such as GPs and health visitors, to ensure continuity of care.
- Staff in the neonatal service told us that that there was close working between the services. Staff from these areas all participated in joint management meetings.
- There were regular Maternity Service Liaison Committee (MSLC) groups which included GP and health visitors from the local area which enhanced MDT working.

Seven-day services

- There was an anaesthetist cover available 24 hours a day, 7 days per week for both maternity and gynaecology services.
- There was a supervisor of midwives (SOM) available 24 hours a day, seven days a week through an on-call rota system which ensured that midwives and women had access to a SOM at all times.

Maternity and gynaecology

- The gynaecology assessment unit was open from 8 am to 8 pm every day, and for women with complications of early pregnancy, with medical cover. Ultrasound facilities were available throughout the clinic times.
- The early pregnancy unit was open 8 am to 8pm every day and accepted referrals for women who were up to 17 weeks and 6 days gestation and with bleeding, pain and previous miscarriage or ectopic pregnancy. Ultrasound facilities were available throughout the clinic times.

Access to information

- Staff had access to the information they needed to deliver effective care and treatment in maternity services.
- In the gynaecology service there was prompt completion of discharge summaries to GP's and most clinic letters were sent within 5 days.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent to care and treatment was obtained in line with national legislation and guidance, including the Mental Capacity Act and Deprivation of Liberty Safeguards (DOLs). Policies were in place regarding these subjects and they were accessible to staff via the intranet. Staff we spoke with told us that they could access the intranet, and demonstrated adequate knowledge about these subject areas.
- In almost all records we reviewed in maternity services were found women's consent was sought appropriately.
- Most elective patients were consented on the day of surgery and not in clinic, which staff said delayed theatre start times.
- Women's consent was sought before disposal foetal remains.

Are maternity and gynaecology services caring?

Good

We rated caring in the service as good because;

Women and their families were treated with dignity, kindness and respect and were positive about their experiences. National survey scores were better than average.

Women who used the service and those close to them told us that they were well informed, and felt involved in decision-making processes regarding their care. There were systems in place to meet people's emotional needs which included bereavement support following discharge.

Compassionate care

- Overall patients spoke highly of maternity and gynaecological services provided at the hospital and in the community and would recommend the hospital to their friends and family. Patients we spoke with across the ICSU were consistently positive about staff. One woman told us staff were, "wonderfully caring and supportive" and another woman's partner told us "the midwives work so hard to make sure my partner was comfortable during labour."
- We witnessed caring behaviour when a healthcare assistant attended to a woman who had recently miscarried.
- There had been improvement in the 2015 CQC survey 'Women's Experiences in Childbirth' with the Trust performing similar to, or better than, the national average on all 17 questions.
- In the friends and family test three of four areas were higher than or similar to the national average. The post natal ward was the only area women scores consistently below the national average. The response to call buttons was reported slightly lower than the national average.
- Throughout our inspection in maternity staff ensured curtains were drawn across women's beds to ensure privacy.

Understanding and involvement of patients and those close to them

- Women's antenatal records contained birth plans that had been reviewed by midwives, and women had been involved and supported in the development of these plans. However, two women told us they felt unable to question the care they were received ante-natally.

- Parent education classes were run by midwives in the community and held at numerous local children's centres across the North London area. These included sessions focussed on providing information about labour, birth and the postnatal period.
- Women had a named midwife during labour and post-natally. Women we spoke with felt involved in their care, were complimentary of staff looking after them. We spoke with a woman in the post-natal ward and she confirmed that she had a named diabetic midwife throughout her antenatal care who was "excellent".
- However one woman we spoke with who had been prescribed medication for controlling high blood pressure did not know what she was taking or why.

Emotional support

- There was a trust wide spiritual care and chaplaincy team available to patients, families and staff of all faiths and none. This was available 24 hours a day 7 days per week.
- A women's health counsellor was available for patients.
- A 0.8 WTE bereavement support specialist midwife was employed in the service. Their contact details were given at the time of bereavement by hospital staff and was available for all pregnancy losses. However, at midwives in the community clinics we visited did not have contact details for this midwife. Alongside this, one woman told us that the bereavement midwife took one month to contact her after losing a baby.
- Antenatal records confirmed that assessments for mental health illness, anxiety and depression were undertaken, and that referral was made to the woman's GP or a perinatal CAMHS service where required.

Are maternity and gynaecology services responsive?

Good

We rated the responsiveness of the service as good because;

The service took account of the needs of different people including those in vulnerable circumstances. There were numerous specialist midwives and nurses in post, and specialist clinics were provided to support people with complex needs.

The gynaecology service was meeting referral to treatment times. We observed that individualised pathways of care were delivered accordingly. Complaints were monitored and action was taken to improve the quality of care provided.

Service planning and delivery to meet the needs of local people

- Maternity services served women across North and North Central London boroughs; primarily from Haringey, Islington and Camden. Haringey and Islington are the third and fourth most deprived boroughs in London respectively.
- Community midwifery was provided across the boroughs for antenatal and post-natal care in community settings such as at children's centres and in women's homes.
- The number of births that the maternity service delivered from January 2015 to October 2015 was 3109. The service was funded to deliver 3330 babies in that period.
- Senior managers understood and arranged services to appropriately serve the populations served. The trust cared for a higher proportion of women who were in the moderate to high-risk categories including women having elective or emergency caesarean sections, epidural for pain relief with a normal birth, women carrying low birth weight babies and comorbidities including diabetes or obesity related problems. Forty percent of the women served were of from Turkish, African, Afro-Caribbean and Eastern European descent and services were planned to meet the specific health needs of these populations, including sickle cell anaemia and diabetes. 32% percent of the women who gave birth at the Whittington between January 2014 and January 2015 were those aged thirty-five and above, higher than the England average of 20 percent. The trust provided maternity services to the nearby Holloway prison.

Access and flow

Maternity and gynaecology

- Bed occupancy rates at the trust were significantly higher than the England average between April 2013 and June 2015. From April 2015 to June 2015, the bed occupancy rate was 73.9% against an England average of 60.8%. We was told that this was due to the high intake of transitional care babies (babies either born prematurely, small for gestational weight or babies whose mothers had diabetes), increasing their length of stay in the unit and increasing the time that mothers stayed on the ward to be with their babies.
- The capacity in the service was managed well. The service was closed on two consecutive days from 19 September 2014 to 20 September 2014 due to refurbishments of the post natal ward. There were no requirements to close maternity services to women in 2015.
- Staff and women told us there were some delays in discharging women post-natally, caused by delays in reviews by paediatricians and midwives and locum staff not having full access to Medway. Some arrangements to expedite discharge arrangements were in place i.e. night staff taking bloods before the morning, to ensure results came back quicker. However, this was not being monitored by the service.
- Between May 2015 and October 2015, 17.4% of births took place in the midwife led unit and less than 1% of deliveries were home births. The trust did not set a specific or strategy for home births but wanted to increase this number year on year.
- In maternity services the average length of stay for elective cases was 3.16 days, similar to the national average. The average length of stay for non-elective cases was 4.75 days, above the national average.
- The maternity dashboard showed that between January 2015 and November 2015, the percentage of pregnant women accessing antenatal care who were seen before 12 weeks and 6 days gestation was only 82%, below the 90% target. To address this, the Trust was actioning recommendations from commissioners.to review their booking letter template.
- We saw from data that 100% of women received one to one care from a midwife on the labour ward in September 2015. We were told by the trust that an average of 98% of women received 1-1 care between December 2014 and November 2015.
- In the perinatal death report, which was submitted to the executive board in July 2015, it was stated there were 3,566 births at the unit in 2014/2015 and a stillbirth rate of 3.9 per 1,000 births which was lower than the national average. There was a neonatal death rate of 1.1 per 1000 births which was also lower than the national average.
- There was an open system to access triage and women were advised to wait. There were no delays reported to us during our inspection. There was no monthly figure or breakdown of common admissions to triage, though a handwritten admissions book was used and women were risk scored for priority to be seen. The matron told us there were mainly antenatal presentations and a midwife on the unit told us some women who attended post-natally with wound infections that were acquired following birth at other hospitals. Staff were encouraging women to return to the hospital they delivered. In one case a woman told us they had delivered elsewhere, were passing clots post-natally and wanted to be seen by triage at the Whittington due to location. She told us the midwife only accepted to check her when the woman cried on the phone. A public health midwife surveyed 14 women who attended triage between August and September 2015 acknowledged the small sample size though showed women wanted information about transferring booking as an option and a simple booking system. These recommendations had yet to be implemented at the time of our inspection.
- In the Maternity Day Unit, there was an appointment system offering surveillance and observation of women of advance maternal age from 38 weeks gestation with pre-eclampsia, obstetric cholestasis or reduced fetal movements or multiple births and other high risk concerns.
- A midwife screening coordinator managed all of the routine antenatal screenings. The trust achieved above acceptable rates in its HIV Screening and Downs Syndrome Screening for the year 2015/2016, as set out by NHS England. However, new born blood screening (NBBS) avoidable repeat rates were 3.3%, higher than the acceptable threshold of 2.2%. This was because 33 out of 1012 samples sent to the laboratory had to be retaken. This was for reasons such as initial samples being contaminated or samples being taken when

babies were too young (on or before day four, where day 0 is the date of birth). An action plan was in place to reduce avoidable repeat rates and for staff to complete NBBS eLearning annually.

- Community maternity clinic opening times were misleading. Three clinics, Broadwater Farm, North Bank House and Park Lane were advertised as being open from 9:00AM to 5:00PM in literature provided to women. However, midwives at all three clinics were closed by 3:00PM during our inspection.
- The total number of deliveries in 2014 stated ranged from approximately 3,200 to 3,500 in different data sources. 98.3% were single deliveries, similar to the national average at 98.5%. 93% of neonates were born at term, higher than the national average of 91%. The number of women giving birth aged 35 to 39 was 25.4% and aged 40 and over was 6.2%, both higher the national averages at 16.3% and 3.9% respectively.
- Bed occupancy was consistently higher than the national average, and stood at 73.9% between April and June 2015.
- When we requested data of postnatal readmissions within 30 days, we were told this was not routinely monitored. However, the service undertook a preliminary audit of Postnatal Readmissions carried out on 7/12/2015. Period reviewed 01/01/2014 -01/12/2015, showing highest reasons for readmission were sepsis and post-partum haemorrhage between August and October 2015.
- Medical termination of pregnancies were offered at the hospital, and 52 procedures were carried out between April 2014 and March 2015.
- Medical outliers for gynaecology patients impacted on the staff's ability to provide sensitive care for women having sensitive procedures. Cancelled elective caesarean rates were not monitored. There were no elective cancellations in obstetrics. In gynaecology services there were 2 elective cancellations in September 2015,11 in October 2015 and 3 in November 2015.
- Staff told us that capacity was an issue in community gynaecology clinics. In response, senior managers told us junior doctors rotas had been amended so they could provide support.
- The percentage of women who were seen by the gynaecology service within two weeks from referral for cancer treatment was 98% between November 2014 and October 2015, against a national target of 95%.
- In gynaecology, the referral to treatment targets were consistently met; 90% of women were seen within the 18 week pathway.

Meeting people's individual needs

- The unit had environmental issues and was awaiting plans for refurbishment. There were en suite rooms on the post natal wards and staff worked to maintain women's privacy and dignity. There were some limited facilities for partners to stay in the unit.
- Over half of the women, their partners and family members told us delays ranged from 30 minutes to two hours for an antenatal appointment in the hospital or at clinics within the community.
- Women told us antenatal appointment times were flexible and the consensus was that women were given choices to schedule times to suit them.
- Translation services were readily available and they were familiar with the process of booking an interpreter. Translation services were provided via a telephone interpreter and also from face-to-face interpreters. Staff confirmed family members could not be used to translate, in line with trust policy. GP referrals we reviewed confirmed this.
- A number of specialist midwives were available to support the needs of vulnerable women and there were very close links to a safeguarding midwife and the vulnerable adults team. There was a teenage pregnancy midwife for under 19's and women under this age were also seen by the Young Adults Team. Staff were supported with a range of protocols and pathways for supporting women in vulnerable circumstances.
- A trained Lead Midwife held Female Genital Mutilation (FGM) clinics in the community and these clinics were also held on a Saturday and sometimes in women's homes.
- The trust ran midwife led clinics at HM Prison Holloway on three days a week for expectant mothers.

Maternity and gynaecology

- We observed two patients that were late for their antenatal appointments. The maternity administrator liaised with a midwife to make adjustments for the midwife to see them that same day.
- A Whittington Health booking in pack was available for all women that booked at the service which detailed all stages of care and signposted women to relevant services.
- There was a wide range of maternity information leaflets available to women both in the hospital and in community settings including public health such as the risks of smoking to mother and baby and birth information including spontaneous rupture of members available on labour and postnatal ward. We found that there were no readily available leaflets or literature in other languages other than the dating scans booklet (a Downs Syndrome Screening Test Booklet), which was provided in Polish, Romanian, Turkish, Arabic, Chinese, Urdu, Spanish & Vietnamese.
- There were a total of 10 midwife teams, with eight of those teams being community based spread across Islington and Haringey. Of those eight teams, they ranged from three to six midwives in each, with higher numbers in the Haringey teams.
- The bereavement midwife provided support to women who had experienced a still birth, termination of pregnancy or unexpected neonatal death. This midwife was 0.8 WTE. Midwives emailed or called to refer women to them. Midwives in two clinics we visited did not have details available on site. The bereavement midwife told us other women could access the perinatal mental health team, a psychologist or psychiatrist was provided by another trust and women could not self refer and. There was no monitoring of referrals or delays. Choices were made available to women for burial or cremation. There was sensitive disposal of fetal remains before 20 weeks.
- Enhanced recovery programme was available for each elective caesarean case, though staff could not demonstrate this was used for all women. A booklet used to give women information about the programme did not accurately describe the women's pathway.

Learning from complaints and concerns

- There were posters displaying how to make a complaint and comment boxes in prominent areas in the hospital.
- We spoke with five patients across three community clinics who, although shared no concerns about their care, all confirmed that they did not know how to make a formal complaint should they need to.
- There were variations in how community midwives assisted their patients in making complaints and in how learning from complaints was shared. Two midwives at an Islington clinic told us they would try to prevent a patient from discussing their concerns with PALS if possible.
- Complaints were discussed at Team Meetings or discussed on a one-to-one basis. Learning from trust wide complaints was undertaken at team meetings where the 'message of the week' bulletins were reviewed.
- The complaints the service received was monitored on the maternity dashboard. Between January and November 2015 27 complaints were received.
- The service responded to concerns about noise levels and lack of confidentiality raised by two women regarding a bed located next to the midwives station on the post natal ward. This bed was closed for use in November 2015.
- Whilst most complaints were responded to in a timely fashion a complaint made in September 2014 regarding the conduct of member of administrative staff had not been.
- No complaints were referred to the Parliamentary & Health Services Ombudsman (PHSO) between July 2014 and December 2015. This suggests that patients felt that their complaints were handled in a satisfactory manner by the trust.

Are maternity and gynaecology services well-led?

Good

We rated how well-led the service was as Good because;

Maternity and gynaecology

There was a robust maternity dashboard which covered indicators for clinical governance and risk management and was routinely reviewed by staff and the service governance structures.

All staff we spoke with told us their managers were approachable, supportive and visible.

However;

Although there we recognised there were effective systems for governance and risk management, a positive culture and good public engagement, safety risks we identified which placed women and staff at risk of avoidable harm had not always been addressed.

Some concerns were expressed by staff to us about the board's engagement in maternity services.

Vision and strategy for this service

- Staff we spoke with across the maternity service were not aware of a formalised vision or strategic plan for the service. Senior managers confirmed that this would be a priority for 2016, as recent focus since the summer of 2015 had been on permanent recruitment to the leadership of the head of midwifery, clinical director for obstetrics and gynaecology and divisional director of operations
- At board level, there sense of direction focused on increasing the number of births the service was expected to expand from 4,345 deliveries between April 2016 and March 2017, rising to 4700 in the following two years. This suggested that its existing premises would not be fit for purpose to meet the increase in delivery activity.
- To address the trust's issue around physical environment and space constraints of some of its existing maternity services, they had submitted a business case to the TDA for redevelopment of the maternity and neonatal units. The trust was awaiting a response. The aim is to improve clinical standards but also to meet patient expectations. The trust also hopes to improve on the quality and safety of the obstetric theatre provision. The trust had plans to improve the accessibility of the theatres to improve patient flow/ reduce delays. In addition, the trust wants to further the delivery capacity to provide real choice for women.

Governance, risk management and quality measurement

- There was a robust maternity dashboard which covered indicators for clinical governance and risk management and was routinely reviewed by staff and the service governance structures.'Red flags', i.e. when an upper threshold was breached and required immediate action to maintain safety, were reviewed regularly internally, with Clinical Commissioning Groups and other external stakeholders.
- A monthly normalising birth meeting was held, and agenda items for discussion included SBAR, mandatory training, labour ward.
- There was a risk register for both maternity and gynaecology which was maintained and regularly reviewed. There were action plans to mitigate and address risks. Use of the risk register was discussed by the practice development team during 'back to basics training'.
- There were regular governance meetings in both maternity and gynaecology. Governance and risk issues were discussed at Whittington Health Clinical Quality Review Group Meeting, trust quality committee, band 7 meetings, joint maternity and NICU clinical governance meeting with MDT attendance and the labour ward business meeting.
- We reviewed the minutes of these meetings which confirmed that discussions about complaints, audit outcome, risk and incident analysis was occurring.
- Identified risks were addressed in a timely way and had controls or action plans in place. Some risks had been on the risk register without a risk mitigation plan being put into place. However, other reported risks such as the lack of adequate staffing in the second obstetric theatre had not been addressed.
- There was proactive communication with staff regarding risk management every week on the post natal ward, led by the risk midwife who communicated risk and key information to maternity staff, from the 'Cats Eyes' publication.
- On the trust's board assurance framework in July 2015 maternity was identified for service development with the 'risk that we do not grow our maternity work and that the Trust Development Authority do not support

our full business case and that there is a risk to the future maternity and neonatal services on site. Mitigations included regular communication with the TDA, marketing plan, review of maternity activity, close partnership working.

- However, we were concerned that the areas we identified that had the potential to or had impacted on women's safety, namely the lack of staff presence in the second obstetric theatre, the low rates of compliance with mandatory training and the failure to check resuscitation and other equipment in the community were not identified.

Leadership of service

- Prior to our inspection, concerns were stated about weak leadership in maternity by the trust board. The department was overspending and underperforming and an increase in birth numbers critical to business case. Despite the potential pressure to achieve this increase, staff did not mention any concerns to us. All staff we spoke with told us their managers were approachable, supportive and visible.
- The leadership team was newly formed and as a result was not yet fully established. Recruitment of permanent staff to the triumvirate leadership of the head of midwifery, clinical director for obstetrics and gynaecology and divisional director of operations had been a focus in 2015 with permanent post holders commencing in September 2015, June 2015 and April 2016 respectively. Staff were aware of changes at this level but were reassured by a stable team of senior midwives.
- The senior leadership team felt the recent changes to the trust executive team were a positive indicator to deliver the trust wide vision and strategy.
- Midwives felt well informed and we saw minutes of band 7 midwife meetings were circulated to all staff.
- The supervisors of midwives (SOMs) were independent of the trust management decisions, in line with recommendations of the Parliamentary and Health Service Ombudsman report 'Midwifery supervision and regulation: recommendations for change' (2013).

Culture within the service

- We heard no concerns about bullying, harassment or victimisation across the service. There was evidence of effective communication with staff.
- Medical and midwifery staff felt supported by clinical leaders and managers, and felt some leaders were approachable.
- Good appraisals were evident in maternity services and midwives spoke positively about opportunities for development.
- Sickness levels were similar to than the national and trust average where recorded
- The trust had provided a full response and action plan to address the Kirkup report which made recommendations for maternity services.
- Midwives spoke positively about the diverse representation, particularly of staff from black and minority ethnic backgrounds, at senior levels in the service.

Public engagement

- We saw evidence of the trust establishing links with Maternity Services Liaison Committees (MSLCs). MSLCs are a forum for maternity service users and providers, and commissioners of maternity services to come together to design services that meet the needs of local women, parents and families and professionals. We looked at the notes taken from a MSLC Development Meeting held in November 2015. It showed improvements wanting to be gained, such as: 'Better care for women, babies & families'; 'promotion of services'; 'voice for users'; 'reaching further into the community' & 'outreach to disadvantaged groups'. The committee advised the trust on the maternity service provision.
- A birth reflections clinic, giving women who had used the service the opportunity to discuss their birth with trained professionals, had been established and was run by two midwives.
- A survey of hard to reach, vulnerable women was taking place to include women affected by FGM, young parents and women from a local prison. Results of this survey were not available at the time of our inspection.

Staff engagement

Maternity and gynaecology

- Trust wide staff survey results were reviewed within maternity service in July 2015, however minutes from this meeting showed it was incomplete and there was no evidence of actions taken following discussions about the service.
- There were regular away days for senior leaders. At the October 2015 band 7 midwifery away day reviewed leadership styles with an external coach.

Innovation, improvement and sustainability

- The maternity service won the Royal College of Midwives Better Births Award for postnatal and new born care in 2015.

Services for children and young people

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

Information about the service

The Whittington Hospital paediatric department provides a comprehensive paediatric service for children and young people from birth to 17 years. Services provided include a paediatric emergency department, paediatric ambulatory and day care unit, general and specialist outpatient clinics, in-patient care, a high dependency unit and children's community nursing care.Surgical services for children over the age of two years include planned general surgery, ear, nose and throat (ENT) surgery and urology. This is undertaken in the day surgery unit. Urgent orthopaedic and general surgery is also undertaken from the day and in-patient wards. The neonatal unit comprises 23 cots including six intensive care cots, six high dependency cots and 11 special care cots. The unit also offers three mother and baby rooms, allowing for transitional care for well mothers and their developing pre-term infants. On average the neonatal unit has 400 admissions per annum with 24-hour specialist neonatal consultant cover. Seven neonatal consultants oversee the care of the infants.

The children's emergency department provides a 24-hour emergency service in a separate area for children with facilities including a large waiting and children's play area, nappy changing and breast feeding facilities. Children and young people could access services through their GP, health visitor, midwife or accident and emergency. The trust provided a consultant–led service and worked closely, when necessary, with paediatric sub-specialists from teaching hospitals throughout London. The trust is committed to education and helps to train students from a rage of universities in London.

We attended three clinical handovers and spoke with a range of staff involved in children's and young people's services. This included; fifteen nursing staff, six doctors, a range of allied health care professionals, managers and support staff including receptionists and ward clerks. We undertook an unannounced visit to the ambulatory care unit.

Services for children and young people

Summary of findings

We rated children's services at the Whittington University Hospital as **good** overall because;

The hospital provided safe, effective, caring and responsive support to premature babies, sick children and their families. There was an open and transparent approach to reporting and learning from incidents. Infection prevention and control measures were in place to minimize risks to those who used the service. Medicines were managed safely and staff followed relevant guidance to ensure the best outcomes for children and young people.

Patient safety was assured though vigilant monitoring of any deteriorating child and in providing optimum staffing ratios, effectiveness of services were geared to reducing emergency readmission rates, caring was evident throughout the whole service where a robust multidisciplinary team approach to care prevailed.

Responsiveness of the service was manifest through close working arrangements with community-based services especially the 'hospital at home' service which ensured that children could expect to be cared for at home via community nursing services.

The service was well led and all the staff we spoke with responded positively about providing high quality care that was aligned to the trust-wide mission and vision. There were some discrepancies in door entry security within the vestibules of children's clinical areas. Staffing levels of doctors and nurses were good and thus minimized risk. The overall care environment and ambiance of the clinical areas which made up children's services was good and complemented by a recently commissioned children's ambulatory care unit

Are services for children and young people safe?

Good

We rated safety for children's services as **good** because;

Children's services at the Whittington hospital had developed reliable incident reporting systems that the various staff members we spoke with were able described in significant detail. All staff were aware of their responsibilities to report and lessons were learnt where incidents had taken place.

The clinical areas were visibly clean although the intensive care aspect of the neonatal unit was in an older part of the hospital and therefore not as pristine the newer parts of children's services. There were robust systems in place to ensure that children and their families were protected from the risk of harm associated with hospital-acquired infections. Staff undertook regular training to ensure they could recognise and respond to the needs of vulnerable patients.

However,

Although the data indicates that take-up of Level 1 safeguarding training has improved significantly, the uptake and access to Levels 2 and 3 safeguarding training required further improvement.

Incidents

- We spoke with a range of medical, allied health professionals, a school teacher, play specialists and nursing staff. All were able to describe the hospital incident reporting system, and when questioned were fully able to explain their roles and responsibilities with regards to the reporting of incidents using the Datix reporting system. This software application allows staff members to report adverse events and near misses and facilitates initial recording through to investigation and subsequent root cause analysis. The nurses and doctors we interviewed explained to us and cited examples of how lessons learnt had been formulated from reported incidents using the Datix system. We were told by a paediatric nurse consultant that Datix reporting were positively viewed by all staff as good for leaning opportunities. Staff were able to give examples of how

the Datix process operated and we were shown samples of patient notes where Datix reporting had been documented. The nursing sister of the children's ambulatory care unit told us that there was a low level of incidents but that she was confident that all staff on the ambulatory care unit were fully able to utilize the Datix system of reporting incidents. Similarly the staff nurses we spoke with were fully able to describe the Datix process and they told us that they received regular email bulletins related to Datix reports and the lessons learned. The practice development nurse we spoke with told us that staff were fully compliant with the rules pertinent to Datix reporting. We examined the software shortcut to the Datix web form via the ward computer which facilitated ease of use by staff members wishing to escalate and report an incident.

- Information provided to us in advance of our inspection indicated that there had not been any never events reported within children's services. A never event is a (Serious Incident Framework, NHS England, March 2013).
- The data from the children's inpatient survey showed that parents and carers were confident in the ability of children's services to provide safe care for their children.(average score of 9.45/10)
- We examined the total of five serious incidents involving children which were reported by the trust, of which one applied to acute children's services between September 2014 and September 2015.The incidents reported were attributed to the children's services across the trust including the community. The one serious incident reported about the acute children's services involved the finding of a confidential document by a member of the public outside of the hospital. The matron and ward manger of the children's ward explained that this serious incident concerned the loss and subsequent retrieval of a confidential handover sheet with patient details. This breach of confidentiality where the handover sheet was found in a public domain was reported via the Datix system and fully investigated. The handover reports had been printed on white paper and were easily confused with other less important documents. Subsequent to the Datix inquiry a change in colour of the handover sheets from plain white to pink was implemented. Furthermore new procedures for securing confidential waste at the conclusion of each shift had been introduced. Notices and confidential waste bins in staff rooms and handover locations were introduced subsequent to this serious incident. We spoke with two neonatal consultants who confirmed that the pink sheets had replaced the white sheets after the serious incident and that the new procedures had been successfully implemented.
- We ascertained from the staff members we interviewed that training in the use of Datix was part of the induction process and student nurses we spoke to on placement at the Whittington Hospital children's services unit had also been made aware of the reporting system and had observed their mentors using the process.
- We reviewed the progress of a further serious incident which had occurred just prior to the CQC inspection of children's services which had been initially reported via the Datix reporting system which then resulted in the raising of a serious incident requiring investigation (SIRI) 72 hour report. This response followed the universal processes for reporting and learning from serious incidents requiring investigation. We inspected the 72 hour case review proforma and noted that it related to an adolescent child with emotional difficulties. Correct procedures had been followed and the safety of the child assured through prompt appropriate and transparent actions involving interagency collaboration.
- There had been no recorded instances of pressure ulcers, falls or catheter related urinary tract infections in children's or young people's services.
- We were told by the matron and other staff including consultants we spoke with that there were monthly mortality and morbidity meetings which were multi-disciplinary in nature. These were augmented by multi-disciplinary monthly risk and quality meetings for both community and acute care staff. At these meetings complaints, risks and the overall patient experience were discussed. A further weekly consultant meeting also considered risk. Consultants we spoke with told us that they attended the mortality and morbidity meetings and that all clinical governance meetings considered Datix reports and where action plans were monitored.
- The staff we spoke with were fully conversant with the duty of candour and were able to give examples of how this duty had been applied in practice. The 'Duty of

Candour' requires healthcare providers to disclose safety incidents that result in moderate, severe harm, or death and we observed wall mounted posters within children's services which explicitly explained the duty of candour for visitors to the wards. Any reportable or suspected patient safety incident falling within these categories must be investigated and reported to the patient, and any other 'relevant person', within 10 days. This procedure was confirmed to us by members of the PALS team we interviewed. Organisations have a duty to provide patients and their families with information and support when a reportable incident has, or may have, occurred and the staff working throughout children's services who we spoke with told us that they had a good understanding of their roles and responsibilities in relation to the duty of candour. To illustrate this we were told by the matron and ward manager of the children's ward of a recent incident report via Datix which ad concerned a medication error. The duty of candour had been fully implemented and the parent of the child had been made aware of the error via a personal phone call. The error had been cascaded via the ward manger to the matron.

Cleanliness, infection control and hygiene

- Staff had a good understanding of their roles and responsibilities in relation to cleaning and infection control processes and practices.
- We made observational checks of the cleanliness of the environment in the areas which made up children's services at the Whittington hospital and all were compliant with national standards, including 100% hand hygiene audits dated November 2015. We noted that all the hygiene protocols pertinent to the clinical areas we visited were in date and that staff were fully compliant.in adhering to them.
- We were told that cleaners are ward based and that a link nurse for Infection prevention and control (IPC) had been appointed for children's services who conducted monthly infection control audits.
- We interviewed the lead nurses for infection control on the neonatal unit and the children's areas. Both were aware of and could name the lead nurse in the trust for IPC. There was evidence throughout the hospital of the need for frequent hand sanitisation exemplified through the use of holograms and posters. We inspected a sample of the IPC minutes dated July 15th 2015 .These were available to staff via email. The IPC Whittington Warriors are a group of link nurses who meet every 6 months and the IPC hospital team issued weekly bulletins. All staff received IPC training and we inspected the data base for attendance and saw that it was 89% complaint.
- The infection control policies were fully available to view and we inspected a sample of these via the trust intranet and noted that they were up to date.
- There were monthly hand washing audits carried out throughout children's services and an inspection of the previous 3 months audit results showed 100% compliance. These results were communicated to the staff of the children's unit by email and were discussed at the ward meetings. We inspected the cleaning protocols used throughout children's services. Via the intranet and also saw them in place in the sluice areas.
- Children's services had their own group of cleaners and we were told that the domestic supervisors were very efficient in guiding the cleaning staff. There was guidance available to help staff clean patient equipment and we inspected the protocol for this via the staff intranet.
- We saw that staff followed the protocol and the link nurse we spoke to told us that PPE advice was freely available from central Infection control.
- We observed staff frequently using the hand sanitizers and washing their hands. We noted that all staff carried personal containers of alcohol gel. Parents we spoke with told us that they had seen staff members frequently washing their hands and that they had also been given advice of how to wash their own hands on entry to the clinical areas.
- We inspected the sluice areas and saw that waste management was complaint with national standards. The slice areas were tidy and clean and we inspected the single ward commode which was clean with an 'I am clean' Vernacare sticker applied.
- We inspected the sharps bins throughout children's services and all had been dated .We also inspected the linen storage areas and noted that there was sufficient clean linen available.

- We inspected a range of patient equipment such as blood pressure cuffs throughout children's services and these were all clean and had been appropriately labelled with Vernacare stickers.
- During our inspection we checked hoist, monitors and weighing scales for cleanliness. We saw that the clinical areas of all the children's services were clean and we witnessed the cleaning teams regularly attending to their duties throughout the whole of the service.
- We visited the anaesthetic room and saw that it was visibly clean with well labelled cupboards.
- The play specialist we interviewed showed us the toy cleaning schedules which were up to date and compliant with regulations
- Three of the parents we spoke with told us that the cleaners were always at work cleaning the ward, with one parent saying to us "it makes me feel at home".
- An inspection of the trust board minutes for September 2015 showed that it had no cases of MRSA for that financial year and that the trust had a robust zero tolerance approach to MRSA bacteraemia breaches and continues to keep this as a top patient safety and quality priority. Two new cases of Clostridium Difficel were reported for June and July 2015 (one in each month) making a total of four cases for the year period to September 2015.
- We observed that there were notice boards within the staff rooms detailing both infection control bulletins regarding future meetings and issues such as cdiff rates.

Environment and equipment

- Children's services consist of the neonatal unit which contains a new Special Care Baby Unit and transitional care facility which was was opened in 2007and which incorporates 16 new cots and family rooms and IFor ward with 23 beds including 2HDU beds and 10 cubicles one of which is used for HDU Adjacent to Ifor ward is Rosie's day care unit which has 4 beds which in turn was adjacent to the outpatient department. Children's services also configure a recently commissioned ambulatory care unit which is adjacent to the emergency department. Additionally, several times per week children can attend an adult day surgical unit known as the Treatment Centre. On these occasions the treatment centre is staffed by nurses from children's services.
- We found that clinical areas including the recovery area of the operating theatres to be clean, bright and child friendly. The play room, and independent hospital school were part of the configuration of the main Ifor ward. The school was well equipped with IT equipment and children's books. The large play room with a dedicated outside play area was well equipped with toys and distraction materials and equipment and was operated as a clinically free zone where procedural interventions on children were prohibited.
- We inspected a range of clinical equipment throughout children's services and found it was up to date and fully maintained. Children's services kept their own library stock of medical equipment and this was maintained by the medical physics department. The neonatal unit and the other clinical areas of children's services had sufficient equipment to provide safe care to premature babies and sick children. Staff we spoke to were aware of whom to contact or alert if they identified broken equipment or environmental issues that needed attention.
- We made observations of the paediatric recovery bay attached to the operating theatre. The recovery equipment including that used for resuscitation was up-to-date and fit for purpose. Equipment had been checked daily by the registered nurses who staffed recovery.
- We inspected the resuscitation equipment throughout children's services and the trolleys were clean, secure, updated and had been checked and logged on a daily basis.
- We checked the medicinerefrigerator, the breast milk refrigerator and the domestic refrigerators and all were compliantand up to date with cleaning schedules and temperature monitoring
- Breast feeding pumps were plentiful and a modest fee breast pump hire was available for mothers.

- We were shown a copy of the children's unitlock down policy which was to be implemented in the eventof child abduction or child abscondment but we were told that a simulation to test out the policy had not been conducted.

Medicines

- Medicines and controlled drugs were secured safely and appropriately accounted for in the records we inspected. The resuscitation drugs were securely stored and checked daily.
- We inspected and checked the daily drug fridge temperature log and found that regular checks had been undertaken and recorded to ensure that medicines were stored at the correct temperature.
- The paediatric pharmacist we interviewed told us that they attended children's services on a daily basis to discuss any issues with the senior medical and nursing staff. Pharmacy cover was available 24/7 and staff were able to use mobile phones to access the British National Formulary (BNF) which is a pharmaceutical reference book that contains a wide spectrum of information and advice on prescribing and pharmacology. The nurses we interviewed also told us that staff used the online BNF to check medicine updates
- We were told by the doctors and nurses we spoke with that paediatric pharmacy advice was always available.
- We checked medication records from three sets of patient's notes and found that they had all been appropriately completed with all relevant information including allergies, dosage and route of administration.
- Mothers we spoke with told us that pain management for their children was good and that staff used a visual analogue scale to determine children's level of pain discomfort. We noted that pain management for children was discussed within the handovers we attended.

Records

- Apart from the neonatal unit (which had separate nursing and medical patient records) patient records within children's services were multidisciplinary where all professionals including play specialist could contribute to the individual childs record.
- We inspected three sets of patient records and we noted that the care plans were individually focused. The matron and ward manager of Ifor ward told us that a range of core care plans were held on the intranet and then personalised for each child. Blank care plans were available for use where core plans are not appropriate .We noted that the care plans contained a section to allow parents to contribute to the care plan and to confirm that the care plan has been discussed with them.
- The play specialist we interviewed showed us their own record keeping system they kept for recoding how they had interacted with the children in their jurisdiction.
- We noted that all entries in the patient records were clear and legible with the signatories identifiable. Summaries were noted to be clear and structured. The storage of records was complaint with confidentiality.
- The record inspection we undertook confirmed that risk assessments had been completed and that the physical and emotional needs of children and families had been documented.Parents were actively involved in care planning especially those with children with long term conditions and a matron told us that that there was good emphasis on consent and that additional assessments were made for children with learning disabilities. Additionally the play specialists we interviewed told us that they were actively involved with gaining consent from younger children through play and diversional activities.
- We witnessed the staff in theatre reception using a copy of the Surgical Safety Checklist recommended by the World Health Organisation (WHO) and the National Patient Safety Agency (NPSA). The staff were using a copy of this checklist for each child to ensure that staff were consistent in the checks they performed. All checks performed were completed clearly and contained all the elements included on the WHO checklist.

Safeguarding

- All staff members we spoke to within children's services at the Whittington Hospital had a clear awareness and understanding of the referral process they were to follow should a safeguarding concern arise.
- The trust had a safeguarding strategy in place, which followed the key principles as set out in "Working Together to Safeguard Children" (2015) it states that "It

is the responsibility of employers to recognise that in order for staff to fulfil their duties in relation to safeguarding and promoting the welfare of children and young people, they will have different training needs which are dependent on their degree of contact with children, young people, adults. Whittington Health meets statutory requirements in relation to Disclosure and Barring Service (DBS) checks. All relevant staff completed a DBS check prior to employment and those staff working with children are required to complete an enhanced level of assessment. Systems are in place to ensure that all members of staff who work with vulnerable adults or children, or staff that have access to patient's personal information have a DBS check every three years.

- We examined the Whittington Health Trust Board minutes of the seventh of January 2015 and the Safeguarding Children Training Report which showed that that take-up of Level 1 training had improved significantly, but take-up of Levels 2 and 3 required further improvement.
- We spoke with the head for safeguarding for children in the trust who informed us that there were approximately two safeguarding issues per month which needed to be escalated. The safeguarding lead had links with the safeguarding link nurses in all parts of children's services and she was able to confirm that all clinical staff had received level three training. She told us that update compliancy was 74% and that she checked the staff training records on a monthly basis. All staff that undergo safeguarding training are awarded a certificate of attendance. Level one training was given to cleaners and porters with level two training to administrative staff. In this context level one training is designed for all staff working in health care settings and includes, for example, receptionists, administrative staff, caterers, domestics, and porters. Level two training relates to all non-clinical and clinical staff that have any contact with children, young people and/or parents/carers and includes clinical laboratory staff, phlebotomists, and pharmacists among others. Level three training is aimed at all clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns
- A combination of face to face and e leaning updates were given to relevant staff complemented by bespoke sessions where necessary. Reflective supervision was given to staff if required. The lead for safeguarding told us that there were some continuing capacity issues regarding the appropriate placement of children with mental health problems.
- The hospital school teacher we spoke with was fully conversant with the safeguarding processes and knew how to contact the lead nurse for safeguarding.
- The matron we interviewed told us that there was an electronic record for education and training especially for safeguarding and we were shown the unit teaching and learning board which was used to record staff update details. We corroborated this by inspecting the training records after an interview with the practice development nurse.
- We examined the mandatory training records for nursing staff on the neonatal unit and found that procedures were in place to monitor attendance at all mandatory training including safeguarding.
- We saw that the trust board received an annual safeguarding report and that safeguarding training was mandatory and was part of trust induction and arranged through the safeguarding team.
- All clinical staff within children's services including the play specialist and the school teachers were level 3 safeguarding updated, and this was confirmed after an inspection of the mandatory updating records. Attendance at Safeguarding updates was monitored by the practice development sister. Any non-compliance was recorded and alternative dates offered. Confirmation of attendance was monitored through the annual appraisal system. The medical staff we interviewed told us that safeguarding updating was part of their annual appraisal system. Doctors we interviewed all confirmed their level three safeguarding updates had been completed.
- The trust had a safeguarding policy, a designated consultant safeguard lead and a designated safeguarding nurse. Staff were fully aware of the process of engaging with the safeguarding policy and all we interviewed were able to describe the mechanisms for doing so.
- Throughout children's services CCTV linked to the key pad entry system was used to ensure people were safe.

Although security measures were good and all clinical areas were accessed by key pad entry staff operating the doors to clinical areas did not always inquire as to the identity of the persons entering. We observed this happening on several occasions including the ambulatory care unit where we were not challenged by the staff member operating the doors. We saw no evidence of a tailgating policy on any of the doors we accessed into clinical areas. Furthermore exit from the neonatal unit by visitors was not monitored.

Mandatory training

- Staff members told us that they were able to use the hospital simulation centre once per week to practice aspects of care such as resuscitation. We visited the simulation centre and found it to be well equipped with a comprehensive range of interactive manikins. Additionally simulation was also made available within the clinical environment of children's services.
- All mandatory training for nursing staff was organised at the beginning of every year by the practice development nurse and coordinated though the annual appraisal system. She was responsible for organising a range of mandatory updating at level two and three including equality and diversity, fire safety, health and safety , infection prevention, information governance, moving and handling ,and BLS. She told us that risk management and conflict resolution was covered through the induction day process. We inspected the mandatory records for Ifor ward and the practice development nurse explained how she ensures compliance attendance among the staff by sending emails to each member of staff three weeks prior to their expiration date. She books the classes but she also acknowledged that much of the updating is via e learning, which for some staff members has to be completed in off duty time. Hence some staff do not like to undertake mandatory training via e learning. Importantly staff who fail to attend are escalated to the team leader and then the ward manager. The practice development nurse also informed us that children's services are prepared for nurse revalidation.
- The nurses and doctors we spoke with as part of the inspection told us that they had attended mandatory updating classes and that the system for alerting them worked well.

Assessing and responding to patient risk

- Sick children were monitored for signs of deterioration through the use of a paediatric early warning score system (PEWS) and SBAR which is the Situation, Background, Assessment and Recommendation technique This structured method for communicating critical information contributes to effective escalation and increased child safety. We were told by the matron that both these methods were used for communicating clinical information about sick children. The matron and ward manger told us that there is always a nurse on duty with PEWS training. The safety thermometer had not yet been implemented but staff were currently examining this to ascertain how it could be made more child orientated. Two of the staff nurses we interviewed told us that they were fully confident in using PEWs and SBAR to determine the status of a deteriorating child. The student nurses we interviewed told us that they regularly witnessed the trained nurses carrying out patient safety checks using PEWS and SBAR .
- Staff we interviewed told us that the use of these paediatric early warning scoring systems enabled them to monitor a number of indicators that identified if a child's clinical condition was deteriorating and when a higher level of care was required. This was especially so in the high dependency area (HDU) of Ifor ward and the sister in charge of HDU told us that staffin all parts of children's services were aware of the appropriate action to be taken if children scored higher than expected on the scale. Children were appropriately monitored and actions were identified in children whose condition was noted to be deteriorating.
- We observed one to one care being delivered in HDU and the sister of HDU told us that 78 bed days were occupied by HDU in November2015. She told us that one to one staffing was applied until the child was stable and then subsequently reduced to one nurse to two children.
- The sister of HDU told us that there was always a nurse on duty within HDU with an advanced paediatric life support qualification (APLS) and that all staff within HDU have either the Resuscitation Council (UK) Paediatric Immediate Life Support (PILS) course or the

European Paediatric Life Support (EPLS) course which facilitates the early recognition of a child in respiratory or circulatory failure and gives staff the knowledge and core skills required to prevent further deterioration.

- We visited the treatment centre where we witnessed good dialogue between the nursing staff and the anaesthetists and we saw the WHO theatre check list was used in the operating theatre and we witnessed staff from the treatment centre undertaking safety checks for theatre such as fasting times and correct limb markings. The World Health Organization (WHO) Surgical Safety Checklist was designed to be used in any operating theatre environment to improve the safety of surgery by reducing deaths and complications.
- There was a process in place for referring to children and babies who were deteriorating to tertiary paediatric intensive care units or neonatal intensive care units via the Children's Acute Transport Service (CATS) which provided a dedicated specialist paediatric intensive care retrieval services for the North Thames region or the London Neonatal Transfer Service (NTS)
- Children and babies requiring intensive care management prior to retrieval were cared for by staff in the neonatal unit or the high dependency unit until the CATS/NTS team arrived.
- We saw that neonatal care for preterm and sick babies at the Whittington Hospital was organised within Neonatal Operational Delivery Network (ODN). ODNs have been established across England and aim to deliver safe and effective services across the patient pathway and help secure the best outcome for patients, in this case neonates. Badger Net is the live Patient Data Management System used by clinicians which allows doctors and nurses to share knowledge and skills. We inspected the perinatal data base network (Badger Net) on the neonatal unit and found it to be fully compatible with other similar services throughout England.

Nursing staffing

- The matron and ward manager told us that they met the 2012 Royal College of Nursing (RCN) staffing guidelines which are a series of standards which detail the minimum essential staffing requirements for all providers of services for babies, children and young people**.**
- We interviewed two first year student nurses who told us that they felt well supported on their placements by their allocated mentors .They confirmed that they were supervised according to the Nursing and Midwifery Council (NMC) 40% rule which are detailed in the NMC standards to support learning and assessment in practice which were published in 2008 and which ensure that whilst giving direct care in the practice setting at least 40% of a student's time must be spent being supervised (directly or indirectly) by a mentor. The students told us that they had no reservations in reporting any incidents to their mentor for guidance. They told us that "the staff are really fantastic" and that they personally felt confident in the care they were giving to the children because they had been so well supported by their mentors.
- Two of the staff nurses we spoke with told us that there were always enough medical and nursing staff on duty and that both had been given preceptorship booklets on induction. The matron told us that the assistant director of nursing for the whole trust was taking a lead in the establishment of safe staffing which was a priority for the executive team.
- We examined the paediatric staff training data base and the head of nursing for children's services told us that there were no significant problems with staffing and that the RCN guidelines were followed. Many of the senior staff we spoke with told us that the Whittington Hospital had a magnetic effect on attracting staff to work there.
- The matron of the neonatal unit told us that there were 7 neonatal consultants in post and always two on duty.
- We examined the staff allocation book on the neonatal unit and it was evident that the staffing standards for the RCN and British Association of Perinatal Medicine were being followed. On the remainder of the children's unit e rostering had been introduced and we inspected both a paper roster for December 2015 and an e roster for January 2016. Our inspection of the rosters showed that the staffing levels were compliant with the RCN recommended staffing levels. Where gaps in staffing were identified in advance for certain shifts in the month the risk was controlled by the use of bank staff.

- The Staff we interviewed told us that they did not use a formal acuity tools to correlate patient dependency with staffing levels. Staffing levels were adjusted as required via the e roster using bank nurses and when necessary agency nurses.
- Children were cared for by a contingent of fully trained and registered children's nurses and neonatal nurses throughout children's services. Infants on the neonatal unit were cared for by registered nurses who had undertaken post qualifying courses in neonatal care
- There were fully trained children's nurses employed within acute children's services and all members of the trained nursing team including the nurses working within recovery had attended the Paediatric Immediate Life Support (PILS) course. The paediatricians and some of the nurses had advanced paediatric life support training
- Play provision for sick children was less than optimum as children's services employed only three play specialists. We were informed by the matron that an advertisement for a further appointment of one WTE play specialist was to start in the near future.
- Parents we interviewed told us that there were enough nurses on duty at all times and that the nurses "went above and beyond" what they expected.
- We attended nursing handovers throughout children's services during which each infant and child was fully discussed. The nursing handovers were not multidisciplinary and primarily concentrated on the nursing management of each child and the plan of care for that day. Additionally we attended medical handovers in the neonatal unit and Ifor ward and these were also configured as a teaching handover for more junior medical staff

Medical staffing

- There were 10WTE general paediatric consultants on the rota and 6WTE neonatal consultants with a total medical staff mix of 64 WTE. We noted that the numbers of middle carer grades and junior doctors was less than the England average.
- Although the trust reported a higher percentage of consultants and a lower percentage of junior grade doctors when compared to the England average the children's services at the Whittington Hospital were fully compliant with the Royal College of Paediatrics and Child Health (RCPCH) Facing the Future criteria specifically with regard to patients being seen by a consultant within 24 hours of admission. The consultants we spoke with assured us that the consultant cover was optimal and that competition for junior doctor's posts was high.
- Junior doctors we spoke with confirmed that placements within the Whittington Hospital children's services division were highly prized and that the hospital had all the attributes of a teaching hospital. The consultants also told us that the consultant rota met the RCPCH standards. Facing the Future provides a vision of how paediatric care can be delivered to provide a safe and sustainable, high-quality service that meets the health needs of every child and young person. Facing the Future: Standards for Acute General Paediatric Services sets out ten standards for high quality, safe and sustainable acute general paediatric services.
- Doctors and nurses we spoke with told us that junior medical cover was satisfactory and the junior medical staff we interviewed were confident that there were sufficient numbers of staff available to care for the children and babies.
- Doctors we spoke with told us that medical cover was good with enough middle grades available at all times. Trainees told us that the consultants were fully involved in care delivery.
- The nurse consultant we interviewed told us that there were sufficient numbers of medical staff on duty at any one time and the practice development nurse also told us that she believed that the unit is well staffed. She believed that children's services had a magnetic pull on staff regarding recruitment and retention. The nurse consultant described the trust as " it is like a family and welcoming "
- The RCPCH standard that a. The handover was complemented by a comprehensive teaching presentation from one of the consultants. A computerised handover sheet was projected on to a media screen for all to see and this helped facilitate an accurate handover. All admissions and in-patients were presented by one of the junior doctors promoting high

level discussion between the consultants pertinent to each child's management. We noted that there was appropriate awareness of safeguarding issues throughout the handover.

Major incident awareness and training

- We examined the major incident plans and all the staff we spoke with were familiar with the major incident plans, including fire, winter and summer preparedness.

Are services for children and young people effective?

Good

We rated the effectiveness of services for children and young people as **good** because;

The trust utilised a range of policies and guidelines, which were based on national guidance. Auditing of compliance with national guidelines took place; where there was identified poor compliance, action plans were developed to address the shortfalls.

There was very good evidence of multi-disciplinary working. There were systems in place to ensure that the clinical, psychosocial and general health needs of children were met; this was delivered through a comprehensive assessment process, which was family centred. The trust performed very well on the national audits for diabetes.

Evidence-based care and treatment

- All grades of staff we spoke with told us that evidence based practice (EBP) guidelines and protocols were available via the trust intranet and the trainee doctors we spoke with told us that the EBP and NICE protocols and guidelines were easy to access. During the inspection we checked a sample of the protocols and confirmed that they were contemporary and up to date.For example the NICE jaundice guidelines and NICE neonatal sepsis guidelines.
- The theatre nurse we interviewed told us that she used the WHO theatre checklist and we witnessed her using this EBP tool.
- The service had participated in a full range of service delivery audits and the paediatric nurse consultant informed us of how the unit had participated in the British Thoracic Society Audit on asthma and the College of emergency medicine asthma audit.
- We examined the Clinical Audit Programme for 2015/2016 and saw that children's services were involved in a wide range of clinical audits including for example the National Paediatric Diabetes UK annual audit and the management of respiratory distress and use of surfactant in new-born infants.
- The doctors and nurses we spoke with told us that they were participating in a range of audits. We reviewed the list of 17 audits being undertaken in the year 2015/16 and these included RCPCH and NICE audits. We examined the summaries of a range of audits and noted that action plans had been written following the results such as a bronchiolitis audit. The epilepsy consultant we interviewed told us that the unit fully participated in the national epilepsy audit .There were concerns expressed as there was no epilepsy clinical nurse specialist in post although an appointment was imminent.
- Consultants told us that they were participating in research and were involved in publishing scholarly papers in peer reviewed journals.
- The trust's 'Quality Account 2014/15' report showed that the trust participated in several national clinical audits relating to paediatric services. These were: the National Paediatric Diabetes Audit, the Childhood Epilepsy Audit, and the Neonatal Intensive and Special Care Audit (NNAP) run by the Royal College of Paediatrics and Child Health, the Fitting Child Audit (care in emergency departments) run by the Royal College of Emergency Medicine, the national study of HIV in Pregnancy and Childhood run by the Royal College of Obstetricians and Gynaecologists and the national clinical audit on Paediatric Eczema run by the British Association of Dermatologists.
- The results of the NNAP audit (November 2014) included a recommendation that action should be taken regarding the recording of retinopathy screening data. The action log showed that this was being reviewed. The issue was regarding data entry rather than the actual completion of the checks, and the risk of long-term

harm if a check was not completed was assessed to be 'rare'. This demonstrated that the service acted on audit results to address issues raised and monitored and logged their progress.

- The children's unit results from the National Paediatric Diabetes Audit 2013 -2014 showed that from a sample of 62 patients the children's unit had 36% patients with HbA1c <58mmol/mol (compared to 23.9% in England and Wales). Their adjusted mean of HbA1c 66.9mmol/mol is equivalent to the Whittington being 5th out of 43 hospitals in London and the South east .This equates to children's services having a higher proportion of children with well managed diabetes than the England average.
- We noted that the unit intends to undertake a 15 step challenge and saw that information about the audit was on the staff noticed board but this has not yet been undertaken. The 15 Steps Challenge was a series of toolkits which remain part of the resources available for the productive care work stream. They were co-produced with patients, service users, carers, relatives, volunteers, staff, governors and senior leaders, to help audit care in a variety of settings through the eyes of patients, to help capture what good quality care looks, sounds and feels like. The 15 step challenge is so named after a parent said "I can tell what kind of care my daughter is going to get within 15 steps of walking on to a ward"
- Although the plans to open an adolescent bay within Ifor ward are close to completion a "you're welcome" audit has not been undertaken. The Department of Health You're Welcome quality criteria were first published in 2005, following concerns regarding contemporary healthcare for adolescents, and recognition that patterns of health-related behaviour laid down in adolescence impact on long-term health behaviours. An updated version was published in 2011 and establishes principles that enable healthcare professionals working in children's services and elsewhere to improve services by making them more young person friendly.

Pain relief

- Children's services used The ward manger told us that a range of pain assessment tools are used including smiley faces and visual analogue scales. Patient and nurse controlled analgesia was also used.to mange children's pain
- The nursing staff we spoke with told us that there was a good multi-disciplinary team (MDT) approach to the management of child pain and the trainee doctors told us that they had access to the hospital pain team and other pain management strategies from the Children's Palliative Care Service (Life Force). Life Force is a team of specialists, who provide care and support to families who have a child with a life limiting or life threatening condition
- The play specialists and other care staff had access to a full range of diversional play materials. Including 'Starlight distraction boxes' containing diversional toys.
- Topically applied local anaesthetic was applied routinely prior to cannulation and was used in conjunction with diversional play.

Nutrition and hydration

- The special care baby unit had level 2 UNICEF) accredited baby friendly status. The UNICEF accreditation is designed to provide parents with the best possible care to build close and loving relationships with their baby and to feed their baby in ways which will support optimum health and development. Stage 2 accreditation is achieved when a service demonstrates that all staff have been educated according to their role. The standards state that all health care staff must be trained to support a mother to express her breast milk for her baby. Breast feeding facilities on the neonatal care unit were in place and staff members' were noted to be positive in helping and supporting breast feeding mothers. The neonatal unit provides breast pumps at a £40 deposit and provides all mothers with a Whittington breast feeding pack entitles "Whittington babies" .These packs are funded through a neonatal unit charity. The packs contain a drinks container, a pen, a note book, a BLISS breast feeding handbook, a skin to skin contact booklet entitled look at me and a premature baby leaflet.
- Breast milk storage on the neonatal unit met the Royal College of Nursing (RCN) Breastfeeding in children's wards and departments guidance for good practice.

This entailed providing mothers who needed to express breast milk with a dedicated facility that was appropriately furnished with well-maintained and sterilised equipment for the safe expression and storage of breast milk. Fridges used to store expressed breast milk should be labelled as such and posters or advice leaflets on safe storage instructions provided. We inspected the fridges where expressed breast milk was stored and they were appropriately secured to prevent unwarranted access.

- Food for children is frozen and ordered from the independent food provider .The food is reheated on the ward. We inspected the menus and they offered a wide range of dishes. The dietician works closely with the ward and provides feedback about the success of the independent suppliers initiative. We observed the ward nutrition hostess as they prepared the menu choices. This was undertaken with full health and safety considerations including the use of microwave food thermometers.
- One of the children we spoke with told us that the food choices on the ward were good and that Caribbean food was available. Additionally the mothers we spoke to told us that the food for children was good.
- The student nurses we spoke with told us that the trained staff explained to them the reasons why care was delivered to children in certain ways and that they were able to participate in nutritional assessments of children which were completed regularly.

Patient outcomes

- Data provided by the trust showed that the emergency re-admission rate for children within two days of discharge was lower than the England average for non-elective admissions and there were no reported re-admissions for elective admissions.
- Data provided by the trust showed that the rates of multiple emergency admissions for children aged one to 17 years for asthma was lower than the England average. The multiple admission rates for asthma were 15.7% compared to the England average of 17%.
- Data provided by the trust showed that there had been less than six emergency admissions for diabetes and epilepsy.
- The neonatal unit contributed to Badger net which provides a complete platform solution for the collection, storage, and reporting of live perinatal patient data.

Competent staff

- Data from the paediatric data base showed that there were 56 registered nurses of various grades, seven HCA's and 4 four play specialist in post on the children's unit.
- The directorate report for children's services demonstrated that 100% of the medical staff had commenced the online appraisal service as part of the revalidation process. Currently children's services have an 81.6% appraisal compliance rate.
- Parents of children we spoke with throughout children's services told us that care delivery by staff was very good.
- The neonatal consultants we interviewed told us that the Whittington was "a fabulous place to work" where training for junior doctors was exemplary.
- All staff working in paediatric wards had undertaken paediatric immediate life support courses (PILS) and had been annually updated. This allowed the nurses to provide care to seriously ill children or children in cardiac arrest until the arrival of a cardiac arrest team. Such children were relocated to the HDU and awaited retrieval if necessary.
- The matron we interviewed informed us that all nurses working in the paediatric wards were qualified children's nurses.
- All recovery staff were general or adult trained nurses who received in situ training on the specific care of children recovering from an anaesthetic by the qualified paediatric anaesthetists.
- We were told by the matron of children's services that the trust was supportive of post qualifying nurse education, which was offered primarily by Middlesex University. Nursing staff had access to a full range of modules and courses. Specifically for example, nurses were sponsored to undertake study modules to acquire skills in neonatal nursing. The need for post qualifying education was identified at the annual performance reviews and prioritised according to need.
- Parents we spoke to told us that the staff were friendly and caring and that they felt safe and welcome in the

clinical areas Parents were especially happy with the play areas and play facilities. Parents also told us that they had confidence in the staff caring for their children and babies.

- The doctors we interviewed told us that children's services provided good training for medical trainees and they told us that there was significant competition among applicants for training places at the Whittington.

Multidisciplinary working

- We observed very good working relationships between all grades of staff and all professional disciplines working in children's services.
- The medical handovers we attended were very comprehensive and the theme of the week on that occasion was "resilience" for both staff and patients and this was highlighted on the notice board of the seminar room. We noted excellent communication between the doctors and the senior nurse. There was excellent reference to the role of the school teachers and a full discussion of psychological issues pertaining to individual children. The doctors also discussed the parental contribution to care and the role of care by parents .Additionally there was good reference to the role of the play specialist in care delivery. The handovers were very multi-disciplinary in nature and throughout the inspection we noted that multi-disciplinary working. Was fully embedded.
- We were told by the nurses we interviewed within the neonatal unit that there was good multidisciplinary team (MDT) working and that neonatal networks functioned well together with good relationships between the unit and the tertiary referral centres and the neonatal transfer team.
- We noted during nursing handovers that there was a high level of corporate working and team spirit.
- We were told by the play specialist and the hospital school teacher, that MDT working across the service was good with both feeling very much part of the team.
- We spoke with two junior doctors and they were highly complementary about the support they received from their consultants. Many of the consultants gave the junior staff their personal mobile phone numbers in case they needed advice.
- The nurse consultant we interviewed told us that MDT working within children's services was excellent and that the MDT post ward round huddles were an effective way of embracing MDT working. The nurse consultant also told us that the clinical director was a champion on integrated care and multi-disciplinary working and we saw consultants, other doctors and nurses in dialogue and noted excellent professional relationships.
- We witnessed consultants and other doctors having friendly one to one conversations with the domestic staff.
- The clinical phycologist attended the MTD meetings and the weekly and monthly MTD meetings showed low levels of complaints. The introduction of the" ask me anything" boxes by the consultants was seen by the nursing staff as commendable.
- The matron told us that "anybody can write in the patient's notes".

Seven-day services

- Children's services including the neonatal unit operated across the week, with day care medical procedures and surgery coordinated Monday through to Friday with differing specialities on differing days within Rosie's day ward and the treatment centre.
- Seven day services were in place with weekend working for AHP's including pharmacists.
- Children requiring surgery outside of normal operating hours were cared for on Ifor ward before going to surgery and then subsequent recovery after the next available operating slot. Out of hours emergencies were dealt with on a case by case basis and operated on at any time.
- Children requiring intensive care management and ventilation were stabilized by the resuscitation team within the high dependency area of Ifor ward before being retrieved as appropriate by the CATS team.
- There was access to out of hour's diagnostics and pharmacy.

Access to information

- Staff had access to evidence base guidance, policies and procedures via the trust intranet.

- In both the neonatal unit and the paediatric clinical areas helpful leaflets covering a wide range of topics were available for parents but primarily in English.

Consent

- Staff told us how consent was obtained from parents and where appropriate from the child or young person concerned across children's services in the trust. The trust had robust policies pertaining to consent and we found that consent was obtained in line with trust policy and the principles of Gillick competency assessment. "Gillick Competence" refers to any child who is under the age of 16 who can consent, if he or she has reached a sufficient understanding and intelligence to be capable of making up their own mind on the matter requiring a decision".
- Student nurses we spoke with understood the difference between consent and assent in younger age children and the play specialists helped in gaining assent by using hospital play equipment and in language they could understand of what was going to happen to them during procedure. Nurses we spoke with told us that their colleagues always endeavoured to explain aspects of care to children with learning disabilities.
- We witnessed a nurse gaining consent within the day treatment centre and we observed the play specialist in the treatment centre using the theatre preparation booklet to prepare a family for the procedure. We saw that the play specialist was involved with gaining assent/consent from younger children and that she used language the family could understand and she gave a good explanation of what was going to happen.
- The matron told us that there was good emphasis on consent and additional assessments were undertaken for children with learning disabilities.
- The patient records we inspected confirmed that consent procedures were robust. The WHO safety checks prior to surgery included checking that consent had been obtained.

Are services for children and young people caring?

Good

We rated caring for children and young people services as **good** because;

Care was observed and said by parents to be delivered with kindness and compassion. Children were fully involved in their care and independence was encouraged.

Parental involvement of care was encouraged and children's services had a family centred care philosophy which extended across each area. Strategies were used by staff to ensure that children and young people had age appropriate support during the delivery of their treatment and care.

Parents and children were involved in planning their care and information was shared with them so they could be fully informed on what would happen to them. There was access to specialist expertise to support the delivery of children and young people's care needs.

Compassionate care

- We observed infants, children and families being looked after in a caring and compassionate manner. Parents we spoke with told us that they thought the hospital was a compassionate organisation and that the staff always kept them up to date with their child's progress and condition and that they felt comfortable for example in leaving their child to go shopping. The parents and their children told us that they were well supported by the staff and that call bells were promptly answered.
- The mothers we spoke with told us that they appreciated the parent's room where they could relax and that they were always involved in decisions about their children.
- Parents told us that staff attitudes were good and that the staff appeared happy in their work. One mother told us "it has been unbelievable; the nurses have taken more care than I thought"
- Parents we interviewed on the neonatal unit were highly complementary of the care being received by their babies. We were shown a sample email from a parent which was full of praise for the staff of the neonatal unit.

Services for children and young people

- Two of the staff nurses we spoke with told us that they felt well cared for and were highly complementary of the support they received from the matron. They told us that they are given feedback on care delivery from the friends and family test results.
- The student nurses we interviewed told us that the staff were very caring to the children and their families.
- We observed that there was a family centred approach to the care of patients and their relatives, which extended to the anaesthetic department where the anaesthetists encouraged a parent to come to the anaesthetic room and remain with their child until they had been anaesthetised. We saw that an anaesthetist used age appropriate language to reassure a child in the anaesthetic room.
- The junior doctors and other staff such as student nurses we spoke with told us that there was significant emphasis on the six Cs which underpinned their practice. The Chief Nursing Officers' campaign to encourage compassionate care in English hospitals is based on '6 Cs' which are Care, Compassion, Competence, Communication, Courage and Commitment.
- A parent we interviewed in the treatment centre told us that "the staff are very good" and we observed that the nurses provided good caring and compassionate care to a mother whose child was awaiting surgery. The mother told us that there was a good supply of toys for children to play with in the treatment centre.
- The nurse consultant we spoke with told us that "if the staff feel well cared for then the children and their families will be well cared for".
- We visited the dedicated hospital school and interviewed one of the teachers .There were two full time teachers and two learning assistants in post plus a head teacher and one part time teacher. The dedicated school room in the children's unit was spacious and it operated during term time. The school service also offer home tuition and covers an adjacent mental health unit. The hospital school room was always staffed by at least one teacher plus a teaching assistant and the head teacher. During holiday periods the play specialists provide cover within the school. The school teachers provide either bedside teaching or school room teaching and the school room is a safe and caring haven and is wireless networked to enable sick children to access their own schools virtual learning platforms. Although sick children could also use their own mobile phones, the use of phone cameras and access to social media was strictly monitored and governed.
- The teacher we spoke with told us that the organisation was a caring and competent organisation especially for children with long term conditions. The esprit de corps of the hospital was perhaps exemplified by the Whittington cat bags which are sold in the foyer and freely available and carried by many in the local community .The teacher said "this feels like a local hospital and I am very impressed with the follow up social care –there are many good professionals here"
- A mother we spoke with told us that she was a long term user of children's services and that she had been very happy with the care she and her family have received. The mother told us that she had witnessed the nurses delivering care and conducting observations on her child and we noted that a STAMP assessment had been completed (STAMP is the Screening Tool for the Assessment of Malnutrition in Paediatrics and is a validated nutrition screening tool for use in hospitalised children aged 2-16 years)
- The consultants we spoke with told us that they had good relationships with the local tier 4 child and adolescent mental health unit, Simmons House and that psychology support was available to inpatients with mental health conditions.
- We noted that the care plans were designed to allow parents to contribute to the plan and to confirm in writing that the care plan had been discussed with them.
- There were family rooms in the neonatal unit and parents were allowed to stay on the ward overnight with their sick children.
- We observed that doctors and nurses maintained high levels of privacy and dignity and that breast feeding mothers had access to private rooms to express their milk.
- The performance dashboards for August and September 2015 stated that children's services achieved 100% in the NHS Friends and Family Test from May to August

2015, which was better than the trust average of 95%. This meant that 100% of the respondents to the survey would be likely or extremely likely to recommend the service to their friends and family.

- In the CQC Children's Survey (July 2015), information was collected on the experiences of nearly 19,000 children and young people. This included information on the care of 104 children and young people at The Whittington Hospital NHS Trust. The Whittington scored 'about the same' as other trusts on all questions, except for 'Planning Care' (parents and carers were asked if staff agreed a care plan for their child's care with them) for which they scored better than other trusts (9.5/10). They scored 10/10 forchildren spending most or all of their stay on a ward designed for children or adolescents, and not on an adult ward.

Understanding and involvement of patients and those close to them

- We spoke with staff from Roses day unit which is adjacent to IFor ward including the ward clerk, a play specialist and a staff nurse and noted that significant effort was put into communicating with children with learning disabilities using the Picture Exchange Communication System (PECS) and Makaton which is a language programme using signs and symbols to help people to communicate. Consultants we interviewed were complimentary about the effectiveness' of the play specialists in communicating with children with learning disabilities.
- The parents we spoke with told us that the doctors and nurses kept them well informed with information about their babies and sick children. However leaflets were primarily .available only in English although we noted that a cot death leaflet was available in Urdu.
- We examined the ward information leaflet which covered security, food and drink, nursing and medical staff and privacy and noted that all families were given a privacy and dignity leaflet which was only available in English.
- We observed staff talking with parents and children, explaining their treatment and giving information about their child's progress.

Emotional support

- We observed all staff members interacting with children and their parents in a polite and friendly manner.
- Children's services participated in The London Deanery's "TalkLab's Better conversations" initiative which is designed to explore the impact of three way conversations between doctors and adolescent patients and their families or carers. The doctors we interviewed told us that this had helped them communicate more effectively with young people requiring care.
- Although a "you're welcome" audit had not been completed within children's services the staff considered themselves to be young person friendly and were actively planning to open a dedicated adolescent section of Ifor ward later in the future.
- Psychology support was available throughout children's services.
- One of the senior nurses we spoke with told us that she was concerned about the rising numbers of children being admitted and the ability of the children's nurses to manage this group of patientsappropriately although we were told that specialised mental health nurses could be employed from specialist agencies.
- Parents were offered facilities to stay with their children in hospital and could remain at all times to provide emotional support.
- The children's services school service offered significant levels of support to children in hospital especially during examination periods. All children irrespective of length of stay were enabled to attend the hospital school which was designated as a non-clinical safe environment.
- Staff we spoke with including doctors told us that the Language Line and access to interpreters was always available to children and their families.
- Staff working in children's services told us that they had access to a range of clinical nurse specialists.

Services for children and young people

Are services for children and young people responsive?

Good

We rated the responsiveness of services for children and young people as **good** because;

The children's services within the trust met the needs of young patients (0-17years), their parents and carers. There was ready access to children's services via the children's accident and emergency unit or via the 10 am till midnight GP referral service offered within the ambulatory care unit. There were formal arrangements in place for children to be transferred to other local hospitals if more complex care was required.

The care ambiance decor across children's services was found to be clean and bright with good playroom and school facilities.

Children scheduled for day care interventions were invited to attend pre-assessment to facilitate them meeting with the play workers and the nursing team prior to admission. This provided an opportunity for children and their parents/carers to ask any questions.

The hospital school provided on-going educational opportunities for children admitted to hospital and was fully equipped with networked computer facilities to prevent children falling behind with their school work during a period of admission.

There were close working arrangements with the community elements of the trust via the hospital at home initiative which ensured that children could expect to be cared for at home via community nursing services following admission. This team works seamlessly with the acute services team to support early discharge for appropriate children.

Service planning and delivery to meet the needs of local people

- The nurses and doctors we interviewed were highly complementary about the hospital at home service developed by the trust .This service provides a virtual ward within the child's own home where children who are referred to the service from the emergency department or Ifor ward and are offered shared care from the hospital team who work in partnership with the hospital at home nurses who deliver care in the home. The parameters for this service are structured and it is aimed at children who are acutely unwell who require interventions that can be safely given in the community. We were shown a quotation from a mother "it is always scary when your child is not well but the nurses were fantastic. They came every day and I could phone them if I was worried. I was not aware of how comprehensive the service would be." There were plans in place to rotate nursing staff through the hospital at home service.
- The consultant nurse who was new in post had a remit to develop transition strategies for children about to be transferred to adult services. She had led the development of an asthma transition pathway and she had been working with GOSH in a bench marking exercise. Additionally she had liaised with GOSH and UCLH to examine areas of good practice. She had also conducted a survey with staff to determine attitudes about transition among the MDT team. She told us that she hoped to have completed a literature review and have developed models of transition by January 2016. She was also planning a survey with her colleagues in the community to gain consensus on which transition areas to focus on. He told us that champions for transition were scheduled for appointment in March 2016. Although a transition plan existed for young people with asthma and epilepsy in the trust there was no formal policy in place. The epilepsy medical consultant we interviewed told us that there were shared transition clinics for a range of medical conditions including epilepsy, asthma and the heamoglobinopathies.
- This was a multi-disciplinary clinic with a specialist diabetes nurses and dietitian input. In addition, quarterly transitional care diabetes clinic were held for teenagers with adult diabetic consultants to aid their transition to adult care.
- Services for babies and children in the trust had been developed to work in conjunction with adjacent larger tertiary children's and neonatal services in other hospitals. The neonatal unit has a level 2 UNICEF accreditation Baby Friendly award.

Access and flow

Services for children and young people

- Patient flow and bed occupancy was orientated to local demand for paediatric services from local primary care physicians and the dedicated paediatric emergency department, and the ambulatory care service which also offer a service for GPs who request a service for children requiring assessment. The children's services division caters for the needs of the local paediatric population through the provision of clinics. The doctors and nurses we interviewed told us that discharges were managed effectively with the assistance of the children's hospital at home team for Islington residents.
- Information provided to us in advance of our inspection indicated that the median length of stay was in line with the England average on all four indicators for both elective and non-elective admissions where children were under one year of age, and for elective admissions for those aged one to 17.
- There were arrangements in place for the transfer of critically ill children to specialist centres in London via the CATS and NTS retrieval service. We were told by doctors and nurses that these arrangements worked well and policies for the transfer of patients could be accessed electronically.
- Children's services had dedicated post-operative recovery areas for children.
- Parents were encouraged to remain with their children whenever possible and were offered accommodation via put you up beds within the ward bays.
- Parents of children attending for day care accompanied their child to the anaesthetic room for surgery.

Meeting people's individual needs

- Parents we spoke with acknowledged that translation services were available to them. The doctors and nurses we interviewed were fully aware of how to organise translation services for families.
- We saw that there were a number of posters and information leaflets for families around the various areas of children's services. We noted a range of specific leaflets for families throughout children's services. For example within the neonatal unit there were a range of specific leaflets for new mothers. Contained within the Whittington breast feeding pack entitled "Whittington babies"
- The hospital school was very well equipped with net worked computers and books. School teachers were able to liaise directly with individual children's own teachers.
- The hospital based Child and Adolescent Mental Health Liaison team liaised with the paediatric department on a daily basis to ascertain if there were any children with mental health issues. This team could be accessed 24 hours a day, 7 days a week.
- The unit has a dedicated private breast milk expressing room and a knitted breast display which was used to show mothers the most appropriate way of expressing milk from their breasts.
- We found that parents were enabled to stay with their child whilst in hospital.
- Mothers we spoke to told us that the food given to their children was good.

Learning from complaints and concerns

- Learning from complaints was shared via team meetings with staff receiving feedback from the Patient Advice and Liaison Service (PALS).
- The nurses and doctors we spoke with told us that the unit handled complaints well with good liaison with PALS.
- We visited the PALs department and inspected their data base of child related complaints for one calendar year. The levels of complaints were small with no major isues noted. The PALS officers told us that they endeavoured to resolve complaints before they reach the formal stage i.e. before the 25 day period. Most of the complaints were noted to be of minor concern and primarily related to outpatient appointments and parking. For the year November 2014 to 2015 there were 42 PALS referrals of which 21 were related to complaints.
- We noted patient feedback cards displayed on notice boards on the neonatal unit
- Data from the friends and family tests and the children's survey was generally favourable although the score for facilities for parents staying overnight was 7.03 out of 10.

Are services for children and young people well-led?

Services for children and young people

Good

We rated how well-led the services for children and young people were as **good** because;

There were systems in place to ensure good governance and monitoring of standards for children, young people and infants who required acute medical care and surgical intervention and investigations.

Staff were very proud to work for the trust and it was clear from speaking to parents that they were satisfied with care delivery. Staff were aligned to, and supported the trust wide mission of "Helping local people live longer, healthier lives" and the trust vision of "provide safe, personal, co-ordinated care for the community we serve".

Vision and strategy for this service

- The view of the senior nurses we interviewed was that the chief executive was fully in charge and knew what was going on throughout the trust. They believed that the paediatric service had benefited from the new ITSU structure implemented by the chief executive. There was now a perception that this had facilitated a corporate view of paediatrics which spanned both the community and the inpatient services
- Staff spoke positively about providing high quality care that was aligned to the trust-wide mandate of ensuring that patients received safe, clean and personal care. Staff members were aware of the trust wide quality improvement strategy and were able to describe the shared vison for the trust of the chief executive and the management team.
- We identified that there was an all-encompassing vision and strategy, which was attributed to the overall provision of children's services at the trust. This encapsulated neonatal provision, acute care provision, day care, ambulatory care, outpatients and the community paediatric services including the hospital at home service.
- Nurses we spoke with told us that people in the trust have more confidence in the new CEO who has useful monthly open meetings for staff. They feel that the excellence awards are strong motivators. Nominations for these awards are designed to

Governance, risk management and quality measurement

- There were arrangements in place for governance, risk management and quality measurement associated with the care of children and infants across the trust. We found that the arrangements enabled them to measure the quality of the services they provided, as well as having appropriate governance systems in place. Doctors and other health care professionals we spoke with told us that the mortality and morbidity meetings held in children's services were an effective strategy to escalate risks where required. These meetings and the associated quality board meetings facilitated monitoring of action plans and to consider and reflect on situations when the delivery of care had not gone according to plan. These meetings allowed staff to learn from incidents and to consider and implement any actions that may have needed to be taken. Additionally these meetings considered reviews of policies, medical pathways, reviews of existing and new risks, safeguarding concerns and financial and human resource performance. For example a safeguarding newsletter was produced every 2 months.
- Children's services within the trust had few risks on its risk register with action plans and controls in place to reduce risks. We spoke to various members of staff who were conscious of the risk register and the actions plans that had been put in place. One of the most important risks was the lack of a specialist epilepsy nurse.

Leadership of service

- Staff working with children on a daily basis told us that that day-to-day clinical leadership was good and that they received support from their immediate line managers. The staff nurses we interviewed felt well supported by the senior team and they told us that they read the weekly chief executive bulletin which kept them up to date with events throughout the trust. The staff were well motivated and when asked to score themselves against the CQC ratings they did not hesitate to award themselves and their service as outstanding for care delivery. Telling us that "we think the matron is outstanding"
- The nurses we spoke to told us how supportive the matron of children's services was to them

Services for children and young people

- The student nurses told us that the ward team was well led by the matron and ward manager.
- The senior nurses we interviewed told us that overall leadership had improved since the appointment of the new chief executive. A play specialist we interviewed told us that she felt very comfortable with the unit managerial structure and would feel free to speak out without fear of retribution.
- Consultants we interviewed told us that overall leadership is good with one telling us that "I think the Whittington hospital is a hospital with a heart ", and "The hospital has a good open culture". They spoke highly of the senior leadership and appreciated the internet forum where emailed questions could be sent to the chief executive.
- The middle grade and junior doctors we spoke with told us that they felt very well supported by the group of consultants.
- During the doctors handover we observed how courteous the consultants were to the junior medical staff with the lead consultant saying "well done everyone".

Culture within the service

- Most of the staff that we spoke with told us the trust was a good place to work with many of them having worked there for many years. Staff were confident in being able to raise concerns and felt comfortable with the transparency and openness culture being promoted by the chief executive and his senior management team.

Public and staff engagement

- Staff engagement was facilitated through regular forums with the CEO and his team, and via regular news letters.
- Public engagement with children, young people and their families was still at an early stage of development and had been used for example to help in the design and decor of the planned adolescent bay within Ifor ward. A children's forum was in the planning stage of development.
- Staff we spoke with confirmed that a "15 step challenge" and "You're welcome audit had not been undertaken.

Innovation, improvement and sustainability

- The trust's vision of delivering excellent integrated care for users of children's services when and where it was needed was fully embedded within the staff culture and the nurses and doctors we spoke with were proud of the key achievements of the trust in recent years especially in the development of the hospital at home scheme.
- Sustainability in driving the culture forward within the trust was evident in the openness of the way in which complaints were dealt with

End of life care

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

Information about the service

The Whittington Hospital provides end of life care to patients with progressive life limiting illness. Conditions include cancer, advanced organ failure, such as heart and renal failure and neurological conditions. The palliative care team at Whittington Hospital provides support to patients and staff on all wards within the hospital. This team also provides training to staff on the wards in various aspects of palliative care. In 2014 the hospital reported 355 patients' deaths which took place in the hospital. There was 411 patients referred to the team in 2014/2015.

The majority of all patients referred to the team in 2014/2015 where diagnosed with cancer (54%).The specialist palliative care team was led by the lead palliative care consultant and a lead nurse. The palliative care consultant worked part time (0.6 whole time equivalent), there were three palliative care nurses (2.2 whole time equivalent).

Bereavement support was provided by the mortuary staff and the chaplaincy team. During our inspection we spoke with ten patients and some of their relatives. We also spoke with 37 members of staff including; senior trust managers, the palliative care team, mortuary staff, chaplaincy team members, nursing staff, medical staff, allied health professionals, and porters. We reviewed various documents, which included medical records and 'do not attempt cardiopulmonary resuscitation' forms.

Summary of findings

We rated end of life care as good overall because;

We found that staff providing end of life services were caring, the service was effective and well led. However, the safety of end of life services provided at Whittington Hospital required improvement. The end of life services also required improvement across responsive domain.

Patients told us staff were caring and compassionate and that they were involved in planning their care and making decisions. We observed staff being respectful and maintaining patients' dignity, there was strong person centred culture. Patients in their last days were suitably assessed and their nutritional and hydration needs were met. Care and treatment was delivered in line with current evidence-based standards. Patients had appropriate access to pain relief. The trust had scored much better than the national average for clinical indicators in the national care of the dying audit. Palliative care and end of life team members were competent and knowledgeable.

There were no serious incidents relating to end of life care in the hospital. Staff received appropriate end of life training. They knew how to report concerns.

There was good end of life care awareness across the hospital. The trust appointed both, a non-executive lead, and an executive director to take lead and provide representation of end of life care at board level. Specialist palliative care team members felt supported

End of life care

in their work and worked well as a team. Staff were clear about their roles and their involvement in decision making and demonstrated a positive and proactive attitude towards caring for dying people.

However, not all staff had received adequate training including training in operating syringe pumps, Mental Capacity Act or training related to patients' depravation of liberty. Patients DNR CPR forms were not always completed accurately. 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 and provision of seven day services. They did not monitor discharge times and if there were any obstacles to patient's discharge. There was no formal rapid discharge pathway to ensure speedy discharge of patients who wished to die at home or another location. Staff did not always record and analyse if patients were cared for at their 'preferred place of care'. The trust did not gather and analyse patients and relatives views in relation to end of life care to inform service delivery and planning.

Are end of life care services safe?

Requires improvement

We rated the safety of end of life care as requiring improvement because:

Not all staff had received adequate training in operating syringe pumps, Mental Capacity Act or training related to depravation of liberty.

Patients DNR CPR forms were not always completed accurately.

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.

However:

Patients in their last days were suitably assessed.

There were no serious incidents relating to end of life care in the hospital.

Staff on wards, where end of life care was provided, had received appropriate end of life training.

Staff knew how to report concerns.

Medicines, including opioids, were managed safely.

Suitable equipment was available and maintained.

Incidents

- There have been no never events related to delivering end of life care. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level.
- No incidents related to end of life care at the hospital were reported by the trust through the national reporting and learning system (NRLS) May 2014 to August 2015.
- There were no incidents related to end of life care provided by the hospital through the strategic executive information system (STEIS) in June 2014 to November 2015.

End of life care

- The specialist palliative care team reported no serious incidents through the trust's electronic incident reporting system in November 2014 to November 2015.
- We looked at an investigation report relating to one incident from May 2015 where suboptimal care was provided which potentially contributed to patient's death on Cloudesley Ward. Urgent review by the medical team was not instigated by nursing staff at night in a situation where patient's health had deteriorated. When the patient became unresponsive nurses noted 'do not resuscitate order' (DNAR) at the front of their medical notes and did not commence cardiopulmonary resuscitation. However, the DNAR form related to a previous admission and was out of date. Staff should have attempted full resuscitation but this was delayed due to confusion around the DNAR order. The incident was investigated by a care of older people consultant and a matron, supported by head of nursing and clinical director. Root cause analysis was undertaken and learning points were identified and shared at the mortality meeting and at the deteriorating patient group in July 2015. In addition the DNAR policy was updated with explicit advice regarding how DNAR form should be withdrawn and filed at the end of an admission.
- Staff we spoke with were aware of how to report an incident or raise a concern. All the staff told us they were encouraged to report incidents using the electronic reporting system.
- Hospital deaths were discussed during specialist palliative care multidisciplinary meetings. The responsibility for mortality and morbidity meetings and audit was held by clinical leads. The data was presented departmentally or wider if necessary. Each audit identified themes for learning if one of these considered end of life care the end of life team were involved in the discussion.
- Incidents relating to end of life care were discussed at the 'end of life care group' meetings with learning and action points being identified.

Cleanliness, infection control and hygiene

- The mortuary and viewing areas were well ventilated. However the floor in the mortuary was not clean and viewing areas appeared to be in need of decoration. All areas were cleaned by a designated member of staff but cleaning records were not maintained on daily basis. There was limited storage in the post-mortem room, clean linen was kept in the open on a trolley.
- Mortuary staff did not always follow guidance set by infection control policy or procedures. Staff wore uniforms but not all staff adhered to the trust's infection control and hand hygiene policies, we observed some mortuary staff wore rings and jewellery.

Environment and equipment

- The mortuary had been licenced by the Human Tissue Authority in April 2014 to allow post mortem examination and storage of bodies. Equipment used in the mortuary was maintained and checked regularly. This included suitably certified and checked trollies and refrigeration system which were maintained by the trust's engineers.
- The mortuary was suitably equipped to store the bodies of bariatric patients; there were specific trollies and large fridges to accommodate them.
- There were facilities available in the mortuary to store bodies long term. Staff told us these facilities were sufficient to meet the needs of the hospital and local population.
- People reaching the end of their life were nursed on the general wards in the hospital. Staff told us, whenever possible, patients were to be cared for in side rooms on wards in order to offer quiet and private surroundings for the patient and their families. They also said some patients at their end of life were cared for on open wards as use of single rooms was prioritised for patients who required isolation.
- Equipment such as commodes, bedpans and urinals was readily available. Pressure-relieving equipment, including mattresses, was available for patients requiring them.
- Staff told us that syringe pumps used to give a continuous dose of painkiller and other medicines were available to help with symptom control in a timely manner. The trust told us that only one type of syringe pump was used at the hospital. Nurses told us they felt

confident in using this equipment and that they had received adequate training to be able to do so. However, records indicated that not all staff received training in operating syringe pumps.

- Patients were equipped with call bells in order to attract the attention of a member of staff when necessary.

Medicine

- Controlled drugs were managed appropriately.
- Medicines administration records checked by us were accurate. Patients told us they received medicines in timely manner and staff explained the benefits and potential risks involved with medicines administered.
- The hospital used a comprehensive prescription and medication administration record chart for patients which facilitated the safe administration of medicines. Specialised prescription charts supported prescribers to follow the agreed protocols for people who had medicines administered via syringe pumps. Medicines delivered via syringe pumps, were prescribed appropriately and staff were provided with guidance supporting them in making informed decisions.
- The specialist palliative care team developed end of life medication protocols, these were available on the hospital's electronic prescribing system. They liaised with pharmacy department to produce a daily report on EOL protocol prescriptions at individual patient and clinician level. This facilitated the teams' awareness of patients, within the hospital, who were approaching the end of life.

Records

- We reviewed 22 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms. Thirteen of these were fully completed in line with the trust's DNR CPR policy. Six of those did not contain information related to mental capacity assessments. In four cases there was no records of conversations held with patient's relatives, in six it was not clear if patient was aware there was a DNACPR order in place. It was not always clear who had approved the decision as some signatures were illegible and some forms were not countersigned by an appropriate clinician.
- Where patient had a community DNACPR forms these were not routinely reviewed at the time of admission to ensure the decision made was still valid.
- The trust conducted a monthly DNAR audit by reviewing a random sample of patients' notes. The inspection team reviewed the audits conducted between April and August 2015. In total, 35 patients' records were audited; the audit highlighted a number of issues with the documentation. The doctors did not discuss DNAR decision with nine out of 35 patients and did not document their decision for DNAR on seven occasions. On nine occasions a nurse did not sign the DNAR document to confirm they were aware of the DNAR status. In most cases the review date was not completed on the form. The DNAR policy stated that unless there was a specific review date, decisions were valid for the duration of the admission by default. The July 2015 audit mentioned an incident where information related to a patient and their DNAR status was consistently handed over despite there being no supporting documents on the patient's notes. This incident was appropriately recorded and investigated by the trust.
- Records did not always indicate the preferred place of care/preferred place of death or the wishes and preferences of patients and their families.
- Risk assessment forms were mostly completed and accessible. It included falls risk assessments and skin integrity assessments.
- Care plans were accessible to all staff.
- The mortuary records, which included body release forms, were accurate.

Safeguarding

- Most staff we spoke with knew who the named leads for adult and children safeguarding were. All were aware of actions they would take should there be a need to report a safeguarding incident.
- Records indicated that all members of the specialist palliative care team had completed a safeguarding training for both adults and children which were appropriate to their role within the past twelve months.

Mandatory training

- The trust employed 1320 nurses in 2014/2015. Only 100 nurses across the hospital (46) and community (54)

received specific syringe pump training. Nurses told us that they felt confident they would receive support and training on individual basis, from the specialist palliative care team, in operating syringe pumps should there be a need.

- The trust told us that regular end of life teaching sessions were held at the hospital. Records indicated that many of the staff received an introduction to palliative care and end of life training between September and December 2015. The specialist palliative care team members also facilitated the 'sage and thyme' foundation level workshop, developed to meet the level 1 skills requirement described in the 2004 NICE guidance on 'Improving Supportive and Palliative Care for Adults with Cancer'.
- Training was available at four levels to ensure the appropriate skills are maintained for the appropriate developmental needs of staff. The stages included mandatory training (such as sage and thyme communication skills), essential information e-learning or face to face training, enhanced skills (e-learning) and the development of more specialist knowledge for those working with people with at the end of life and providing a leadership role.
- The training for foundation and core medical trainees was based on their curriculum requirements. Core medical trainees had individual training sessions with a palliative care consultant. The specialist palliative care team also provided tailored sessions to individual specialities on request, for example surgery or respiratory teams.
- The palliative care team members said that they had completed mandatory training which included equality and diversity, health and safety, infection prevention and control, resuscitation, manual handling and conflict management. Mandatory training also included fire safety, risk management, duty of candour and safeguarding adults and children. Training summary records were kept to indicate how many members of staff had completed this training and when.
- Sixteen out of seventeen staff members, including those who work within mortuary, pain team and chaplaincy, completed duty of candour (DoC) training and 15 staff members completed safeguarding of vulnerable adults (SoVA) training. Also, 40% of the volunteers (81 individuals) completed SoVA training. None of the specialist palliative care team had completed Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act (MCA) training and only two other staff members, from mortuary and pain team, completed it. None of the volunteers completed DoLS, MCA or DoC.
- Porters involved in the transfer of bodies between the ward and mortuary had all been trained in the trust's procedures for transporting bodies to the mortuary and the use of equipment. There were always two porters involved in the procedure.

Assessing and responding to patient risk

- The trust had system for flagging patients who were receiving end of life care. Doctors and nurses were aware of how to refer patients to the specialist palliative care team and felt that referrals were made in timely manner.
- The results of the national care of the dying audit published in May 2014 showed that only 82% of patients had been recognised as dying at the end of their lives, this was much better than the England average of 61%. The trust scored better than the national average for those patients who had been assessed within their last 24 hours, with 93% compared to the England average of 82%, being assessed (having 5, or more, assessments).
- The trust used a warning score system for monitoring acutely-ill patients, to alert staff of deterioration in their condition. The tool allowed staff to monitor patient functions, such as their heart rate, blood pressure, temperature and oxygen levels at the bedside and staff calculated an early warning score for each patient. It was used appropriately to alert appropriate clinician to patients who may be deteriorating.
- Most staff had received training in basic life support. There was standard emergency equipment available to support adult and children patients in an emergency throughout the hospital.
- We observed patients had easy access to call bells and we observed their calls were responded to promptly.
- Patients were reviewed by doctors at least daily to check that the plan of care remained appropriate. Observed changes in the person's condition resulted in appropriate adjustments to the documented plan of care to better meet their new needs and preferences.

End of life care

Nursing staffing

- The hospital specialist palliative care team consisted of a lead nurse and two palliative care nurse specialists working part time (2.2 whole time equivalent). The team provided care only within the hospital. They also provided support to hospital staff, patients, and families and operated five days a week 9 am to 5 pm.
- Specialist palliative care team members did not feel staffing levels were sufficient to allow for a seven days face to face service and were focused on training individual hospital teams to address staffing shortage. The trust had recognised that they did not meet the national guidance issued by the Department of Health and the National Institute for Health and Care Excellence related to provision of seven day services. Local risk register updated in October 2015 stated that the trust worked on a business case development to address the seven day working issues. There were palliative care 'link' nurses, on most of the wards we visited and staff knew how to contact the specialist palliative care team should there be a need.
- The sickness rate among the palliative care team members at 0% (October 2014 to October 2015) which was much better than the trust's average sickness rate of 1.2%.
- There was a part time vacancy (0.3 whole time equivalent), it reflected 28% of the total nursing post allocated to the team.

Medical staffing

- There was only one palliative care consultant working who was working part time (0.6 whole time equivalent). It was not in line with the Association for Palliative Medicine of Great Britain and Ireland, and the National Council for Palliative Care which states there should be a minimum of one consultant per 250 beds. The hospital had approximately 350 beds. The palliative care doctor was responsible for providing care within the hospital, engagement with local palliative care providers and educational initiatives. There were no feasible plans to increase the number of consultants in the near future.
- There was lack of out of hours on-call support provided by a consultant at night during the week and weekends.

Security

- Access to the mortuary was controlled by the mortuary staff, security team and porters office. There was video surveillance in operation outside of the mortuary entrance to ensure only authorised people accessed the hospital mortuary. Record of visitors and staff visiting the mortuary was kept and we saw staff were using it accurately.

Major incident awareness

- Mortuary staff were unclear on how the capacity would be increased in case of major incident. They said they were not included in any pan-London or national emergency mortuary arrangements to support with response of emergency services. There were approximately 64 spaces used at the time of the inspection and staff told us that was a usual number. There were no additional foldable racking system available on site which could be used to increase storage facilities. A manager told us that temporary cold rooms could be arranged at short notice should there be a need.

Are end of life care services effective?

Good

We rated the effectiveness of end of life care as Good because:

The trust had scored much better than the national average for clinical indicators in the national care of the dying audit. Patients nutritional and hydration needs were assessed. Care and treatment was delivered in line with current evidence-based standards. Patients had appropriate access to pain relief.

Palliative care and end of life team members were competent and knowledgeable and there were good examples of the multidisciplinary team working. The trust provided quality training to ensure staff were competent and able to meet patients' needs adequately.

Evidence-based care and treatment

- There was unified approach to end of life care across at the hospital, the specialist palliative care team were proactive and they have responded to changing national guidance related to end of life care. However, the number of specialist palliative care doctors and

nurses did not meet requirements of the national guidance. This meant that the team was unable to provide seven day face-to-face services across the hospital.

- The Liverpool care pathway was phased out by the trust in 2014, as required by the national guidance. The trust replaced it with another end of life care plan which supported staff to focus their care to specific needs of people at their end of life. Staff were aware of the five priorities for care set out by "One Chance to Get it Right" report recommending the approach to caring for dying people.
- Senior members of staff were unclear how the effectiveness of the care plan introduced in the hospital would be assessed. The trust did not participate in national survey of bereaved relatives, they did not audit whether patients died at the preferred place or the effectiveness of the discharge processes. This meant that the support offered to patients at their end of life was not fully informed by the local evidence.
- There were accessible, easy to use resources available on the intranet to guide care, workshops and general learning, in meeting patients' palliative care needs. There were tools accessible to staff which assisted with decision making, helped to identify distress and issues associated with capacity, also assisted with symptom control. Staff were directed to e-learning resources to supplement their learning. Information available included opioid conversion guidance, palliative care guidelines, and a syringe driver prescribing example chart. The end of life care intranet section covered and was updated in line with the Leadership Alliance for the Care of Dying People's five priorities of care.
- DNACPR policy was approved by the trust's board in March 2015 and was scheduled to be reviewed every three years. The policy complied with the recent changes recommended by the court of appeal related to resuscitation order (DNAR). It advised staff to use a 'cardiopulmonary resuscitation decision tree' in making decisions relating to DNAR. The policy complied with the published guidelines such as those published by the Resuscitation Council and The Association of Anaesthetists and General Medical Council's guidance.
- The specialist palliative care team established networks with other regional palliative care services. They were involved with the PallE8 Palliative Care Group, a clinically-led expert reference group for specialist palliative and end of life care for adults and children. The group covered north central London, north east London, and west Essex. Participating in the network helped the team to share their experience and knowledge and discuss and learn from approaches taken by other organisations providing end of life services.
- The trust did not use the self-assessment tool which had been developed by the National End of Life Care Intelligence Network in partnership with Public Health England, to help monitor the quality of services. They had established an 'end of life steering group' to monitor and maintain the standards of end of life care. The group was chaired by the medical director for integrated care and they met monthly.

Pain relief

- Patients told us they had access to pain controlling medication whenever required.
- The trust's results from the national care of the dying audit for hospitals, showed that at the time of the patient's death there was documented evidence that 'use when required' medication had been prescribed for 68% of patients, this was much better than the England average of 51%.
- There was an operational guide on how to manage key symptoms of dying patients. It provided advice on managing pain, restlessness and agitation, breathing difficulties or nausea and vomiting. The staff we spoke to were aware of this guidance and used it.
- Nurses we spoke with had knowledge of the treatments and symptom management to address pain appropriately.
- One specialist palliative care nurse was a 'prescribers', able to prescribe pain control medication in situation where doctors were not immediately available.
- There was a pain team which provided pain control support for those patients who were not meeting the referral criteria set for the specialist palliative care team.
- One of the questions of the national survey of bereaved families was checking whether pain support was

adequate and how well pain was relieved during the last three months of life. The trust did not participate in this survey therefore we were unable to assess it adequately and compare with other hospitals.

Nutrition and hydration

- Most patients we spoke with were happy with the food and drink provided by the hospital.
- We observed that all patients had access to drinks that were within their reach.
- The national care of the dying audit found that only 81% of patients had a review of their nutritional requirements, this was much better than the England average (41%; 2013/2014).
- As indicated by the national care of the dying audit, in 79% of cases patient's hydration requirements had been reviewed which was much better that the England average of 50%.
- We observed nutritional assessments were completed and that nursing records such as nutrition and fluid charts were thorough and summarised accurately. We saw that menus catered for cultural preferences.
- The malnutrition screening tool was used across the hospital. It was used as part of the admission or initial assessment of a person to assess people's nutritional status. Staff were aware of the referral process and criteria for patients who required speech and language therapist or dietician's input.

Patient outcomes

- The trust scored worse or much worse than the England's average in five, out of seven, organisational key performance indicators. Areas where improvement were required related to: formal feedback from bereaved relatives; clinical protocols promoting patients privacy, dignity and respect, up to and including after the death of the patient; continues education, training and audit; access to specialist support in the last hours or days of life; access to information relating to death and dying. They scored better or much better in all ten clinical key performance indicators related to patients' outcomes.
- The hospital formed the end of life steering group to improve the outcomes related to operational indicators and end of life services overall. This group met monthly, they developed an action plan in response to address shortfalls in end of life care. However, we noted that the trust was slow to respond to findings of this audit results of which were published in May 2014. Although at the time of the inspection we have noted that there were improvements related to the trust board representation and training and education, there was no process for gathering feedback also access to specialist support in the last hours or days have not improved. The trust did not meet the requirements related to end of life care as set out in the national guidance published by the Department of Health, Royal College of Physicians or the National Institute for Health and Care Excellence.
- The trust had not participated in the last national survey of bereaved families (VOICES). Therefore were unable to assess outcomes, compare the care provided with other hospitals and use it to improve the service.
- There were no local initiatives for feedback gathering to ensure the service met patients and their relatives' expectations and to check if they were happy with the care received at the hospital.

Competent staff

- General palliative and end of life care skills training was provided by utilising both eLearning and face-to-face approaches. Specialist care consultant told us that academic pathways would be established where necessary to develop expertise and specialist knowledge in palliative care skills. Post-graduate learning opportunities were provided through local universities or through distance learning courses.
- Records indicated all mortuary and chaplaincy staff members had their appraisals within the past twelve months. However, only four out of nine palliative care staff members had their performance reviewed in the past twelve months. The one eligible pain team staff member did not have their appraisal. The other team members joined within the past year and were not yet appraised. Volunteers did not have their performance routinely reviewed.
- The specialist palliative care team provided 'sage and thyme' training aimed to build confidence and staff skills needed in sensitive, open and honest communication with patients and their families. This training was offered to all teams including therapy, nursing and medical staff and healthcare assistants.

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- Palliative care and end of life team members were competent and knowledgeable. They were aware of the most recent developments within their specialities including changes in national guidance and regional and local initiatives.

Multidisciplinary working

- The specialist palliative care team were represented at the end of life care group, the cancer board, the organ donation committee, the deteriorating patient group and the acute medical emergency group. In addition, the team was represented at lung, upper and lower GI and at the 'unknown primary' and acute oncology multidisciplinary meetings.
- The specialist palliative care team were involved with local community specialist palliative care teams in Haringey and Islington. 85% patients referred to the hospital team lived in one of these two boroughs. The specialist palliative care team was represented at the Islington 'last years of life' group and developed close links with local hospices, especially Marie Curie Hospice in Hampstead where the palliative care consultant worked part time.
- Although allied health professionals were not part of the palliative care team, the team developed close links with occupational therapists, physiotherapists, dieticians and speech and language therapists as well as other professionals involved in patients care at the hospital and in the community.
- The team had established close links with other providers of end of life care including local hospice, charitable organisations, primary care providers and community nurses. These were used to establish educational initiative network with an aim to improve patients experience while they move across care settings.

Seven-day services

- The palliative care team was available to provide face to face support Monday to Friday from 9am to 5pm. Not all nurses were clear on what out of hours support was available to patients. The seven-day service was not contracted by the local clinical commissioning group.
- The specialist palliative care team were delivering end of life resource training sessions to medical and senior nursing staff who were on call out of hours. In their view it helped to improve care and access to specialist palliative care support seven days a week and mitigated the risks related to the absence out of hours specialist palliative care provision. It also helped to ensure that all staff were fully aware of the resources available to support the care of patients at the end of their life.
- The pharmacy department provided a dispensing and supply service and clinical pharmacy service to all wards seven days a week. On-call pharmacists was available at night.
- There was no identified bereavement officer and the bereavement support was provided by the clerical staff that were based at the mortuary, they were working part time Monday to Friday.
- The pastoral care team provided daily support to patients and relatives to ensure that the spiritual needs of dying patients and their relatives were met
- Mortuary staff were available Monday to Friday between 8am to 4pm. There were arrangements and out of hours procedure to allow bodies to be released out of hours and during the weekend and provision of a 24hours on call service to facilitate viewings, admission of deceased persons from external sources and release of deceased persons from the mortuary

Access to information

- All DNACPR forms were filed in patient notes and were easily available to staff.
- Nurses and doctors told us they felt they had sufficient access to information in order to support clinical decision making. Resources were accessible via the electronic requesting and reporting system used for palliative care referrals (hospital, hospice and community) and for syringe driver resources. It included individual end of life care plan aid (which replaced the Liverpool pathway). There were 'comfort and communication' pages, to support the end of life care plan aid, last days of life leaflet and a dedicated palliative care discharge summary template.
- The palliative care lead nurse told us that the electronic reporting and requesting system allowed the team to track and audit activity at an individual patient level.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

End of life care

- Patients' capacity to consent was not always recorded on the DNACPR forms. CPR status documentation internal audit completed in May 2015 also indicated that capacity assessment section of the form was not always completed. Eight patients without capacity had a DNACPR order in place but only in five cases (62%) this had been discussed with the patient's family. The audit recommended that a repeat audit should be carried out to check if completion of the 'capacity assessment box' and documentation of discussion with family had improved but did not set timescale for this action.
- Staff on wards were not clear on guidance they would use, or actions they should take, if they were unclear whether a patient had the capacity to consent. Records indicated that none of the specialist palliative care team had completed training related to Mental Capacity Act and Depravation of Liberty Safeguards.
- Not in all cases patients views related to resuscitation were clearly recorded in their notes and on the 'do not attempt resuscitation' form.

Are end of life care services caring?

Good

We rated caring as good because:

Patients said staff were caring and compassionate.

Patients said they were involved in planning their own care and making decisions.

The palliative care team members performed patient reviews in a sensitive, caring and professional manner, engaging well with the patient.

We observed staff being respectful and maintaining patients' dignity, there was a person-centred culture.

Compassionate care

- Most of patients and relatives we spoke to told us staff were very caring and that they had no complaints or concerns.
- We observed that staff demonstrated a positive and proactive attitude towards caring for dying people. They described how important end of life care was and how their work impacted on the overall service. Staff were compassionate and caring to patients and their relatives. All the staff we spoke to were very clear about their role in ensuring people received appropriate support.
- Staff told us that the comfort and dignity of the dying person was prioritised. Symptom control, physical, emotional, psychological, social, spiritual, cultural and religious needs were appropriately addressed. And the person was supported to eat and drink.
- One of the questions of the national survey of bereaved people was checking whether family members were satisfied with the service provided and if they felt involved in the care planning process. The trust did not participate in this survey therefore we were unable to assess it adequately and compare with other hospitals.
- The trust did not carry out any internal audits to assess quality of the service provided by the specialist palliative care team. Most of the feedback provided by patients was provided informally. We have seen that some patients and their families had expressed their gratitude by sending a letter or a thank you card.
- We observed that staff handled bodies in a professional and respectful way. The mortuary staff told us that patients that arrived at the mortuary were cared for appropriately by the nursing staff shortly after death. Nursing staff were provided with training how to perform procedures respectfully. Mortuary staff monitored the quality of the service provided and provided staff with immediate feedback if any concerns were highlighted by them.
- Porters told us they had no concerns regarding staff handling bodies on wards and thought they were respectful and maintained patients' dignity.
- Patients' records and nursing care plans demonstrated that regular comfort ward rounds took place to ensure patients were kept comfortably.

Patient understanding and involvement

- Staff provided patients with information on how to contact the palliative care team and where able to obtain additional support and information if required.
- Nurses were professional, explaining to patients about their medicines and encouraging them to take them.

End of life care

- We observed that staff made efforts to contact family members after their relative had died and in many cases had involved them in the decision making process.
- Not all patients had care plans which specified their wishes regarding end of life care and what their preferred place of death was.
- Most patients' notes indicated they were kept actively involved in their own care and relatives were kept involved in the management of the patient with the patient's consent.

Emotional support

- Staff were aware of the need for relative to be involved in patients' care and informed of decisions related to their treatment, especially when in critical condition or while being resuscitated. There was a relative's room near the resuscitation room. A senior nurse said staff felt confident with discussing issues related to end of life and were aware of what support was available to family if their relative died. Staff had access to brochures, which explained where the family could obtain support and what steps to take after their relative died. This also included contact details for the hospital's chaplain.
- There was no routine emotional support available to staff. A senior nurse said staff were supporting one another
- Families were not routinely invited back to the ward to speak with the doctor who provided care to their relative at the end of their life. Bad news were delivered by the senior nurse in charge of the ward or by the doctor involved in patients' care.
- There was no bereavement officer, their duties were performed by the mortuary clerical staff member. They were supported by the mortuary staff.
- The chaplaincy held annual ecumenical memorial services for children who died in the hospital. The team was available daily to provide spiritual and emotional support when appropriate. A group of volunteers working with the chaplaincy team offered spiritual support to patients of all or no faiths.

Are end of life care services responsive?

Good

We rated the responsiveness of the end of life care service as Good because:

Specialist palliative care team members were visible within the hospital and nursing staff knew how to contact them. The team were able to respond to calls for their support within 24 hours on more than 95% of occasions.

The fast track discharge of patients to die at home or in a care home was facilitated via fast track continuing care referrals which ensured funding was agreed prior to discharge of a patient.

However;

The trust did not monitor effectively discharge times and if there were any obstacles to patient's 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'. They did not always record and analyse if patients were cared for at their 'preferred place of care'.

Service planning and delivery

- The hospital monitored referral response rate and the information provided indicated that between April and September 2015 the specialist palliative care team were able to respond to 98% of referrals within 24 hours.
- A plan of care was developed to meet the dying person's needs. Everyone approaching the end of life was offered the opportunity to create their own personalised care plan. A care plan aid was available to guide the multidisciplinary team in devising a plan of care. The care plan was reviewed and revised as appropriate. An assessment of needs for specialist palliative care support was made and referral was made via an electronic patients' record management system.
- There was an alert system, viewable by all staff, which generated a daily report of patients previously known to the hospital palliative care, the Haringey community team and Islington community patients. The hospital team facilitated Haringey community palliative care

team gaining direct access to view the system and developed a secure link to allow emailing of their specialist palliative care patient records for those patients discharged to the local hospice.

- Whittington Health were a member of the partnership board since November 2014 when the community palliative care team in Haringey was transferred to North Middlesex University Hospital. The community palliative care staff transferred over to the network. The specialist palliative care team felt it offered a much more integrated model of care for patients with palliative care needs in the borough of Haringey. The team was involved in engaging with clinicians and GPs in determining a model offering the most appropriate local service for patients.
- There was 411 patients referred to the team in 2014/ 2015. Majority of all patients referred to the team were diagnosed with cancer (54%). The trust gathered information on which team had referred the patient to the specialist palliative care team however it was not routinely analysed to establish which specialities and wards accessed the palliative care more than others. Therefore it was not possible for the team to raise awareness of their service with specific clinical teams.
- There were palliative care link nurses on some of the individual wards who acted as links between palliative care team, the staff and patients of the clinical areas where they work.
- There were no specific designated palliative care beds in the hospital. Some of the patients at the end of their life were cared for in the main ward areas. Staff told us occasionally there was a shortage of single rooms which would allow privacy for these patients.
- There was no clear procedure for burial of foetuses with some being refrigerated for over three months. We have brought this issue to the attention of the senior management of the trust at the time of the inspection.

Access and flow

- Specialist palliative care team members were visible within the hospital and nursing staff knew how to contact them.
- The fast track discharge of patients to die at home or in a care home was facilitated via fast track continuing care referrals.Once a patient and/or their relative decided they would like to die at home or in a care home, the multidisciplinary team on the ward worked closely with the discharge co-ordinators to ensure the paperwork, needed to agree funding to provide care after discharge, was completed in a timely fashion. Once complete the paperwork was faxed or emailed to the relevant borough for approval. Whittington Health hosted the continuing care team who approved referrals. If a patient was to return to their own home then the district nurses liaised with the resource team in the council to organise a package of care and prepare the home to receive the patients for discharge.
- Haringey borough's continuing care team was hosted by Haringey Clinical Commissioning Group. The Whittington Health discharge co-ordinators liaised closely with this team who organise all services for Haringey residents.
- The specialist palliative care team aimed to discharge patients within 72hrs of identifying that they would prefer to die at home and told us they monitored their performance in order to establish where the delays were occurring. They were in a process of amending the pathway in Islington to make the pathway more streamlined.
- There were no formal agreements with any of the ambulance services for rapid discharge of patients. The transport facilities used for discharges and transfers could respond on the day when requests for discharge were made.
- A senior nurse told us that when a patient died on open ward their body could be kept in one of the bays for a few hours, while other patients were in the same shared bay to allow family viewing. There was no written protocol in place to inform the decision related to length of time body could be kept on the ward for. A member of staff told us that it usually would be a much shorter period of time and was depending on relatives' wishes. The porters told us that they were able to respond to calls made requesting body transfer promptly and they were able to prioritise accordingly.
- There was no rapid discharge system to ensure patients who were in the last days and hours of life could die in their preferred place. The trust did not monitor response times to identify if there were any obstacles to discharge

for patients to ensure patients died in their preferred location. We were informed data related to discharge times was not available due to assessments being undertaken by more than one team.

- Nurses we spoke to were mostly aware of patient's wishes related to preferred place of care and the place where patient wished to die; however, these wishes were not always recorded in patients' notes. The trust did not collate any data related to it and was unable to benchmark against other services, inform service planning and improve the quality.

Meeting people's individual needs

- None of the palliative care staff members or volunteers completed learning disability awareness training. Only three volunteers and one member of the pain team completed dementia training but records indicated it was not provided to the palliative care team members.
- If the doctor making the assessment believed that a person was dying they were required to clearly and sensitively explain it to the person, in a way that was appropriate to their circumstances. Staff were aware that information should not be forced when the patient does not want to discuss the issue. Unless the person indicated otherwise, their family and those the person had identified as important to them were also made aware of the situation.
- Staff told us that occasionally they were unable to provide single room to patients in the final days and hours of their life due to there being a limited numbers of side rooms. There was no end of life dedicated room which would provide a peaceful environment for patients in the last days and hours of their life. There were limited facilities for relatives in order to allow them to spend time with the patient.
- There was various printed information available to patients and their relatives including leaflets on what needed to be done when someone was dying or on services provided by the bereavement office and the specialist palliative care team. This information was only available in English.
- Staff told us that translation services where available and there was general no delays in accessing them when required.
- The national care of the dying audit for hospitals in England found that 41% of patients had a spiritual needs assessment at the trust this was better than the England average (37%).
- Chaplaincy, team members told us they visited wards regularly and they were informed of those patients who were at the end of their life so they could provide appropriate support. However, they also said staff did not always routinely highlighted whether they had discussed the patient's spiritual requirements with them or indicate patients' preference at the time of admission.
- Mortuary viewing facilities, although in need of redecoration, were appropriate and allowed relatives privacy.
- There was a procedure for the management of deceased patients' belongings. Record of deceased patient's belongings was kept and possessions were adequately secured and accounted for.

Learning from complaints and concerns

- The trust had not completed an analysis of complaints related to end of life care to inform service improvement plans.
- Staff told us that complaints were handled in line with the trust policy. The trust received only three formal complaints related to end of life care in April to November 2015. Patients which these were related to were cared for on Meyrick, Victoria and Mercers Wards. We noted that all three incidents were investigated and the hospital responded in a timely manner. It was the chief executive or their deputy who responded to complainants and the responses sent highlighted areas where the hospital needed to improve.

Are end of life care services well-led?

Good

We rated leadership as good because:

End of life care

The trust appointed both, a non-executive lead, and an executive director to take lead and provide representation of end of life care at board level. The trust had undertaken gaps analysis to inform future development and improvement in provision of the end of life care.

We noted that specialist palliative care team members felt supported in their work and worked well as a team. Staff were clear about their roles and their involvement in decision making. All staff we spoke with demonstrated a positive and proactive attitude towards caring for dying people. There was good end of life care awareness across the hospital with staff on individual wards taking responsibility in leading in the field.

Vision and strategy for this service

- There was an end of life gaps analysis and service development plan based on the national guidance for provision of the end of life care set by The National Institute for Health and Care Excellence. The document listed speciality direction and key developments over the next five years, such as development of advance care planning and focus on holistic approach, multidisciplinary education and integration of services. However, there was no clear strategy to address short term financial resource constrains and staffing shortage within the specialist palliative team in order to increase availability of face to face specialist support.
- The specialist palliative care team were very committed to across the hospital training provision, analysed training needs across the trust and devised training to meet variety of staff needs. This was seen as a key point in delivering quality in end of life care.
- There was good end of life care awareness across the hospital with staff on individual wards taking responsibility in leading in the field and specialist palliative care team providing support and expertise when required.
- We reviewed an action plan in response to the national care of dying audit. This set out the key areas the trust would improve around the delivery of end of life care. It covered the areas where the organisational KPIs were not met or were the trust performed below the expected standard. Actions were allocated to clinical and operational leads and progress was monitored by the end of life group and the trust's board.

Governance, risk management and quality measurement

- The specialist palliative care team was managed within a large medicine, frailty and network service division which included some integrated community services, therapies, and elderly's support services, among others.
- There was limited evidence that the trust had adequate systems for evaluating and monitoring the quality of the service. For example to identify patients who were not offered palliative care in their last days and hours of life, relatives views, whether patients at their end of life were cared for at their preferred place, or specialist palliative care team response times.
- Executive medical director for integrated care and the trust's chairman were nominated by the trust to lead the development of end of life care. It helped to ensure accountability at board level for the quality of end of life care as recommended by the "More Care Less Pathway" report and the national care of the dying audit.
- As recommended by the "More Care Less Pathway" report (2013) and the national care of the dying audit for hospitals, all trusts should also have a designated lay member with specific responsibility for care of the dying. To ensure public and patient representation was established and maintained within the trust and to champion end of life care. The trust did not address this requirement.
- Staff were clear about the role of the senior responsible clinician in end of life care and their involvement in decision making.
- Risks related to end of life care were logged on the local risk register. It included lack of availability of specialist palliative care support seven days a week. These risks were monitored through end of life group. The team had noted that the risk was mitigated through effective handover processes and increased provision of training for nurses and doctors. There were no additional resources available, due to lack of commissioning, to enhance the staffing levels in order to increase specialist palliative care team presence.

Leadership of service

- There was good leadership within the specialist palliative care team, led by the palliative care consultants and the nursing lead. We observed that the

team were, responsive and very active in promoting good quality care. Outside the trust, the team were involved in regional end of life groups and developing links with external providers. However, the team was constrained by lack of staff. This affected ability of the team to respond promptly to local and national initiative, such as participation in national audits (VOICES) and measuring patients' outcomes.

- The clinical lead and end of life lead were aware of issues relating to their specialities and had developed action plans to ensure service improvement. The hospital formed the end of life group, which met monthly, to improve the service and monitor implementation of action plans.
- The trust board's chairman was appointed to provide leadership and accountability at the board level and was responsible for the quality of end of life care. The trust had also appointed an executive director with a responsibility for leading and providing representation of end of life care.

Culture within the service

- Staff on the wards and members of the palliative care team we spoke to were focused on providing a good experience for patients. They were patient-focused and aimed to provide the best possible care. The team were passionate about supporting patients, families and staff in end of life care. All staff we spoke with demonstrated a positive and proactive attitude towards caring for dying people. They described how important end of life care was and how their work impacted on the overall service.
- Specialist palliative care team members felt supported in their work. They told us they were encouraged by their immediate line managers to report any concerns they had and could discuss any issues with their manager.
- We observed that the palliative care team worked well as a team. They spoke about supporting each other and helping out whenever required. They felt involved in all decisions made and changes implemented and were able to help with service improvement.

Public and staff engagement

- To ensure public and patient representation was established and maintained within the trust, they were required to appoint a layperson as part of the board to champion end of life care. This requirement was not fulfilled.
- The trust did not participate in the bereaved families' survey in order to gather relatives views related to end of life care received by the patients who died at the hospital.
- Staff within the hospital were engaged with end of life care and specialist palliative care members told us that increased training provision helped with raising awareness of issues related to end of life care among them. Nurses we spoke to were aware of the specialist palliative care team and end of life training available to them.

Innovation, improvement and sustainability

- There was limited capacity to undertake national trials at present due to low staffing levels.
- Although the trust had long term strategy in place for palliative care team and end of life care this had not fully address service sustainability. We found that it was unclear how patients outcomes would be monitored, and how resources would be managed to meet requirements of national guidance.

Outpatients and diagnostic imaging

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

Information about the service

The Whittington NHS Trust runs outpatient, diagnostic and imaging services from several locations including The Whittington Hospital. The organisation was established in April 2011 following the merger of the Whittington Hospital NHS Trust with NHS Islington and NHS Haringey community health services.

The trust provides hospital care to a population of over 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. Total outpatient attendances were 279,969 between January 2014 and December 2014.

We inspected outpatient clinics at the Whittington Hospital site. These were located throughout the hospital with reception desks and waiting areas in each outpatient area. The trust provides outpatient services across a wide range of specialities including radiology and diagnostics, cardiology, ophthalmology, gastroenterology, urology and orthopaedics.

We spoke with 69 patients and their relatives, 85 staff including consultants, medical staff, radiographers, radiologists, assistant practitioners, nurses, healthcare assistants and reception staff. We observed care and treatment and looked at 10 patient records. We also reviewed performance information about the hospital.

Summary of findings

We rated the outpatient services overall as **requires improvement** because;

Effective and safe systems were not always in place to monitor and manage risk effectively in outpatients.

Outpatient staff showed an understanding of the need to report incidents, However, staff were not consistent in reporting incidents and they were not always reported in line with trust policy. This meant the trust did not have an oversight of all incidents that occurred within outpatient services.

We saw that learning from incidents was inconsistent across the specialities and learning from incidents was not shared across the outpatient department as a whole.

Patients' personal identifiable information was not always kept confidential or stored securely. We saw patient personal information left on top of open trolleys in some clinics unobserved by staff and confidential waste and patient records left unsecured in reception areas overnight. This meant there was a risk of patient records and personal details being seen or removed by unauthorised people.

Systems and processes were not always reliable or appropriate to keep people safe. This meant there was a risk patient's patients were waiting longer than appropriate to be seen.

Outpatients and diagnostic imaging

Infection control standards required improvements. For example, we found risk assessments were not always completed and all nursing staff did not follow infection control processes.

Outpatient and diagnostic imaging services did not identify all risks to patients or effectively manage risks that had been identified.

Patients were not always treated with dignity and patient's privacy was not always respected.

Trust-wide governance systems were not strongly established and there was a lack of adherence to, and knowledge of, policies and procedures.

Most patients were positive about the care they received.

Managers of outpatient departments were accessible and respected by staff.

Are outpatient and diagnostic imaging services safe?

Requires improvement

We rated safety for outpatient and diagnostic imaging services as **requires improvement** because;

Incidents were not always reported in line with trust policy and staff in the outpatient department were not clear about what should be reported. There was a system for reporting incidents but it was not always used. We saw that the learning from incidents was inconsistent across the specialities and incidents were not shared across the outpatient department as a whole.

There were no effective systems in place to monitor and manage risks to patients in the outpatient department. For example; patients' personally identifiable information was not always kept confidential. We observed patients' notes on trolleys in corridors in the outpatient department.

Records were not stored securely. Records were stored in unlocked yellow bags and left in the outpatient reception area. This meant there was a risk these records were vulnerable to theft and unauthorised access and that patient's personal details were not kept confidential.

Staff in all outpatient clinics visited reported that there were daily occurrences in which patient records were not available. They told us they prepared duplicate records and showed us an example where one patient had 20 duplicate records.

Staff compliance with safeguarding training did not meet the trust's target. This meant that not all staff were adequately trained in their responsibilities for safeguarding children and vulnerable adults.

However:

Equipment was clean and checked as safe to use.

Medicines within the outpatient service were well managed and stored appropriately.

Incidents

Outpatients and diagnostic imaging

- There had been no Never Events (serious, largely preventable patient safety incidents that should not occur if proper preventative measures are taken) between September 2014 and September 2015.
- There had been one serious incident (SI) reported in outpatients and diagnostics between September 2014 and September 2015. The SI was due to an issue identified in May 2015 relating to endoscopy waiting times and the trust has completed additional clinics to reduce the endoscopy backlog. In May 2015, it identified that there were a number of patients who had been incorrectly booked onto Patient Administration System (PAS) and were not offered an appointment for their procedure. This resulted in a back log of patients who were not seen within target timescales. A clinical harm review was completed for all patients on cancer pathways which did not identify any incidents of harm to patient's as a result of the delays in undertaking endoscopy investigation.
- At the time of our inspection the trust were still completing a review of non-cancer pathway patients to identify any harm as a result of the delay with their endoscopy.
- Incidents were not always reported in line with trust policy. For example, staff raised concerns that records were often not available for clinics and patients told us they had to wait longer to be seen as a result. One member of staff told us they never reported as incidents as "it had always been that way". Another told us they should report them but did not have the time as clinic were so busy.
- Staff were familiar with the electronic reporting system although they told us there was no formal training on how to use it
- Managers and clinicians we spoke with were able to explain their responsibilities with regard to the duty of candour legislation. The duty of candour legislation requires an organisation to disclose and investigate mistakes and offer an apology to patients, however most nursing staff we spoke with could not explain their responsibilities under the legislation.

Cleanliness, infection control and hygiene

- Staff within the outpatient and radiology departments told us they regularly undertook infection control inspections. We saw that the imaging department had completed an infection control audit on the "general environment and fittings" in November 2015. This found chairs that were not washable, and high levels of dust in clinical areas. This meant the department were not compliant with three out of eleven elements of this standard.
- We saw that sharps containers (these enable the safe storage and disposal of all categories of sharps waste or example hypodermic needles), were available in each clinical area. However, the majority in the outpatient department were past the three month recommended deadline to continue in use. For example we looked at 16 sharps boxes in the main outpatient area, 6 were within the three month timeframe, 8 were out of date and 2 were in use but not dated. In the Muskoskeletal physiotherapy department, we saw four sharps boxes, two were not dated and one was dated as having been started in 2008. One member of staff told us they continued to use them until they were full.

  The National Institute for Health and Care Excellence (NICE) clinical guidelines, "Healthcare-associated infections :...(HAI) (2012) "Safe use and disposal of sharps") states that sharps "boxes … should be disposed of every three months, even if they are not full". This meant that trust were not compliant with this guidance.
- 100 % of nursing staff had completed infection prevention and control training and 65% of medical and dental staff had completed the training which was below the trust target of 100%. The trust were aware of the need to ensure all staff completed mandatory training. They told us that the new divisional structure which had been agreed in July 2015 would ensure individual heads of divisions would be responsible for ensuring staff were up to date with mandatory training.
- Notices were displayed in clinical areas explaining the actions staff should take in the event of an injury from a needle or other sharp object.
- We saw regular hand hygiene audits from the imaging department that confirmed staff were compliant with legislation.

Outpatients and diagnostic imaging

- Hand gel was available in clinical areas. Staff told us they were aware of infection control guidelines however we observed nursing and clinical staff who were not observing the infection control guidelines by washing their hands or using hand gel between patients.
- Clinical areas appeared clean and there were systems to monitor checks of cleanliness.
- In the radiology and diagnostics department we found clinical waste was stored appropriately. All clinical waste and handling procedures must comply with Environmental Protection Act (1990) that states waste must be managed safely and ensure the environment remains free from harm. This meant the trust were complying with regulations to manage and store waste safely.
- There were systems in place for the segregation of waste materials such as x- ray solutions and sharp items.

Environment and equipment

- Resuscitation trolleys in outpatients were located in each clinic and were checked on a daily basis.
- In the radiology department we observed staff used personal protective equipment (PPE). For example, lead gowns, which protect staff from the effects of radiation.
- There was a replacement programme in place for radiological equipment.
- We saw the April 2014 inspection report on compliance with Human Tissue Authority (HTA) minimum equipment standards and the Whittington Hospital had met all of the applicable HTA standards.
- The trust provided us with information relating to Nuclear Medicine, the location and services provided, along with information about who held the necessary certificate from 'The Administration of Radioactive Substances Advisory Committee' (ARSAC) licence.
- Lifts were available for patients who found stairs difficult and clinics were accessible for patients. Staff told us that in some clinic areas they had additional seating in corridors.
- There were no separate facilities for children for clinics held in the main outpatient areas.

Medicines

- There was a pharmacy on site and a separate dispensary in the outpatients department. They checked and replenished stock medicines in all departments and provided an outpatient dispensing service.
- We saw audits of medicines management had been completed and where actions were needed they had been taken.
- The radiology department used patient group directives (PGD) policies to allow staff who were not trained to prescribe medication to give one or two specific medications for certain procedures. For example; contrast agents. All PGD's were authorised appropriately and in date.
- Protocols were in place for radiographers which outlined how contrast agents should be used. Staff confirmed they took patients history and checked to establish any contraindications when they completed the pre examination questionnaire before administering the contrast agent.
- We saw that in outpatient's clinical areas room and fridge temperatures were checked daily to ensure medicines were stored at correct temperatures.
- In the radiology department medicines were stored in locked cupboards. Lockable medicine fridges were in place, with daily temperature checks. This meant that the department were following the Department of Health (2003) Controls Assurance Standard: Medicines Management (Safe and Secure Handling of Medicines).
- FP10 prescription pads were securely locked away

Records

- There were inconsistencies in the storage of records. Patients' personally identifiable information was not always kept confidential. Patient records were left on open trolleys in corridors in some areas in the outpatient department. For example in clinic 3D we saw patient records on an open trolley that had been brought up from medical records and were left in the corridor for afternoon clinic. Opposite was a treatment room and patients walking past could see patients personal information. In another clinic, patient records

were piled on trolleys, and in yellow bags under a desk in clinic areas. Staff told us sometimes they had no yellow bags so patient records were stacked on the floor.

- In clinic 3C, records were stored in unlocked yellow bags and left in the outpatient reception area overnight. Staff told us porters came in the morning to collect yellow bags from the day before. This meant there was a risk these records were vulnerable to theft and unauthorised access and that patient's personal details were not kept confidential.
- We saw that confidential waste bags were left in some reception areas overnight. For example on level 3 we saw three confidential waste bags behind reception. Administration staff told us they were always left there until collected and could stay there a week. One of the bags was open and in use and patients personal information could be viewed by unauthorised people as reception was not manned at all times during the day and administration staff went home at 5 pm.

  Staff told us some clinics often ran late or did not finish until later in the evening. This meant confidential information could be left on the reception desk by patients until the next day and viewed by other patients and staff. Staff told us it had been like that a long time and one told us they had raised it as a concern more than once with their manager but nothing had changed.
- Staff told us that some clinics on levels one to four had a room they could use to store patient records. On level 3 we saw the room used to prepare records for clinics. Records were not locked away but on open shelves and piled on the work surfaces. Staff told us the room was used by administration and nursing staff as their work space and was accessed by cleaning staff who started at 5 pm. This meant there was a risk patient's personally identifiable information was not kept confidential and records were not securely stored as they were not locked in secure cabinets.
- We raised a concern with the trust on the day and they arranged for all confidential waste to be locked away and patient's confidential information to be removed form reception areas.
- Lockable trolleys were not available however the trust told us they had placed an order for these.
- Record storage was not identified as a risk on the trust risk register.

Safeguarding

- Staff compliance with level 2 safeguarding training did not meet the trust's target of 90%. Level 2 safeguarding children is the minimum level required by the Royal College of Nursing for all registered nurses.
- The "Safeguarding children and young people: roles and competences for health care staff Intercollegiate document(2014) stated that level2 is the minimum competency level for "all non-clinical and clinical staff who have any contact with children, young people and/or parents/carers" This meant that all staff were not adequately trained in their responsibilities for safeguarding children.
- The Royal College of Paediatrics and Child Health (Intercollegiate document 2014) states that there is a requirement for paediatric radiologists to undertake level 3 safeguarding children training. Records showed that no radiologists had level 3 safeguarding children training as of the time of the inspection.
- Safeguarding adults level one training was included as part of the mandatory training package. All outpatient nursing staff we spoke with told us they had completed training in either safeguarding adults or children, whichever was most relevant to their area of work.
- Staff were aware of their role and responsibilities and how to raise and escalate concerns in relation to abuse or neglect for vulnerable adults and children. We saw there were safeguarding policies in place and clear procedures to follow if staff had concerns.
- Information about how to report any safeguarding concerns and safeguarding adult's information was displayed in outpatient clinics.
- There was a strategic plan for safeguarding adults which was an integral part of quality.

Mandatory training

- All staff within the outpatient and diagnostic imaging service were aware of the need to attend mandatory training in areas such as moving and handling, and safeguarding.

Outpatients and diagnostic imaging

- A data protection audit report completed in July 2015 found that the trust's compliance with mandatory annual information governance (IG) training had risen to 74% from the 68% achieved in the 2014/15 year. However, compliance was still below the Trust target of 95%.
- There was an induction programme for all new staff.

Assessing and responding to patient risk

- There were systems to triage new referrals and send appointments to patients; however these were not always safe and effective.For example; we saw that paper referrals into the access centre were placed in trays to await triage by the clinician. We looked at one tray of over 50 ophthalmology referrals, the earliest dating from the beginning of November 2015. Staff told us triage of ophthalmology referrals had been an ongoing issue.
- We saw e-mails to clinicians from administration staff raising concerns at the number of referrals waiting to be triaged. On 10th November 2015 an e-mail was sent to one ophthalmology clinician stating there were 150 referrals, dating back to 13th October 2015 awaiting triage in the tray.
- We saw that amongst the 50 referrals from November 2015 awaiting triage there were three requesting "urgent assessment". One stating the patient needed to be seen within 7 days, another that treatment needed to be started within three weeks. Both timelines had passed. We brought this to the attention of the trust on the day. They arranged urgent appointments with the clinician.
- Managers told us that they had a service level agreement with the Royal Free Hospital in London to provide ophthalmology clinics, at The Whittington Hospital. They were aware of delays to triage of referrals and it had been a longstanding issue.
- Concerns about triage timescales had been put on the risk register in March 2014, the risk was not specific to ophthalmology and stated…"If out patient referrals are not reviewed within 24 hours then there will be delays in the turnaround times resulting in gaps for patient treatment pathways". This highlighted that patients were at risk of harm as there were no effective systems in place to mitigate the risks to patients when urgent referrals were not appropriately triaged.
- Staff told us that not all of the current patient care records would be delivered from the records department when required. Staff told us this was for a number of reasons including that records were still with the administration team, or could not be quickly traced.
- In these instances, staff would create a temporary set of notes for patients, the hospital were aware that the use of temporary notes meant that there were duplicate notes for some patients. There was no process in place to ensure that all temporary notes were later filed within the patients original notes.
- This concern was added to the risk register in March 2014; it stated that "If patient case notes are incorrectly tracked or not tracked at all then these will not be available when the patient attends the organisation. This results in duplication of notes and clinical staff not knowing what is required for the patient and thus impacting negatively on patient care".
- In the medical records library we observed there were 42 shelves each with 90-150 sets of temporary folders. Staff told us they were working their way through the temporary folders, but it all took time and some of the temporary notes were for non-active cases. Once patient notes were no longer required they were sent to the external storage provider to be stored until needed. This meant patients permanent notes were not at the hospital so the temporary notes could not be added. This meant there was a risk clinicians would make judgements on the care and treatment a patient was to receive without having complete patient information available to them. This meant that the hospital was failing to assess, monitor and mitigate the risks relating to the health, safety and welfare of outpatients.
- We were unable to ascertain the percentage of patients per location seen in outpatients and radiology without their full medical records. This was because trust systems used specific criteria that were not effective enough in identifying missing records.
- A data protection audit report completed in July 2015 found there was "a very limited level of assurance that processes and procedures" were in place for "delivering data protection compliance". The audit had identified a "substantial risk that the data protection compliance will not be achieved. It stated that "immediate action"

was required to improve and control the environment. We found patient's personal confidential information was accessible to unauthorised people in outpatient clinics.

- Due to difficulties obtaining necessary patient information prior to interventional radiology, in October 2015 the imaging department audited the use of patient safety checklists designed locally. As a result they adopted the National patient safety agency WHO checklist for radiological examinations.
- The audit had raised concerns about the archiving of the checklist in patient notes. Out of 9 cases only one had evidence in patient notes. This meant they could not evidence the appropriate process had been followed and patient safety and equipment checks completed. It recommended that the patient safety checklist were scanned into the patient's electronic record. Radiology staff confirmed this process was now place and they planned to repeat the audit in three months to check the effectiveness.
- Staff were able to describe the actions they would need to take to respond in the event of a patient collapsing.
- Processes were in place within outpatients to manage patients who deteriorated or became unwell in the department. There was an emergency response team within the hospital who could be summoned rapidly.
- There were systems to prioritise urgent and routine new referrals and send appointments as required to patients.

Nursing, Laboratory & Radiology staffing

- Another method was to encourage substantive staff across all outpatients to complete additional hours (up to the maximum allowed by the European directive) when required.
- Manager's and staff told us there use of bank and agency staff was low.
- All staff groups told us staff turnover was low and people liked working at the trust.
- The trust had a revalidation plan in place for those nurses who needed to register in 2016.
- In its 'general outpatients' review in October 2015, the trust stated there were "sufficient nurses in the funded establishment and currently in post to be able to have one registered nurse(RN) and one healthcare assistant(HCA) per clinic".
- The establishment figure for RN's was 11.32 whole time equivalent (WTE) and for HCA's, 12 WTE. The service was not fully staffed as the actual staffing levels were RN, 9.52 WTE and HCA, 8 WTE. This meant they were approximately two RGN and four HCA full time posts below that required. Nursing managers told us that when available vacant posts were covered by bank staffing and recruitment was ongoing. Nursing staff told us bank staff were not always available and this meant they covered more than one clinic when needed. There was one RGN nurse per floor, plus the clinical nurse specialists (CNS) holding clinics and a lead nurse (Band 7) and a matron, covering all four floors to oversee the smooth running of the service.
- The ophthalmology service is staffed by specialist Whittington and Royal Free Hospital staff Monday – Thursday, and on Friday is entirely staffed by the Royal Free.

Medical staffing

- The individual specialties arranged medical cover for their clinics. This was managed within the clinical directorates, who agreed the structure of the clinics and patient numbers.
- Consultants were supported by junior colleagues in some clinics where this was appropriate.
- The staffing skill mix was similar to the England average for consultants, registrars and junior doctors.

Major incident awareness and training

- The trust had a major incident policy which staff were aware of. It identified key contact details and a process for staff to follow.
- There were business continuity plans in place to ensure the delivery of the service was maintained in the event of a major incident.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services effective?

Outcomes of patient care and treatment were not always monitored regularly or robustly. For example, outpatient staff often had to source information about a patient's care and treatment before the patient could be seen.

There were inconsistencies with staff annual appraisals, with overall 45% completed and variances ranging from, 65% for nursing staff and 60% for clinical services.

There was multidisciplinary working to provide integrated patient care. Staff worked well together in a multidisciplinary environment to meet patients' needs.

Staff gained consent for treatment.

Evidence-based care and treatment

- We saw the annual report completed by the "Radiation Protection Service, at King's College Hospital (KCH), which provided an overview of the trust's level of compliance with the relevant legislative requirements for the period January 2014 to December 2014. The principal regulations concerning radiation safety that applied to the trust were the Ionising Radiations Regulations 1999 (IRR), the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER) (and amendments 2006 and 2011), the Environmental Permitting Regulations 2010 (EPR) and the Control of Artificial Optical Radiation at Work Regulations 2010 (CAORAW).
- The KCH annual report stated that the "overall level of compliance with the above regulations was good". They concluded the outcome of audits and inspections in Nuclear Medicine they had reviewed were "good" and some recommendations for improvement were made. For example: risk assessments needed updating for all procedures.
- We saw the trust had an action plan in place to implement the recommendations and IRMER was included in clinical governance meetings.
- The Ionising Radiation (Medical Exposure) Regulation (IRMER 2000) requires doses arising from medical exposures to be kept as low as reasonably practicable. To comply with this legislation patient dose data have been collected and analysed for examinations performed with a view to establishing Local Diagnostic Reference Levels (LDRLs) and comparing against National Diagnostic Reference Levels (NDRLs) where available. We reviewed the dosimetry report January to July 2015 report submitted to NHS England which identified no issues or concerns with The Whittington Hospital.
- There was access to specialist investigations such as magnetic resonance imaging (MRI) or a computerised tomography (CT) scan. MRI is a type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body whilst a CT scan uses X-rays and a computer to create 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 saw internal audits for April 2014 to March 2015 in a number of different specialities, including blood sciences, histology and cytology.
- Each year members of the public undertake unannounced visits to assess how the environment supports, patient's privacy and dignity, cleanliness and general building maintenance. The patient Led Assessment of the Care Environment (PLACE) inspection results showed the trust had scored 97% for cleanliness which was the same as the national average and 88% for patient privacy and dignity, which was above the national average of 86%.

Pain relief

- Pain relief could be prescribed within the outpatient's department and subsequently dispensed by the pharmacy department.
- Patients could be referred to the pain management clinic if assessed as needing this by their consultant.
- We found examples of multidisciplinary working both within and across teams.

Patient outcomes

- We saw the pathology turnaround time as documented on the pathology quality indicator dashboards. It showed that in October 2015, the Histopathology year to date (YTD) target was 80%. The trust were below this target with 21% of patient results reported within 7days and 44% reported within 10 days. The trust told us there was an ongoing issue of a shortage of appropriately

qualified staff. The associated risk of staffing was added to the risk register in July 2014 and was unresolved 15 months later. The trust told us a series of actions had been undertaken by the leadership team to reduce this risk since that time. Patients and staff we spoke with told us there were delays in getting results. One patient told us delays meant they had to wait longer to find out their results and had been anxious for a longer period that was necessary.

- Radiation protection account CT audit showed that dose levels were well below the National average.
- We saw audit information that demonstrated the radiology department regularly audited diagnostic reference levels in CT A&E and CT.
- The Medical Exposures Committee meeting minutes for December 2015 stated the CT department did not have adequate IT systems to identify appropriate referrers. It recommended lists of extended role referrers needed to be updated and systems in place to identify referrers needed to be improved. This meant the trust had identified changes that needed to be made and had an action plan in place to implement the changes.
- The CT department audited 100 patients CT colonography practice from February 2014 to February 2015. It found all significant findings were alerted to the referring clinicians and staff had followed the appropriate protocols.
- Following a previous breast histology audit in 2012-2013 the department decided to audit (2yearly) to demonstrate ongoing governance in this area. The audit in February 2015 found the department managed biopsy results appropriately and they achieved an overall departmental rate of < 5% in line with local North London NHS breast screening programme guidelines and national standards of a pre-op diagnosis rate of 90%. This meant the department had an identifiable record of the multi -disciplinary team (MDT) decision and any subsequent patient management plan where required. This data could be used for future re-audits.

Competent staff

- We saw training records dated December 2015 that confirmed all radiology staff were up to date with IRMER training regulations.
- The trust appraisal policy stated that all staff were required to have annual appraisal using the job description and person specification for their post. Staff that had received an annual appraisal told us it was a useful process for identifying any training and development needs.
- The trust target for appraisals was 90% and across the outpatients and long term conditions (LTC) staff group 45% of appraisals had been completed. Data showed completed appraisal rates were different across departments. Some specialities were not meeting this requirement. For example; Nursing and midwifery were 64% and clinical support services were 60%.
- The February 2015 staff survey highlighted staff concerns about the quality of appraisal.
- The Radiology manager told us all radiology staff had had an appraisal. We did not see records that confirmed this.
- Staff told us they received an induction. This included mandatory training, for example safeguarding level one and, infection control training.

Multidisciplinary working

- The x-ray department had regular meetings with speciality clinicians to review patient care and agree plans. For example; fracture clinic clinicians.
- Staff told us weekly MDTs were in place for patients who had a diagnosis of cancer.
- We saw an audit to assess whether abdominal x-rays are requested appropriately for surgical patients. This identified actions to be discussed within the MDT respiratory team to ensure patients received the most appropriate tests and reduce the need for unnecessary imaging.
- Multi-disciplinary teams (MDT) did not include all staff to co-ordinate effective care. For example, minutes from outpatients steering group meetings demonstrated that outpatient services were discussed in relevant speciality meetings rather than as a whole service. However outpatient issues such as nursing staff, management of waiting lists and double booked appointments were discussed.

Seven-day services

Outpatients and diagnostic imaging

- All radiology services were available from 9am to 5pm Monday to Friday. Radiology services were also available for MRI and CT between 5pm and 8pm on Mondays and Fridays for elective work. There was also an on call service for CT, MRI (cord compression), theatre support for urgent work and fluoroscopy from 5pm to 9am Monday to Friday and 24 hours on Saturdays, Sundays and bank holidays.
- There was a on call responsive consultant led imaging service.
- There was a comprehensive 24 hours 7 days a week, low dose digital plain x-ray service supporting the emergency and urgent care centres.
- There was an open access walk-in x-ray service for GP patients during 9-5 pm Monday to Friday.
- Most outpatient clinics were held on weekdays 9 am to 5 pm with some additional clinics, for example ophthalmology outpatient clinics available on Saturdays to meet demand and waiting time targets.
- Additional late lists were held on demand for patients who required a MRI.
- If no appointment was available for patients within the referral to treatment (RTT) timescale then additional clinics were generated. Staff told us the demand for CT meant there were additional clinics at least once a week. These were mainly staffed by permanent staff working additional hours.

Access to information

- Staff told us they could access policies and procedures via the intranet.
- Staff did not always have sufficient information about patients during clinic due to patient records not always being present.
- The administration staff told us that there were not enough administration staff to manage the workload. Staff confirmed this meant patient records were not updated or returned to records department when they should be

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw records that showed staff received training on the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff said they were confident about seeking consent from patients.
- We observed radiographers following the trust policy on consent. They ensured consent was gained for each scan or procedure.
- Patients were consented appropriately where they had capacity to make decisions.

Are outpatient and diagnostic imaging services caring?

Good

We rated caring for outpatient services as **good** because;

We observed care provided by nursing, medical and other clinical staff. Throughout the outpatient and diagnostic imaging departments, most staff were friendly and professional, putting patients and their relatives at ease

Patient's privacy and dignity were not always respected. Some clinical staff were not listening and responding appropriately to patients' requests with dignity and respect.

We observed administration staff listening and responding appropriately to patients request in a kind and caring manner.

Most patients and relatives told us they found the staff to be kind and understanding.

However:

We observed other nursing staff whose tone was offhand and dismissive when asked questions by patients. Two patients told us that staff did not always listen to them, however most patients said staff were helpful and they felt listened to.

Compassionate care

- We observed care provided by nursing, medical and other clinical staff. Throughout the outpatient and diagnostic imaging departments, most staff were

friendly and professional, putting patients and their relatives at ease. For example, we observed one patient where administration staff went above and beyond what was expected.

- In other outpatients areas staff did not acknowledge patients whilst they waited in a queue to book in. On level 3, one elderly patient was told to sit down in the wrong area by reception staff as the only available seating was in the corridor as the clinic area was full. Patients could not hear names being called from the corridor and we did not observe nursing staff come into the corridor to check who was there.
- In some outpatients clinics we did not find that there was adequate provision to protect a patient's privacy and dignity. For example; in the fracture clinic patients height and weight measurements were taken in the corridor with patient seating next to the equipment. In cardiology, the weighing scale was in full view of the waiting area. This meant all conversation could be overheard.
- 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. Consultations took place in the room every day, patients had no privacy as all conversations could be overheard and consultations were often interrupted as other clinicians and administration staff came into the room to drop off referrals. Administration staff told us they answered and made phone calls whilst patients were in the room having a consultation. This meant patients privacy and confidentiality could not be observed. This issue was not on the risk register.
- In diagnostic imaging, there were private areas for patients to change into gowns and to remain there until their appointment.
- The trust was in the bottom 20% of the national cancer patient experience survey 2013 to 2014 in 10 questions. These included: were patients given a choice of different types of treatment. The top 20% of trusts average score was 90%, this trust scored 71%.
- The trust scored higher than the England average for patient led assessment of the care environment (PLACE).
- The trust was similar to the England average in the Friends and family test for August 2015; however they had been consistently below the average before.
- Chaperones were available if required.

Understanding and involvement of patients and those close to them

- We observed staff did not always inform patients of waiting times. We spoke with patients in the majority of outpatients clinics. Most patients when asked said they were not told of any delays and how long they may have to wait.
- We observed that in some clinics where there were delays patients were kept informed but in others they were not. For example in gastroenterology one of the doctors was unexpectedly absent. The nurse in charge told us they had not known the doctor would not be coming until they rang to check where they were at 10.30 am. We observed patients that had been waiting since 9 am and had not been informed of the delay.
- 10 patients told us they always had to wait and expected to. Sometimes they knew how long delays were. At other times they were not told. We saw there was an inconsistent approach to informing patients of waiting times and the process was not embedded across all outpatient clinics.
- Three patients told us felt well informed and involved in the decision making about their care and treatment from start to finish.
- Patients told us they had received information about their conditions and medicines.

Emotional support

- We observed some staff supporting patients in a compassionate manner. For example; one administration member of staff took the time to sort out a problem and go over and above what was needed to ensure the patients appointment was correctly re booked and checked the patient understood what was happening.
- We found that most staff did not have an awareness of the needs of patients with complex needs and those patients who may require additional support should they display anxious or challenging behaviour during their visit to outpatients.

Outpatients and diagnostic imaging

- We observed one patient with a learning disability waiting in a corridor who was displaying anxious and challenging behaviour. We observed nursing staff ignoring the patient and their carer as they tried to manage their behaviours and did not attempt to support the carer. We spoke with two nurses who told us they did not make any adjustments for patients with a learning disability. One clinician told us nursing and administration staff had no awareness of the needs of people with a learning disability.
- Staff told us no priority or consideration was given when booking first appointments for patients who had learning disabilities. They had to wait their turn; the patient waited 40 minutes before they were seen. We spoke with one administration member of staff who had worked at the trust over six years and had booked the patients follow on appointment. They told us they had not had any training in equalities and diversity and did not know what they were supposed to do. They said they had made the patients next appointment first thing in the morning so they would be seen sooner and not have to wait so long.
- We saw that in some clinics, for example the colorectal clinic there was no room available to support patients/ relatives who may have received distressing information. Staff told us this meant clinics overran and patients waited longer to be seen.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

We rated responsiveness for outpatient services as **requires improvement** because;

Services were not always planned, organised or delivered in a way that met patient's needs.

Waiting times for patients varied on arrival in the outpatient clinics. Some patients could wait several hours to be seen and were not warned of this possibility.

Translation services were not effective or responsive to patient needs.

Facilities were not available for most patients to access drinks in all outpatients departments.

Service planning and delivery to meet the needs of local people

- Managers and staff told us there were capacity issues in some clinics which meant that there were an insufficient number of clinics to deal with demand. For example, fracture clinic and ophthalmology were regularly overbooked due to demand
- Staff told us most routine patients were not offered a choice of appointments. This was confirmed by four patients we spoke with.
- In radiology one member of staff told us if patients did not attend (DNA) for their first appointment they were not offered another appointment and needed to go back to their GP to make another referral. However there were exceptions for children and patients with a suspected cancer diagnosis who were offered another appointment.
- Two week wait appointments were made via the telephone by administration staff. We observed staff in the access centre calling a patient to arrange. They told us four and six week wait patients received their appointment by letter.
- We saw that themes from complaints included patients complaining they had not got an appointment letter. Two patients told us they had to ring to find out when there appointment was as they had not received it.
- Outpatient's clinics were located on four levels. In some clinics for example gastroenterology we saw waiting times displayed on a whiteboard and these were updated throughout the clinic. However in other clinic areas, for example ophthalmology and diabetes clinic,there was no information about how long patients might have to wait. We asked three patients in ophthalmology if they had been told how long they might have to wait. They told us they did not know and never know how long they would wait. In fracture clinic four patients told us they did not know how long they had to wait, two patients regularly attended and told us they had never been told how long they might have to wait.

Outpatients and diagnostic imaging

- We observed that waiting times varied across outpatient clinics. Most patients we spoke with were tolerant and accepted if they were not seen at their scheduled appointment times. However, some complaints had been received about delays in clinics.
- Four patients in fracture clinic 1B told us they were not kept informed how long they would have to wait.One member of staff said they knew they should inform patients but sometimes they were too busy. The fracture clinic appointments were regularly double booked due to need. Staff told us patients were delayed because of the double booking and also because doctors had to leave clinic to deal with emergency's. This meant patients waited longer to be seen.
- In the colorectal clinic the waiting time was an hour and a half. The nurse in charge told us the delay was due to patients receiving distressing news as there was no alternative room for patients to use and waiting times for this clinic overran on a weekly basis. We observed one patient complaining to nursing staff about the delay and stating they would have to go as their car parking ticket was running out. Staff were helpful and informed the patient they could go and put more money in and they would not lose there place. They told us patients had no option other than to get another car park ticket as they would get a ticket if over time. There was no other option for patients who were delayed in clinic.
- Patients attending x-ray department were given a pager when they arrived. The pager was suitable for patients with sensory needs as it buzzed, flashed and vibrated. This alerted patients when there appointment was ready. Two patients told us they thought it was a good idea but they were not told how long they might have to wait.
- The Radiology department well signposted and easy to find.

Access and flow.

- Health Watch Haringey informed us of a long-standing concern about the functioning of the hospital's outpatient's appointment system. They received feedback from patients who told them about long periods spent on the phone making or changing an appointment, and receiving confusing and contradictory letters about the date of their appointment. They told us concerns had been raised directly with the Chair of the trust, who had begun to address system and resourcing issues, which were causing the problems and difficulties for patients. This was confirmed by the outpatient manager.
- Patients told us getting through by phone to the trust to cancel or rearrange appointments was difficult, one patient said," It's very hard to get through and if you do no one answers and a message says "ring back, and you can't leave a message.

  The trust told us they had made changes to the "access booking system to solve some of these problems. Patients were still unable to leave messages but audit information from the trust showed they were responding to more calls.
- However we found that when patients tried to phone clinic reception areas they were often unable to get through. Two administration staff told us they used to have two staff on reception but now there was usually only one. This meant they could not answer calls as well as respond to patients arriving at reception. We observed phones ringing in two reception areas at different times and administration staff did not answer the calls. Staff told us there was no facility to leave messages on reception phones.
- Patients told us they had problems contacting the trust to cancel appointments. One patient said they tried to phone when they could not attend on the day and could not get anyone to answer the phone. This meant they would have been recorded as did not attend (DNA) their appointment.
- Between January 2014 and December 2014 the trust DNA rate was consistently worse (9%) than the England average of 7%.
- Trust data showed that 2.25% of patients waited over 30 minutes to see a clinician of which 50.6% were recorded as arriving late. However we could not be assured the data accurately reflected the experience of patients across all outpatient clinics.
- The trust had been performing worse than the national average for the percentage of patients (all cancers) seen by a specialist within two weeks of an urgent GP referral.
- They had been performing better than the England average for patients (all cancers) waiting less than 31 days from diagnosis to first definitive treatment.

Outpatients and diagnostic imaging

- The trust was performing worse than the England average between May 2015 and August 2015 for the percentage of patients waiting six or more weeks for diagnostic treatment.
- The trust had a high proportion of people waiting more than six weeks for diagnostic appointments, from May 2015 to August 2015, when compared to the England average.
- The trust were performing better than the national average for the percentage of patients waiting less than 62 days from urgent GP referral to first definitive treatment for cancer waits.
- Since November 2014 the referral to treatment (RTT) percentage within 18 weeks non-admitted and incomplete pathways (IP) was better than the standard and similar to the England average.
- Diagnostics and investigations waiting times for the trust averaged, 27 days for CT scans, 41 days for fluoroscopy,13 days for mammography, 34 days for MRI and 19 days for nuclear medicine. These were within the 42 days national standard.
- 63% of patients were seen within the six weeks target for "non consultant" waiting time, for example Muskoskeletal services. This meant 37% of patients were not seen within the target.
- Managers told us demand for CT had increased 27% over the last year. The service used funds from the waiting list initiative to pay their own staff to work additional hours rather than employ agency staff. There had been a 30% increase in demand for magnetic resonance imaging (MRI) and funds from the waiting list initiative were used to enable permanent staff to work additional hours. This meant patients received a more consistent service and patient flow and staff workload could be managed more effectively.
- Outpatient's appointments were the subject of complaints. We saw there had been reductions in complaints from the previous year.

Meeting people's individual needs

- A translation service was available to enable staff to communicate with patients where English was not their first language. Written information was available in different languages and large print by request. However we spoke with staff and patients who raised concerns about access to the service.
- The service director told us the referral criteria and process for booking had changed in the July 2015. Clinicians were now required to request interpreters at for each separate appointment. Administration staff told us this did not always happen as alerts were not always put on the electronic booking system. Most consultants used the patient's paper record for their consultation and did not access the electronic record which meant it was left to the administration staff to arrange interpreters. Central booking staff in the access centre told us they would not know if a patient's needed interpreting services for a first appointment unless the GP wrote it on the referral.
- Staff said patient appointment times were regularly changed around but no one changed the interpreter time, for example, one patient attending ophthalmology day surgery in October 2015 had an appointment for 4.15 and an interpreter had been booked for this time. The appointment was brought forward to midday but no one had changed the interpreter booking. The interpreter had been called at 2pm to say they were needed as the patient could not consent to the treatment as did not understand and could not get there until 3pm. They told us this situation was a regular occurrence and staff did not record them as incidents.
- The translation service booking team told us they had no access to the patient's electronic system. This meant they had no way of knowing if the patient had other clinic appointments or if the appointment had been changed unless notified by the clinician or administration staff. We were given many examples where nursing and interpreting staff told us that on a daily basis interpreters were required but had not been pre-booked.
- Three staff told us they felt the change to referral criteria had put patients at risk. The criteria stated referrals to the interpreter service could only be made for "a child or vulnerable adult, or who had a sensory or hearing impairment, or where there were specific reasons the telephone interpreting service could not be used." This meant that unless the referral stated these needs then an interpreter would not be booked.

Outpatients and diagnostic imaging

- For example: a breast cancer patient who needed an interpreter to be present at their spring 2015 appointment did not get one because the referral did not state "oncology" on it therefore it did not meet the criteria. At the December 2015 appointment staff found the patient had stopped taking the medication they had been prescribed when it ran out because they had not understood they needed to take it for five years. They had not had any medication for two to three months.
- One member of staff told us this was not reported as an incident. They had said to the clinician this should go on datix who said they were too busy. This meant that the patient had been put a risk of harm because they had been unable to access translation services when they needed to.
- The translation service had two permanent interpreters and used agency interpreting staff when required. One member of staff told us they "were concerned about the number of patients not receiving a service" , another told us the patient appointment letter said patients had to ring the department they are going to be seen in to arrange an appointment. This meant the patient had to have someone who spoke English to read it to them as all letters were written in English.
- The trust provided access to a telephone interpreting service; however one member of staff told us "orthopaedics refused to use it as the phone takes too long". The largest percentage of patients requiring interpreting service were Turkish speaking, with Spanish as the second most requested language.
- Three administration staff in different clinics were not able to tell us how they accessed the "alert system" on patient electronic records. For example, this could alert them that patients had dementia, a learning disability or safeguarding issues. This was important as staff had told us clinicians relied on administration staff to let them know important information about the patient
- Staff told us that if patients were waiting in the clinic for long periods of time they were not able to provide them with suitable nutrition and hydration. They were no longer able to request sandwiches for patients and if clinics were busy and people were sat in a corridor they could get missed. One clinician gave us an example where an oncology patient had been brought in by hospital transport early had been left sitting in a long corridor where they sat for four hours with nothing to eat or drink. They said no one was responsible for checking patients and the member of staff had organised and paid for food and drink for them. They had organised a room where the patient could lie down and rest while they waited to be seen.
- Dermatology services provide one stop clinics in order to improve services for patients.
- Managers told us they knew that water was not available in all clinics as this was recorded in the general outpatients review dated October 2015. On the day of the inspection we observed that clinics in 4A and 4B had access to water should patients need it. In fracture clinic on level one we observed staff offering water to one patient.
- Training to meet the needs of people living with dementia was provided by the trust.
- Bariatric patients had their own weighing scale in a treatment room. This meant there privacy was respected.
- Bariatric chairs were available in the waiting areas in some clinics, for example; 4A and 4B clinics.
- We saw there was limited access to dedicated facilities for distressed patients or relatives across outpatients. Staff told us some clinics had a room they could use whereas other areas were dependent on utilising a spare room if not in use. For example the colorectal clinic on level 4 did not have a dedicated room they could use.
- We saw there was a limited variety of seating arrangements available for patients in all outpatient waiting areas. For example we saw very few raised height chairs to enable patients who needed them to be seated comfortably.
- Outpatients and diagnostics services were all accessible for patients and lift access was available.
- Patient information leaflets were available on request in different languages and in large print, however all information explaining this was in English. Staff told us English was not the first language of approximately a

third of patients attending outpatients department. This meant that patients that could not read English would not know they could have information in their preferred language.

- Information leaflets and notices were displayed to remind patients of the importance of notifying the radiologist of any associated risks. For example: if patients were pregnant.
- There was adequate numbers of seating and equipment available in all of the outpatient areas.

Learning from complaints and concerns

- There were inconsistences in how staff told us complaints were discussed in the departments. In radiology complaints were discussed at team meetings and shared.One clinician said complaints were never discussed at their meetings so they never got any feedback on incidents or complaints unless they were directly involved.
- Five administration staff told us "nobody listened to their complaints or concerns". One administration member of staff that had been in post over five years told us they never had team meetings and never received feedback about complaints or incidents.
- We spoke with five nursing staff about learning from complaints; they were unable to give us examples where learning had taken place.
- In radiology three staff gave examples of learning from complaints and explained what had changed as a result.
- The patient advice and liaison service (PALS) had an office in the main entrance area where there was visible information regarding how to make a complaint.

  The location was central and accessible although signage to the office was poor.
- Initial complaints that had not been able to be resolved by individual managers in each clinic department would be directed to PALS.
- Between April and November 2015, there had been 38 outpatient complaints. Themes included; appointment letters not received or very late notice, cancellation of appointments, delay in being seen and receiving test results. These were the same complaints that patients told us about during our inspection. One patient who regularly attended outpatient's clinics told us they thought things were improving. They had recent experience of contacting the access centre to change an appointment and found staff very helpful. Cancellation of appointments was highlighted by two patients as an issue. One said they had been cancelled more than once for different clinics.
- The PALS team had processes to capture themes and share them with relevant teams. Staff said that in some specialities the clinician's response to complaints could be slow and this meant complaints were not completed within the required timescales.
- Management staff told us that links between the complaints team, service unit links and the head of quality and safety were not yet embedded. Changes were in progress within individual specialities to manage these issues. For example; the PALs team co-ordinated response times and would follow up referrals with clinicians if they were not responding within timescales.This meant the trust was responding to more complaints within the required timescale although this was still a work in progress.
- In most of the areas we visited we did not see information displayed on how to make a complaint. However, one notice board on level 4 did have PALS contact information.
- Staff told us leaflets were available in outpatients departments however we did not see any other than in the ophthalmology clinic on level 3 by reception.
- Radiology staff confirmed that they were aware of complaints and had received feedback via staff meetings.
- The trust policy stated that there was no mandatory complaints training provided to staff, but it was provided on an ad hoc basis. The principles of good complaints handling were included in the policy. When the PALS team received complaints that required investigation by managers there was an electronic system to delegate responsibilities and track progress of the complaint.
- Managers told us that analysis of complaints was completed by PALS and that feedback on any trends or themes would be provided if it was relevant to each department.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services well-led?

Requires improvement

We rated leadership in outpatients & diagnostic imaging services as **requiring improvement** because;

Risks were not always identified, and when identified were not always managed effectively or in a timely manner.

Issues that threatened the delivery of safe and effective care were not identified or adequately actioned, and actions to manage these issues were not always taken. For example, arrangements for provision of translation services.

Systems were not effective enough in identifying and managing the risks associated with protecting patient's personally identifiable information. Whilst the trust was aware of the issue they were unable to quantify the scale of the problem.

Risks regarding the appropriate storage of records had not been identified or managed. This meant the trust was unable to deal with the impact of this adequately.

However:

Radiology staff said they had good leadership and they felt well supported.

Nursing and administration staff were enthusiastic about working at the trust but felt the most senior managers were out of touch with what was happening on the frontline.

Managers in outpatient departments were accessible and well regarded by staff.

Vision and strategy for this service

- The trust identified 'challenges' in outpatient's that included looking at how they could maximise capacity of clinic space and also the environment. They noted that the clinic space was enclosed, and it would be difficult to open up the space due to the footprint of the building and the supporting structures.
- Management teams we spoke with told us about changes that were required within outpatients to make them more user friendly for patients. This included a review of the working hours and planned changes to the booking systems to ensure it was more accessible and responsive for patients. This was planned but with no timescale as to when it would start had been made.
- Most staff were able to describe the trust vision and how they incorporated that in their work.
- Outpatient managers told us of recent changes and recruitment that was taking place to develop the service. This included environmental changes and changes to staff structures.

Governance, risk management and quality measurement

- Risks identified by staff and known to the trust were not all on the risk register. There was a difference in what staff raised as concerns and what were recorded as risks such as; administration staff concerns with the confidentiality and storage of confidential waste and triage of paper referrals in the access centre.
- Although audits had been undertaken to monitor the availability of records. Some outpatient departments recorded missing records as an incident, but other areas did not. This meant the trust was unaware of the extent of the problem and there were no effective audit process in place to check.
- The trust had reviewed the health records department in July 2015. An improvement plan had been put in place. Areas being reviewed included, library management systems, quality of circulating record and staffing levels. The manager told us they had completed the first part of the plan and identified further improvements required in the management of patient records but could not move on to the next step until sufficient staff were in place.
- We asked the lead for the translation service about the concerns raised by staff and shared two of the examples we had been given. They told us they had not been aware of any risks to patients. Changes to the referral criteria and booking process implemented by the trust had not identified what risks their might be and how the change might impact on patients in providing safe and effective care. No audit had been undertaken to look at the impact of changes to the service and patients and staff had not been consulted about their views on the impact of the changes for patients. There was no risk

assessment in place. This meant the trust were not aware of problems and there was no plan in place to manage the risks to patients and effectively monitor the outcome.

- Incident reporting was inconsistent and governance procedures to monitor waiting times, frequency of patient's records being available and storage of records were not always effective. This meant the impact and risk to patients was unknown.
- One member of staff told us one lead nurse covering four floor levels of clinics meant there were times when they were not available when needed. This was a risk as the lead nurse had the keys to the drug cupboards. In one example we were given, staff had needed to access emergency treatment for a patient with diabetes and the lead nurse was not available. This meant there had been a delay in accessing the treatment which was in the locked drug cupboard and patients could be at risk of harm. They told us they had highlighted their concerns to managers however no changes had been made.
- In pathology we saw the UKAS, (United Kingdom Accreditation Service) pathology improvement action report for the trust that identified areas for improvement needed before the service could be accredited (UKAS provides national accreditation to confirm that organisations operate professionally to agreed standards). Some of the improvements needed included ensuring there was a procedure in place to ensure that staff treated human samples and remains according to legal requirements. The "improvement action" stated the department needed to "ensure staff were familiar with relevant documents and produce a questionnaire to demonstrate understanding". The "evidence due" date was August 2015 and the trust was cleared by UKAS on evidence submitted for this on 5 October 2015.
- The laboratory risk assessment for determining the timescales for implementation of corrective and preventive actions for non-conformities (this meant that someone was doing things differently from the norm) criteria for levels of risk raised at internal audit were not defined and the risk assessment was not recorded. The action completion date was August 2015 however staff told us this was not yet completed. Trust managers later told us the action was completed in September 2015.
- There were some structures in place to maintain clinical governance and risk management. For example quality and safety meetings. They reviewed trust key performance indicators (KPI's). For example, complaints and Friends and Family test feedback.
- Staff told us they were aware of the trust's whistleblowing and safeguarding policy and they felt able to report incidents and raise concerns through these processes.
- Staff said they knew about the trusts lone working policy and adhered to it. No concerns were raised by staff regarding this.

Leadership of service

- The trust had polices in place to ensure patients were not discriminated against. Some nursing and administration staff we spoke with were not aware of these policies and could not give us examples of how they followed this guidance when delivering care and treatment for patients. For example, patients with a learning disability.
- Two nursing staff gave examples of how they followed this guidance for patients with dementia.
- The trust had been in the process of reorganising the outpatient services management structure and core line management responsibilities.This had started in July 2015. This meant many staff had different line management, and a change in their role and responsibilities. This was still in progress so was not yet embedded in the teams. The trust told us the new structure would ensure there was a clear accountability management structure.
- Most nursing and administration staff told us that local leadership within outpatients was good. However some nursing and administration staff were concerned about the time it took to get concerns discussed and actions taken when they highlighted issues that impacted on patients and staff.
- Outpatient's staff told us communication with the board and senior managers had improved and things were beginning to change. They said that changes to the executive team over the last two years had been positive, one said they felt they were " communicating and out there with the teams".

Outpatients and diagnostic imaging

- Radiology staff said they had good leadership and they felt well supported. Three staff told us their line management was “excellent” and “it was a very good place to work.”
- Managers told us that staff in outpatients worked together to resolve any conflict and everyone shared the responsibility to deliver good quality care.

Culture within the service

- We saw that in the February 2015 staff survey the trust were in the top 20% of trusts for staff feeling they had support from immediate line managers. It was in the bottom 20% for, appraisal, working extra hours, work related stress, bullying and harassment and career progression and discrimination at work. Staff we spoke with raised similar themes to those in the staff survey.
- Three staff raised concerns about bullying and harassment. One told us they had reported their concern to a senior manager but did not feel they had been listened too and the situation had not been resolved. Another member of staff told us they had raised concerns but did not feel they could go above their line manager and their concern had not been taken seriously and the situation had not been resolved.
- Nursing staff told us that whilst immediate line managers were supportive attending courses to develop leadership skills was difficult as clinics were too busy or short staffed to release people.
- The trust had developed an action plan to address some of the issues raised by staff. This included developing a leadership programme for staff, improvement to the appraisal process and outcomes and support for staff to access training opportunities to support business processes and change management.
- Staff sickness absence rate has varied across time, but the rate had been below the England average.
- In radiology and diagnostics staff told us there was an open and transparent, safe, caring and responsive culture.
- Staff retention was high and staff were committed.

Public engagement

- The trust told us they had over 700 volunteers and used a large number of volunteers to provide support to patients in outpatients. This included offering water to patients. During our inspection we did not see volunteers providing this service.
- The trust gained patients views about services in a number of ways. They requested feedback from Friends and Family Test and we saw posters on some notice boards in outpatient clinics. Between July and November 2015, 87% of patients recommended the service. The trust did not separate its responses into specialities so we were unable to determine how many responses were specifically about individual outpatient services.

Staff engagement

- The staff survey for 2014/15 showed that 39% of staff had responded. One of the comments in the survey was around lack of transparency of opportunities and career progression. Staff said they could not take up opportunities due to work pressures and not being released.
- We saw the ‘directorate staff survey action plan 2015 to 2016’. Priorities included ensuring all staff received; a well -structured appraisal, encouraging management behaviours to inspire and motivate staff and act as leaders, encouraging staff to reach their potential, and identifying training, development and career path opportunities.
- Throughout the inspection, most staff were welcoming and willing to speak with us. Staff described their role and said they enjoyed working at the trust.
- The trust encouraged staff to respond to the staff friends and family test (SFFT) online questionnaire which was sent out quarterly. Areas which were in the top 20% of the 2014 to 2015 included; staff agreeing their role made a difference to patients who used the service. 78% in Q4 (compared to 75% in Q2) of staff recommended the care at the trust. 61 %in Q4(compared to 59% in Q2) would recommend it as a place to work which was an increase on the previous quarter. Staff engagement was a key indicator for the trust in measuring how well it managed its staff and the SFFT test was one way of measuring progress on a quarterly basis.

Innovation, improvement and sustainability.

Outpatients and diagnostic imaging

- The trust is a teaching hospital for undergraduate medical students (as part of UCL Medical School) and nurses and therapists (linked to Middlesex University School of Health and Social Sciences).

Outstanding practice and areas for improvement

Outstanding practice

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.

Areas for improvement

Action the hospital MUST take to improve

Within maternity the service must ensure the safety of women undergoing elective procedures in the second obstetric theatre and agree formal cover arrangements.

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 acute outpatient departments the hospital must improve storage of records and ensure patient's personally identifiable information is kept confidential.

Action the hospital SHOULD take to improve

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 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 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.

Outstanding practice and areas for improvement

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'.