

Barts Health NHS Trust

# Whipps Cross University Hospital

## Quality Report

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

## Ratings

### Overall rating for this hospital

Accident and emergency

Medical care

Surgery

Intensive/critical care

Maternity and family planning

Services for children & young people

End of life care

Outpatients

# Summary of findings

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# Summary of findings

## Overall summary

Whipps Cross University Hospital is in Leytonstone, east London, and serves 350,000 people in Waltham Forest, Redbridge, Epping Forest and other areas. It provides a full range of inpatient, outpatient and day case services as well as maternity and accident and emergency departments. The hospital serves an area with a wide variation in levels of deprivation and health needs, ranging from the most deprived 5% to among the most affluent 30% of electoral wards in England.

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

CQC has inspected Whipps Cross Hospital four times since it became part of Barts Health on 1 April 2012. Our most recent inspections were in May and June 2013, when we visited the A&E and maternity departments, outpatients, surgery services and care of the elderly wards. We issued three warning notices to the trust relating to infection control, safety and availability of equipment and supporting its workers. We also issued compliance actions.

We had significant concerns about the quality and safety of care in certain areas of the hospital. As part of this inspection, we checked whether the trust had addressed some of these shortfalls, and we took a broader look at the quality of care and treatment in a number of departments.

Our inspection team included CQC inspectors and analysts, doctors, nurses, midwives, allied health professionals, patient 'Experts by Experience' and senior NHS managers. We spent three days visiting the hospital. We spoke with patients and their relatives, carers and friends, and hospital staff. We observed care and inspected the hospital environment and equipment. We held two listening events in Leyton and Walthamstow and

heard directly from people about their experiences of care. Before the inspection we also spoke with local bodies, such as clinical commissioning groups, local councils and Healthwatch.

We found some good areas of practice and many positive findings. Patients held staff in high regard and felt them to be committed, compassionate and caring. Our observations confirmed this. The intensive care unit (ICU) was safe, met patients' needs and demonstrated how improvements could be made through learning from incidents. Improvements have been made in both accident and emergency and maternity services since our last inspection, and we saw some good practice in these departments. Palliative care was compassionate and held in high regard by staff, patients and their friends and family. We saw some good practice in children's services. The hospital was clean and staff adhered to good infection control practice. Staff worked well together in multidisciplinary teams.

However, a number of improvements need to be made. Prompt action is required in some areas of the hospital to ensure that care and treatment is safe and responds to people's needs. Work is also needed to make sure the hospital functions effectively and to improve leadership and morale.

Staffing levels on the medical and surgical wards need to be increased to ensure patients' medical and other needs are met. The hospital also needs to ensure that staff have access to the appropriate equipment.

The trust needs to make radical improvements to patient flow and discharge arrangements. Too many patients had to wait to be discharged or were delayed in other parts of the hospital. This impacted on the effective functioning of the hospital.

Equipment in parts of the hospital was either unavailable, in short supply, inappropriate or not subject to the appropriate checks. Some of this equipment was essential.

# Summary of findings

The hospital environment was satisfactory, although improvements need to be made to the some wards, the Margaret Centre and outpatients so that patients' needs can be met and their privacy and dignity can be maintained.

Patients need to be made aware of how to make a complaint and the hospital needs to improve how it learns from complaints. In addition, the hospital's risk register needs to be more actively managed.

While some areas of the trust were well-led, some wards needed stronger leadership and better support from the hospital. The governance of the hospital needs to be improved so that staff are empowered to make decisions and know how to make changes or get problems solved. We recognise that the trust has started to make changes, although these need time to become effective.

Staff culture was not sufficiently open and some staff felt inhibited in raising concerns. Morale was low across all staffing levels and some staff felt bullied.

# Summary of findings

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

We always ask the following five questions of services.

### **Are services safe?**

Many aspects of care and treatment were safe. However, some aspects were unsafe. Staffing levels on some medical and surgical wards were not always safe. Equipment in parts of the hospital was either unavailable, in short supply, inappropriate or not subject to the appropriate checks. Some of this equipment was essential. The hospital was clean and staff adhered to infection control practice. The hospital environment was safe, although there were some shortfalls that meant that people's needs were not always met.

### **Are services effective?**

Patient care and treatment was effective and guidelines for best practice were monitored. We saw good collaborative working a number of areas in the hospital. Audits were carried out and used to improve patient care.

### **Are services caring?**

The majority of the patients spoke highly of Whipps Cross staff. Many patients were full of praise and said that staff were kind, caring and attentive to their needs. Patients' privacy and dignity were maintained. Patients received appropriate support to eat and drink. During the inspection we saw staff being attentive and caring towards patients. We did, however, hear at our listening events and via people calling and writing to us, about a number of concerning instances of very poor care. The hospital needs to ensure that the positive experiences we saw and heard about during the inspection are maintained and that instances of poor care are minimised as far as possible.

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

In some areas of the hospital, patients' needs were not being met. While some improvements had been made in some areas, essential checks on patients did not always happen. There were problems with patient flow through the hospital, bed occupancy and discharge planning. This was having a negative impact on patients' experiences. Patient feedback was being obtained, although further work was required to embed learning across the hospital. Patients' complaints were not always appropriately handled. Some patients did not know how to make a complaint, although the trust was beginning to make improvements in this area.

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

There is variability in leadership across the hospital. Some areas were well-led, but others were not and this had an impact on patients' care and treatment. The clinical leadership structure was relatively new and it needs time to become embedded and effective. The trust had recognised this and action had been taken to address some shortcomings in the governance structure,

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such as the introduction of site-level organisational and clinical leadership. The culture was not sufficiently open and some staff felt inhibited in raising concerns. Morale was low across all staffing levels and some staff felt bullied.

# Summary of findings

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

### Accident and emergency

Progress has been made since we last inspected A&E. However, further improvements are required to improve the safety, effectiveness and responsiveness of the service. Managing patient flows through A&E is challenging. When the service is very busy, staff are less able to provide support to patients to help them cope with their treatment and hospital visit. Effective leadership is establishing the ways and means of changing working practices and the culture of the organisation to take the service forward.

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

Urgent action is required to ensure that patient care is safe and meets patients' needs. We found staffing levels to be unsafe on some wards and identified some errors which could have led to harm to patients. On some wards there were not enough nurses to meet the needs of patients. The out-of-hours medical cover was inadequate and patients' needs were not always met. The trust is reconfiguring its staffing arrangements on the medical wards, but prompt action is required in the interim. There remained a lack of equipment on some wards. Patients were often washed in bed and not always offered the option of a shower. There were delays in discharging patients which had a significant impact on patients and other areas in the hospital, such as the surgical department and A&E. Some of these delays were not necessarily attributable to the hospital. However, we did see examples of good practice. Staff were kind and caring towards patients. Patients were positive about the way they had been cared for by staff. Action had been taken to improve patient outcomes. Staff were receiving intensive training on caring for older people.

### Surgery

Overall, surgical services were safe, effective and caring. However, some improvements needed to be made, particularly to the pre-admission ward arrangements. We saw evidence of safe surgical practice and good use of the World Health Organisation (WHO) surgery checklist, which is designed to prevent avoidable mistakes. Measures had been implemented to improve safety on the wards and there had been a reduction of incidents, such as patients' falling. There were good arrangements in place to manage hospital infections and maintain hygiene. Patients were very complimentary about staff and said that they were well cared for. Staff worked well together to assess patients' needs.

However, the way the pre-admission wards were organised needed to be reviewed. Staffing levels and staff skills levels on these wards did not always meet people's needs. Patients sometimes had to wait a long time on these wards.

Problems with the availability of beds in the hospital impacted on surgical services. As a result, patients sometimes had to wait in the recovery area after

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surgery. There were some medical patients on the surgical wards. Patients were not always discharged in a timely way and were not always involved in planning their discharge from hospital. Patients did not know how to make a complaint.

There was a lack of appropriate equipment (oxygen and suction) on some wards. Appropriate checks on emergency equipment were not always carried out.

Staff morale was low. Some staff said that when they raised concerns about patient safety, they felt bullied and fearful of raising further issues. There was some good leadership at a local level. However, staff were concerned about the effectiveness of the trust's governance system as a whole.

## Intensive/critical care

Overall, this was a safe, caring, effective and well-led service. Infection control was managed appropriately. There were enough appropriately qualified staff on duty. There was good education support and the unit learned from incidents and applied best practice guidelines. There were systems in place to monitor quality and safety. However, there were some delays to patients being transferred into and out of ICU and occasional single-sex ward breaches, although this was due to the shortage of available beds in the hospital.

## Maternity and family planning

We saw that improvements had been made in the maternity department, but further progress was needed. The service was clean, which was not the case at our last visit in June 2013. Reporting of faulty equipment and checking of resuscitation equipment had also improved since our last visit. However, other equipment was found to be faulty and there was still need to improve the availability of safe equipment. Enhancements had been made to the way the service learned from incidents and this should continue so that the changes are embedded. Women said that they felt staff cared for them well, although on occasions security staff were discourteous. Staffing levels were appropriate and there was sufficient consultant cover, although some staff said that there were times when they were stretched and could not provide one-to-one care to women in established labour. We found that the maternity service did not always respond to people's complaints in a timely manner. Although systems were in place for reporting and reviewing incidents, we did not always see evidence that appropriate action was taken. The risk register and meeting minutes we reviewed did not always demonstrate the sequence of actions taken to minimise the risk. Staff told us that current changes to the staffing structure were affecting morale and left some staff feeling undervalued.

## Services for children & young people

Overall, children's care at Whipps Cross was a caring, effective and well-led service, with some issues around equipment checks, record keeping and communication with families. Parents and children were generally happy with the care they had received and felt they had been supported by caring and considerate staff. There were systems in place to ensure patients' safety and to



# Summary of findings

minimise risks in relation to medication management, although the effectiveness of the measures in place had yet to be determined. Equipment checks of resuscitation trolleys and records of medication expiry dates were not consistently completed. Children's care and treatment was monitored through participation in local and national clinical effectiveness audits. Facilities were appropriate to provide holistic care to children and young people, including developmental play and educational support. Communication and information provided to families was not always responsive to their needs.

## End of life care

We found that the service was generally safe, effective and caring. Staff worked together well to deliver end of life care in a compassionate and effective way. The hospital was following national guidelines in relation to end of life care and had stopped using the Liverpool Care Pathway. Patients said that they felt well cared for by staff. However, the unit where end of life care was delivered was in need of refurbishment as it compromised patients' privacy and safety. In particular, bathing facilities were not available. There was no out-of-hours palliative medical cover or speciality-specific advice, although the hospital plans to put this in place in 2014.

## Outpatients

Overall, improvements are needed. Outpatient services at Whipps Cross Hospital were caring and well-led with some issues around waiting times, information governance and over-crowded clinics. Transformation projects were in place to improve waiting times and patients' experiences. The department was generally clean and hygienic but waiting rooms were noted to be overcrowded. There were long waiting times for many clinics. However, the trust was aware of these issues and had strategies in place to address them. Patients were pleased with the treatment they received and felt well informed and involved in decisions about their care. Patients' dignity and respect were maintained by staff in the outpatients department. There was evidence the department had made efforts to ensure their services were accessible and responsive to people's needs. Some people did report difficulty in re-arranging appointments that had been made for them.

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## What people who use the trust's services say

Patients' comments were polarised. Many people were very happy with the care they had received. However, we heard a significant minority of patients tell us about the poor care they had received.

During the inspection, the majority of the patients spoke highly of Whipps Cross staff. Many patients were full of praise and said that staff were kind, caring and attentive to their needs. One patient said that the nurses had been "lovely". Another had been "really impressed" and thought the nurses were "friendly... I can't fault them at all".

Comments from the listening events and comment cards included: "I could not complain", "I am generally quite

pleased with service that my relative received. Everyone was very professional and polite", "The staff at Whipps Cross provide excellent healthcare. They are friendly, respectful and treat my situation with the highest confidence", "Excellent, well-oiled machine", "From start to finish, all staff at Whipps Cross Hospital are very caring and respectful. They listen and treat patients in a professional manner", and "The service is very bad."

We heard about a number of concerning instances of very poor care through our listening events and from people calling and writing to us.

## Areas for improvement

### Action the trust **MUST** take to improve

- Ensure staffing levels meet people's needs on all medical and surgical wards.
- Address delays to providing care. Patients' discharge from hospital is sometimes delayed. This impacts on other areas of the hospital and its effective functioning.
- Ensure that equipment on the medical and surgical wards, maternity services and in ICU is always available, appropriately maintained and checked in accordance with the trust's policies and safety guidelines.
- Improve staff morale across all grades.
- Make changes to the culture of the organisation. There is a lack of an open culture. Staff feel bullied and unable to raise safety issues without fear.
- Make changes to the hospital environment. Some parts of the hospital do not meet patients' care needs. The hospital environment in the Margaret Centre and outpatients compromises patients' privacy, dignity and safety.
- Ensure that patients know how to make a complaint. Changes are needed to ensure that the hospital learns effectively from complaints.
- Strengthen governance arrangements. Currently, these are not always effective. Staff do not feel empowered to make changes and the governance structures hinder them at times.
- Ensure that the hospital's risk register is managed more effectively.

## Good practice

Our inspection team highlighted the following areas of good practice:

- Staff were compassionate, caring and committed in all areas of the hospital.
- The ICU was safe, met patients' needs and demonstrated how improvements could be made through learning from incidents.
- Improvements have been made in both accident and emergency and maternity services since our last inspection and we saw some good practice in these departments.

# Summary of findings

- Palliative care was compassionate and held in high regard by staff, patients and friends and family.
- We saw some good practice in children's services, particularly in relation to education and activities for children while in hospital.
- The hospital was clean and staff adhered to good infection control practice. Staff worked well together in multidisciplinary teams.

# Whipps Cross University Hospital

## Detailed findings

### Services we looked at:

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

## Our inspection team

### Our inspection team was led by:

**Chair:** Dr Andy Mitchell, Medical Director (London region), NHS England

**Team Leader:** Michele Golden, Care Quality Commission

Our inspection team at Whipps Cross University Hospital was led by:

**Team Leader:** Seaton Giles, Care Quality Commission

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

## Why we carried out this inspection

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

# 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:

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

Before visiting, we looked at information we held about the trust and also asked other organisations to share what they

knew about it. The information was used to guide the work of the inspection team during the announced inspection on 5, 6 and 7 November 2013. An unannounced inspection was carried out on 15 November 2013.

During the announced and unannounced inspections we:

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

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

# Are services safe?

## Summary of findings

Many aspects of care and treatment were safe. However, some aspects were unsafe. Staffing levels on some medical and surgical wards were not always safe. Equipment in some parts of the hospital was either unavailable, in short supply, inappropriate or not subject to the appropriate checks. Some of this equipment was essential. The hospital was clean and staff adhered to infection control practice. The hospital environment was safe, although there were some shortfalls, which meant that people's needs were not always met.

## Our findings

### Safety

Patients said that they had received good care at the hospital and that they felt safe. Action had been taken on the medical wards to identify the main risks to patient safety and monitor them on an on-going basis. On most wards, this system was working well. Patients were protected from avoidable harm during surgery. The World Health Organisation (WHO) surgical checklist had become embedded into practice. The intensive care unit (ICU) focused on safety, learning from incidents and minimising risk. Staff were aware of, and were using, the trust's system for reporting patient safety incidents. We saw departments acting on safety alerts and learning from incidents. Staff in ICU were actively learning from incidents that had occurred or from patient safety information. However, the method of disseminating learning from incidents was not established in A&E.

### Medicines

There were inconsistencies in the monitoring of medications in children's services. We saw that reconstitution dates of medical suspensions were recorded on bottles stored in the fridge on the children's ward. This meant that expiry dates could be monitored to ensure medication efficacy. In contrast, monitoring records did not appear to be consistently maintained in children's A&E. Medication expiry checklists that should have been completed monthly had not been recorded in five of the months between February 2013 and October 2013.

### Managing risks

There was a mixed picture on managing risks. On the medical and surgery wards, up-to-date patient safety information was displayed which related to key risks, such as pressure ulcers, falls, hospital acquired infections, staffing levels and use of bank staff. However, some risks on the trust's risk register, such as emergency and critical care, were not actively managed or addressed in a timely way.

### Hospital infections and hygiene

The hospital environment was visibly clean. Staff were seen to adhere to good hand hygiene and infection control practice. There were adequate handwashing facilities for staff and patients throughout the hospital. Patients felt that the hospital was clean. Action had been taken to minimise the risk of infection.

### Staffing

Staffing levels were mixed. In some departments, there was a full complement of staff. In other departments, there were either staffing shortages or skill deficits and this impacted on patient safety. Some medical and surgical wards had sufficient staff on duty to ensure safe practice. However, the lack of staff on some medical and surgical wards made them potentially unsafe. On some medical wards we found that relatively junior staff were in charge and there had been a number of incidents as a result. We identified an error relating to staffing issues during the inspection on a ward. A number of wards did not have enough permanent staff and relied on agency staff which could impact on the continuity of patient care. Sometimes shifts were unfilled on a number of wards, meaning that the wards were short-staffed. Out-of-hours cover on the medical wards was insufficient and, on occasions, this had a detrimental impact on patients. The pre-admission surgical wards were open for longer than had been intended due to demand and were reliant on agency staff. Patients reported long waits on these wards.

Staffing in theatres was satisfactory, although staff were concerned about proposed changes to nursing support. Midwife staffing levels were mostly maintained.

Staffing levels in A&E were satisfactory. A&E consultant cover had increased and the department had seen benefits from these appointments, such as a reduction in the number of serious incidents of patient harm. The department was compliant with College of Emergency

# Are services safe?

Medicine (CEM) guidelines on A&E senior clinician presence throughout the day and night and at weekends. The A&E department was currently seeking to improve out-of-hours consultant cover.

## **Safeguarding**

Staff knew about safeguarding adults and/or children and what to do in the event of a safeguarding concern. The majority of staff had received safeguarding training. Safeguarding guidance was available to staff.

## **The environment**

The hospital environment met most people's needs, although there were some significant shortfalls. A&E and the medical assessment unit were newly built. These were good environments in which to treat patients. However, the Margaret Centre was designed in such a way that patients' privacy and dignity were compromised. There were no suitable washing facilities for patients in the Margaret Centre. There was no covered route between the two buildings and we observed one patient in a critical condition being transferred in the rain. The centre was in need of refurbishment. Patient transfers between theatres and wards were often a long journey along public corridors. The outpatients department was suitably designed, although some waiting areas were overcrowded and we also noted adult patients waiting in children's waiting areas.

## **Medical equipment**

Much of the equipment in the hospital was in good working order. For the most part, staff had access to the equipment that they needed. However, some equipment in parts of the hospital was either unavailable, in short supply, inappropriate or not subject to the appropriate checks. Some of this equipment was essential. In ICU, there was only one operational ventilator trolley. The other trolley was not working. The hospital had not provided a replacement in over five months and the interim arrangements for obtaining another trolley were inadequate. Within older people's care, staff said that they had difficulties in finding bladder scanner machines, used to detect urinary retention and infection, which were shared between all the wards. This meant that staff spent time locating and retrieving it before they could use it to treat people effectively. We found this was also the situation at our inspection in June 2013.

In a number of different areas in the hospital, resuscitation equipment was not always checked when required and in accordance with the trust's policy.

In the maternity unit, systems to ensure that essential equipment was available had improved since our last inspection, although further improvement is required.

# Are services effective?

(for example, treatment is effective)

## Summary of findings

Patient care and treatment was effective and guidelines for best practice were monitored. We saw good collaborative working across a number of areas in the hospital. Audits were carried out and used to improve patient care.

## Our findings

### Clinical guidelines

We saw evidence of adherence to national and guidelines. For example, the ICU took part in the Intensive Care National Audit & Research Centre (ICNARC) national audit programme. The hospital had replaced the Liverpool Care Pathway for end of life care with other protocols. This was in line with national guidance.

### Collaborative working

Staff worked well in multidisciplinary teams. Staff from a range of disciplines worked well together when discussing discharging patients. The palliative care team worked well with others when delivering end of life care.

### Audits

We saw evidence of a range of audits being carried out, with the results used to improve the quality of care. This included high-impact intervention audits relating to catheters, venflons (intravenous plastic tubes), central lines, handwashing and methicillin-resistant staphylococcus aureus (MRSA) screening on the medical wards. The results of the audits were fed back to staff so that they could improve the quality of the care being provided.

The paediatric clinical audit programme for 2013/14 was regularly updated in line with National Institute for Health and Care Excellence (NICE) professional guidelines. The children's A&E had participated in a number of CEM clinical effectiveness audits, which measured the department against national standards.



# Are services caring?

## Summary of findings

The majority of the patients spoke highly of Whipps Cross staff. Many patients were full of praise and said that staff were kind, caring and attentive to their needs. Patients' privacy and dignity were maintained. Patients received appropriate support to eat and drink. During the inspection we saw staff being attentive and caring towards patients. However, from our listening events and people calling and writing to us, we have heard about a number of concerning instances of very poor care. The hospital needs to ensure that the positive experiences we saw and heard about during the inspection are maintained and that instances of poor care are minimised as far as possible.

## Our findings

### Patient feedback

The majority of patients said they were impressed by the caring attitude of nursing staff and felt that they were being well cared for. One patient said that the nurses had been "lovely." Another had been "really impressed" and thought the nurses were "friendly...I can't fault them at all". This applied to all of the departments we visited. However, from our listening events and people calling or writing to us, we heard about a number of instances of poor care.

### Communication

Patients said that staff communicated well with them, but there were one or two minor exceptions when more information would have been useful to the patient.

### Privacy and dignity

Patients said that staff respected their privacy and dignity. We confirmed this when we observed care being provided to patients. We saw respectful interactions between staff and patients. Curtains were drawn around bays when personal care and treatment was being provided. However, the trust should note that, on some occasions, patients were treated on trolleys in A&E and this potentially compromised their privacy and dignity. The design of the Margaret Centre, where palliative care is provided, did not enable staff to maintain patients' privacy and dignity.

### Food and drink

Patients were given a choice of suitable food and drink to meet their nutritional needs and had a good choice of food. We saw patients being supported to eat. Some children had to wait a long time without food when waiting for an operation.

### End of life care

Patients at the end of life were cared for with compassion and in line with national guidance.

# Are services responsive to people's needs?

(for example, to feedback?)

## Summary of findings

In some areas of the hospital, patients' needs were not being met. While some improvements had been made in some areas, essential checks on patients did not always happen. There were problems with patient flow through the hospital, bed occupancy and discharge planning. This was having a negative impact on patients' experiences. Patients' feedback was being obtained, although further work was required to embed learning from their comments across the hospital. Patients' complaints were not always appropriately handled. Some patients did not know how to make a complaint, although the trust was beginning to make improvements in this area.

## Our findings

### Responding to patients' needs

Most areas of the hospital were providing satisfactory care, although some required improvements. In some areas of the hospital, such as some of the medical and surgical wards, people's needs were not being met, the quality of care being provided was inadequate and prompt action is required to address this.

On a respiratory ward, we found that one nurse was doing a medication round while another was in a multidisciplinary meeting and that patients were not being turned every hour, as identified on assessments. Monitoring paperwork had not been completed.

On other wards, we found that, although people's medical and social needs were being met, patients said that staff were busy and did not spend quality time with them. Patients told us that staff answered their call bell when they needed help and were responsive to their needs. However, some patients also told us that staff "generally missed the little things", such as having a shower, shaving or being able to look after their hair. It was generally felt that staff did not have sufficient time to communicate with patients and families. Staff confirmed this.

There were 15 patients with medical needs on surgical wards ('outlier' patients). While their needs were being met, these wards were not the most suitable environment for these patients.

Patients reported long waits on the surgical pre-admission wards.

Improvements have been made in the A&E department in relation to responding to people's needs. Hourly checks on patients had been introduced following our last inspection. However, we found that these checks were not always carried out or the documentation was not always completed. When we approached staff about these omissions, most said that they had not had time to complete the observations or that they had forgotten to complete the hourly checks chart. Some protocols to help staff determine where patients should be to receive the treatment they needed worked well, while others did not.

There were issues with the interface between A&E and the Urgent Care Centre (UCC) which is run by another organisation, the Partnership of East London Co-operatives (PELC). These issues were also present at our last inspection.

Patients in ICU had their needs met.

In Outpatients, some patients waited too long to be seen and the waiting rooms were overcrowded.

### Bed occupancy, patient flows and discharge planning

There are significant problems with patient flow in the hospital. Delays to discharge and/or a lack of beds impact on other areas in the hospital: patients have to stay in recovery, ICU or A&E for extended periods until beds become available. There are medical patients on the surgical wards ('outlier' patients) due to a lack of beds on the medical wards. Patients were not always discharged in a timely manner, in part due to a delay in obtaining an appropriate care package from the local authority, but also a lack of consultant and social worker seven-day working. There was an effective system in place to review bed occupancy, although these problems are systemic and action at trust level is required. We found this situation at our last visit in June 2013. The trust, in conjunction with the local authority, needs to take prompt action to improve patient flow in the hospital to ensure that patients receive appropriate care and treatment.

Some progress had been made in improving patient flows and waiting times in A&E and ambulance handover. We saw a number of initiatives in place to improve the flow of patients through A&E. This included a new acute assessment unit and multidisciplinary admissions

# Are services responsive to people's needs?

(for example, to feedback?)

avoidance team. However, on the evening of the first day of our visit, A&E was very busy and there was a queue of ambulances waiting to hand over their patients to A&E. Staff told us this was a regular occurrence. There was delayed access to diagnostics and investigations. Many staff we spoke with told us patients were discharged from the wards in the hospital late in the day and this impeded the flow of patients through A&E.

By contrast, we found that where people had a prognosis of end of life within three months, a 'fast track' process enabled funding and a care package to be arranged in a matter of days from the point of application.

## **Patients' feedback and complaints**

Patients were not always supported to make complaints. Some departments learned from complaints, whereas other departments did not do so effectively. There was little information available and the majority of patients did not know how to make a complaint. However, the trust had recently published some new complaint leaflets and was in the process of disseminating these in the hospital. Some patients who had made a complaint felt that their complaint had not been handled effectively.

The hospital's Patient Advice and Liaison Service office, which provides patients with information and helps them with complaints, had closed. There was a number for patients to call, but when we tried, we were unable to get through.

In maternity, patients' experiences and complaints were used to improve the service and the effectiveness of treatment, although improvements were needed. In A&E, little information about complaints was provided to staff. There was no analysis of trends or dissemination of learning that would help the service improve and prevent similar problems arising again.

The hospital had arrangements to obtain patient's feedback through the NHS Friends and Family Test. Patients were completing the test more often than previously after a drive by the trust to increase returns.

## **Patients with mental health needs**

Systems in A&E did not always support patients with mental health needs. The discharge of these patients from A&E was sometimes delayed because of difficulties securing a registered mental health nurse to escort them to mental health services. There were sometimes long delays in obtaining psychiatric assessment out of hours, although there was a plan for the psychiatric liaison team to be on site 24 hours a day in future.

## **Ward environment**

Some of the medical wards and the Margaret Centre did not meet patients' needs. We did not identify any instances of patients being supported to shower where wards were equipped with walk-in shower rooms. Patients were washed in bed.

# Are services well-led?

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

## Summary of findings

There is variability in leadership across the hospital. Some areas were well-led, but others were not and this had an impact on patients' care and treatment. The clinical leadership structure was relatively new and needs time to become embedded and effective. The trust recognised this and action had been taken to address some shortcomings in the governance structure, such as the introduction of site level organisational and clinical leadership. The culture was not sufficiently open and some staff felt inhibited in raising concerns. Morale was low across all staffing levels and some staff felt bullied.

## Our findings

### Leadership and clinical governance structures

Whipps Cross University Hospital merged with several other hospitals to become Barts Health NHS Trust in April 2012. As such, it is still a relatively new organisation. Following the merger, the trust introduced a clinical leadership structure covering specific specialties, such as emergency medicine or surgery clinical academic groups, across all Barts Health sites. There are distinct advantages to this structure: it creates the opportunity to share best practice, make improvements, streamline services and innovate. However, there are also risks, particularly in the way the trust implemented the new structure. Some staff reported difficulties in working across the three main hospitals. They said it was sometimes difficult to know who was in charge

in specific areas. At times, they found that the governance structure prevented issues being addressed. The trust recognised this and strengthened site level leadership at operational and clinical levels. This had been implemented just prior to our inspection so its impact could not be assessed. It is, in our view, a positive move.

From our inspection of Whipps Cross, we found that one clinical academic group (CAG) for emergency care and acute medicine – had developed the most and was working relatively well. This CAG was aware of the issues it had to tackle and had, or was putting, plans in place to address them. There was effective leadership at all levels in this CAG. However, this was not necessarily the case with other specialties.

We found that some areas of the hospital were well-led. We found well-run wards in the surgical and medical departments. The ICU was well-led. Equally, we found other wards that lacked effective ward leadership and/or support from the hospital, which resulted in poorer care and treatment for patients.

### Organisational culture

The hospital does not have an open culture that allows staff to raise issues without fear. Some staff felt inhibited in raising safety issues for fear that it would affect their jobs. Staff felt that changes to staffing structures were being imposed from the leadership without consultation. Some staff felt that they were being bullied by the organisation.

Morale was low among many staff. This was, in part, caused by the changes to nursing staff structures, but also staffing levels and the ability of staff to meet patients' needs in these circumstances.

# Accident and emergency

Safe	
Effective	
Caring	
Responsive	
Well-led	

## Information about the service

The accident and emergency department (A&E) is open 24 hours a day, seven days a week. It is housed in new, purpose-built premises. There are six resuscitation bays (one of which is for children), 22 major injury bays ('majors') and a minor injuries area. An acute assessment unit opened in September 2013 providing 40 additional beds and bringing together services that used to be provided in three separate units. A majors triage area with three beds opened on the day of our inspection. A clinical decision unit accommodates patients for up to 12 hours while waiting for tests and observations to be completed before a decision on further treatment. An acute ambulatory care service is open Monday to Friday.

A&E works alongside an Urgent Care Centre (UCC) operated by the Partnership of East London Co-operatives (PELC). PELC is a not-for-profit social enterprise delivering out-of-hours GP services as well as two UCCs in outer north east London and west Essex. The purpose of the UCC is to ensure that patients presenting to A&E are seen by the most appropriate clinician, which may redirect them to community-based services or their own GP. In 2012, the A&E and the UCC together saw over 150,000 patients.

We spoke to patients, relatives and staff, including nurses, doctors, managers, therapists, support staff, porters, receptionists and ambulance crew. We observed care and looked at treatment records. We received comments from patients and the public at our listening events, and we reviewed performance information about the trust.

## Summary of findings

Progress has been made since we last inspected A&E. However, further improvements are required to improve the safety, effectiveness and responsiveness of the service. Managing patient flows through A&E is challenging. When the service is very busy, staff are less able to provide support to patients to help them cope with their treatment and hospital visit. The department's effective leadership is establishing ways to change working practices and the culture of the organisation to take the service forward.

# Accident and emergency

## Are accident and emergency services safe?

Although the trust had taken steps to reduce harm to patients, further improvements are required to ensure people are protected from avoidable harm at all times.

### Learning from incidents

Staff were aware of, and using, the trust's system for reporting patient safety incidents. Teams in A&E were given information about the levels of delays in care, patient falls and skin trauma. However, there was no established method of disseminating learning from incidents. Information for staff about progress towards achieving harm-free care was not readily available in A&E. The trust was planning to produce a regular bulletin for staff to address this.

### Hospital infections and hygiene

The environment was visibly clean and domestic cleaning staff were present in each of the areas we visited. Adequate hand washing facilities were available and we saw staff taking care to protect patients from cross infection, for example by using disposable gloves and aprons, being bare below the elbows, and dealing appropriately with clinical waste.

### Safeguarding

Guidance was available for staff on identifying and reporting possible abuse. Safeguarding was included in annual refresher training for staff and senior staff told us that 96 to 98% of staff were up to date with this training. Training records confirmed this. Staff told us they knew how to report safeguarding issues and were aware of the trust's whistleblowing policy, and would feel confident to report to management any concerns they had about patient safety.

### Staffing

The trust had recruited additional A&E consultants to increase the availability of senior clinical leadership and expertise for doctors in training in A&E. It was compliant with College of Emergency Medicine (CEM) guidelines on A&E senior clinician presence throughout the day and night and at weekends. The number of serious incidents of patient harm had reduced following the appointment of additional A&E consultants. Work in other areas was on-going, for example out-of-hours consultant cover.

During our visit we saw good involvement of consultant physicians and surgeons in the acute assessment unit. Work was progressing on consultants' plans to increase the presence of senior clinicians to meet Royal College of Physicians' recommendations.

The trust was consulting staff at Whipps Cross about proposed changes to the deployment of nurses in the hospital, which would align it with other comparable hospitals. The proposals took in account Royal College of Nursing guidance on safe staff nursing levels and the recommendations of the Safe Staffing Alliance about minimum staffing levels to ensure quality care. However, many staff told us they were unclear about how the proposals would affect them personally and were concerned the changes would have an adverse impact, for example, on skills mix and support for student nurses.

A&E relied regularly on agency staff to maintain staffing levels. We spoke to a few agency staff who told us they preferred working at Whipps Cross to other hospitals because they were treated as part of the team and found their manager supportive and approachable.

### The environment and medical equipment

A&E was housed in new, purpose-built premises with new facilities. Staff had no concerns about availability of equipment. However, we saw that a number of routine checks to ensure that equipment was available and in working order were not being made consistently in all areas. Records showed resuscitation equipment was not being checked every day in resuscitation, majors, minors, the acute assessment unit or acute ambulatory care. This was not in accordance with the trust's policy. On one occasion, we saw keys left in the drugs cupboard in the acute assessment unit and medicines were accessible to unauthorised people. There were no temperature monitoring records available for a drugs refrigerator in resuscitation. Staff using these medicines could not be assured that they had been stored at the correct temperature and fit for use.



# Accident and emergency

## Are accident and emergency services effective?

(for example, treatment is effective)

Improvements are required to ensure people's needs are met and that care and effective treatment results in the best quality of life.

### Clinical guidelines

There were a number of protocols available in the resuscitation area of A&E to provide guidance to staff about the best way to treat conditions. Staff were developing protocols in collaboration with other hospitals to ensure they shared best practice, such as managing patients with acute myocardial infarction (heart attack). However, the development of a number of care bundles (a collection of evidence-based interventions) to improve the consistency of treatment and care in A&E and across the hospital were in an early stage of development. The trust had set up the emergency clinical improvement group to take this work forward.

## Are accident and emergency services caring?

Staff were caring, but improvements are required to ensure patients receive care tailored to their needs at all times.

### Communication

Patients and relatives were complimentary about the treatment and care they received. They said staff communicated with them well about their treatment. This included a patient who used the trust's interpreter service. We observed staff speaking with patients and relatives in a caring manner. However, when the service was very busy, patients and relatives were concerned about the lack of information about why they were waiting and what was going to happen to them. For example, a pregnant woman told us she was very worried as she had had a fall and had been waiting for more than four hours for a scan. A few staff told us that pressure to meet waiting time targets meant that they couldn't take time out to reassure patients and make sure their needs, other than clinical ones, were being met.

The trust launched a 'Because We Care' campaign in August 2013, described as "a call to action for

compassionate care across the trust." Staff were unclear about how the campaign worked. A group of healthcare support workers thought that their "hourly chats" with patients in A&E were part of the campaign, but had no way of recording this activity. Staff in acute ambulatory care and the acute assessment unit were unable to show how the campaign had any impact on the way they cared for patients. There was no feedback to staff from the trust about how well the campaign was working.

### Privacy

People's privacy and dignity were respected, although improvements could be made. When we inspected A&E on 22 and 23 May 2013, we saw patients' privacy being compromised when receiving treatment in corridors when cubicles were available. We did not see this practice at this inspection, although when the service was very busy, patients were being cared for on trolleys in corridors.

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

(for example, to feedback?)

Improvements are required to ensure people get the treatment and care they need at the right time, and that the hospital listens and responds to their concerns.

### Responding to patients' needs

At our last inspection of A&E on 22 and 23 May 2013, we found prioritisation of patients' treatment did not always change in response to a change in their condition. A&E was not always meeting national emergency department indicators for waiting times and handover times for patients arriving at A&E by ambulance. 'Time to treatment' and 'time to consultant sign-off' were inconsistent. The trust told us how it would remedy this situation. During this inspection we found the trust's action plan was mostly being implemented, and was beginning to improve the responsiveness of the service.

### Patient flows and waiting times

Progress was being made on indicators for waiting times in A&E and ambulance handover. We saw a number of initiatives in place to improve the flow of patients through A&E. This included a new acute assessment unit and multidisciplinary admissions avoidance team. The admissions avoidance team was effective and working beyond its operational hours of 10am to 6pm on the

# Accident and emergency

evening of the first day of our inspection to provide support when the service was very busy. We saw effective multidisciplinary working to discharge patients from A&E in a safe way and as speedily as possible. However, porters told us they needed training on transferring confused patients.

On the evening of the first day of our visit, A&E was very busy. All bays were occupied. Patients were being cared for on trolleys in corridors and there were not enough seats for all the people in the waiting area. There was a queue of ambulances waiting to hand over their patients to A&E. Staff told us this was a regular occurrence. There was delayed access to diagnostics and investigations. One person we spoke with had arrived in A&E that morning by ambulance at 10.30am, was seen in x-ray at 3pm, and at 7.10pm was still waiting for the results of a blood test.

The trust was monitoring breaches of the national indicators for waiting times in A&E and for ambulance handovers, and held regular review meetings. The service's escalation policy was being revised at the time of our inspection. An escalation policy sets out how the whole hospital responds to increasing demand on A&E to increase patient flow through the service while ensuring patients receive the treatment and care they need. Many staff told us patients were discharged from the wards in the hospital late in the day and this impeded the flow of patients through A&E.

## Hourly rounding

At our last inspection of A&E on 22 and 23 May 2013, we found that patients in A&E did not always have access to food and drink. We saw that hourly rounding had been introduced in A&E to provide on-going monitoring of each patient's condition. Observations included nutrition and hydration. We saw refreshments trolleys in A&E and meals provided for people staying in the acute assessment unit. However, we saw one person in the acute assessment unit who needed help to eat their breakfast, but they did not get this.

We saw nursing staff being encouraged to escalate concerns when a patient's condition deteriorated, triggering a reassessment of their needs and priority for treatment.

However the records we looked at showed that observations were not being consistently completed on an hourly basis. They also showed that some patients were

not being turned as often as required, and there had been instances of missed medication. When we approached staff about these omissions, most said that they had not had time to complete the observations or that they had forgotten to complete the hourly checks chart. However, two nurses we approached simply completed the chart without making the observations. We escalated our concern about this falsification of records to the trust.

## Patient pathways

There were protocols to help staff determine where patients should receive treatment: some worked well, while others did not. Staff were clear that patients with deep vein thrombosis would be treated in the acute ambulatory care service. However, following the reconfiguration of the service, we saw examples where staff were unclear about the patient pathway through A&E for neutropenic patients and women with obstetric and gynaecological complaints. Some patients described problems in accessing A&E through the UCC. For example, one person had been sent through to A&E and become lost. Another person had been redirected to their GP, who told them to go back to A&E.

## Patients with mental health needs

Systems did not always support patients with mental health needs. There was a dedicated bay for patients with mental health needs, which provided a more comfortable and safe environment than the waiting area. Psychiatry professionals were available on site during the day to assist with assessment and discharge. Staff said discharge of these patients from A&E was sometimes delayed, however, because of difficulties securing a registered mental health nurse to escort them to mental health services. There were sometimes long delays in obtaining psychiatric assessment out of hours, although there was a plan for the psychiatric liaison team to be on site 24 hours a day in future.

## Patients' feedback and complaints

The hospital sought feedback from patients. The number of people who completed the NHS Friends and Family Test for the A&E department had increased.

There were weaknesses in the way the trust responded to complaints and learned from them. Some patients felt that their complaints had not been handled well. They felt that the trust had failed to provide a coordinated response in a timely way. They were also concerned that the centralisation of the Patient Advice and Liaison Service meant that they had lost a valuable means of resolving problems quickly and getting help navigating their



# Accident and emergency

treatment and care. Little information about complaints was provided to staff. There was no analysis of trends or dissemination of learning that would help the service improve and prevent similar problems arising again.

## Are accident and emergency services well-led?

There is effective leadership at all levels of the service. The service is establishing governance mechanisms and ways to collect information, which will enhance its capability to further improve performance.

The trust established the emergency care and acute medicine clinical academic group (ECAM CAG) in October 2012 to provide clinician-led leadership of these services

across the trust. More recently the trust had strengthened leadership locally with the appointment of a clinical lead for Whipps Cross. Members of the ECAM CAG and other senior staff understood the challenges faced by A&E and the changes that needed to be made to ways of working and to the culture of the service to bring about improvements.

Nursing staff and healthcare support workers felt well supported through team meetings, briefings and one-to-one supervision. They said that their managers were approachable. Some staff expressed concern that opportunities for training and professional development had been reduced and that there was little on offer in addition to the core mandatory training provided by the trust.

# Medical care (including older people's care)

Safe	
Effective	
Caring	
Responsive	
Well-led	

## Information about the service

Whipps Cross University Hospital provides medical care to people on inpatient wards, some of which specialise in providing care and treatment to frail older people.

We spoke with patients and staff, including doctors, nurses, senior managers and support staff. We observed care and treatment and looked at care records. We received comments from our listening event and from people who contacted us to tell us about their experience. We also reviewed performance information about the trust.

## Summary of findings

Urgent action is needed to ensure that care is both safe and meets patients' needs.

We found staffing levels to be unsafe on some wards and identified some errors which could have led to harm to patients. On some wards there were not enough nurses to meet the needs of patients. The out-of-hours medical cover was inadequate and patients' needs were not always met. The trust is reconfiguring its staffing arrangements on the medical wards, but prompt action is required in the interim.

There was a lack of equipment on some wards.

There were delays in discharging patients, which had a significant impact on patients and other areas in the hospital, such as the surgical department and A&E. Some of these delays were not necessarily attributable to the hospital.

However, we did see examples of good practice. Staff were kind and caring towards patients. Patients were positive about the way staff had cared for them. Action had been taken to improve outcomes for patients. Staff were receiving intensive training on caring for older people.

Action had also been taken on the Warning Notice relating to supervision and appraisal of staff on two care of the elderly wards.

# Medical care (including older people's care)

## Are medical care services safe?

Medical care services were not always safe.

### Patient safety

We found that wards were working to reduce falls and they displayed up-to-date information about the number of falls that had occurred on each ward. There were falls assessments for patients on admission. Some wards had access to physiotherapy and occupational therapy staff to help with patients' rehabilitation.

We found the hospital worked well to reduce blood clots (venous thromboembolism or VTE). On a cardiology ward we found a protocol at the front of each patient's drug chart, which assessed the risk of VTE on admission and 24 hours after admission. It prompted medical staff to decide on the best course of prevention therapy. The ward audited VTEs every month. The rate of VTEs had been very low recently, which was attributed to the risk assessment process which had been in place for a year.

### Staffing

The lack of staff on some wards made them unsafe. We found band 5 nurses in charge of renal and care of the elderly wards. On a cardiology ward we found there had been a recent high level of cardiac arrests, and the most senior nurse was a band 5. On one ward, falls had occurred on five days in October. On four of these days the ward was understaffed due to sickness. The ward had been understaffed for a total of 10 days in October, as shifts had been difficult to fill using bank staff, which had affected its ability to prevent falls.

Another ward had a vacant ward manager position, although a recruitment process was underway. We found a lack of coordination on this ward had resulted in key elements of care being missed, such as poor documentation, incorrect information on forms and dangerous levels of paracetamol being mistakenly prescribed by doctors.

Out-of-hours medical cover for all medical services, including care of older people, comprised three doctors (a foundation year one doctor, a senior house officer and a specialist registrar). This meant that the doctors working evenings and weekends had to prioritise their workload on a risk basis, and there was no time to review patients who had been handed over to them on a Friday for review over

the weekend. There was no seven-day working for consultants. We found examples where one patient had a full fluid lung and another with a chest infection but no duty review had taken place over the weekend.

### Safeguarding

Safeguarding referrals had recently become an online process with referrals now sent to another site within the Barts Health group. The target time for a response from the time of referral was 24 hours, although meeting this target had not been measured as it was a new process.

### Equipment

Within older people's care, staff said that they had difficulties in finding bladder scanner machines, used to detect urinary retention and infection, which were shared between all the wards. This meant that staff spent time locating and retrieving it before they could use it to treat people effectively. We found this was also the situation at our inspection in June 2013.

There was a lack of ultra-low beds on care of the elderly wards, which would help staff to prevent falls. However, the hospital was able to respond swiftly to the need for pressure-relieving mattresses, as a supplier was located on site and provided these within hours of requests.

## Are medical care services effective? (for example, treatment is effective)

Services were effective.

### Staff skills

Whipps Cross was a national audit outlier for respiratory disease (British Thoracic Society national audit programme). Recent audits had not yet fed in to current statistics but showed adequate improvements in outcomes for patients. A senior nurse worked on improving outcomes for patients with respiratory conditions. This included carrying out training and supporting staff to implement individual asthma action plans, and implementing a checklist for chronic obstructive pulmonary disease (COPD) on discharge, inhaler technique and implementing a COPD care bundle across the hospital.

All the staff from each older people's care wards had, or were about to, participate in the Older People's Service Development Programme. This week-long training focused

# Medical care (including older people's care)

on key elements of caring, such as compassion, behaviour, making a difference and improving the patient experience. Staff were assessed before and after the course, to identify any development issues.

## Support for staff

The trust had taken action to address shortcomings in supporting its staff. The issues outlined in a Warning Notice from August 2013 had been met. Appropriate arrangements were now in place to support staff. We found that staff had received their annual appraisals. Team meetings were held regularly and additional support had been provided to ward managers generally.

## Are medical care services caring?

Patients experienced a caring service on medical wards.

We observed staff treating patients in a respectful and kind manner. Staff engaged well with patients on all medical wards, speaking to them appropriately and providing support. We saw instances where staff displayed compassion towards patients. In particular, care for patients with dementia was supportive and compassionate and took account of their condition and needs.

We saw that patients' privacy and dignity was maintained on all of the wards. Patients told us that staff respected them and maintained their privacy and dignity.

Patients consistently told us that they felt well cared for. They spoke highly of ward staff and told us they had great respect for the staff and the way they went about their work. However, patients told us that staff were constantly busy with tasks, which potentially risked the opportunity to spend quality time with patients.

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

People's needs were not being met and the quality of care being provided was inadequate in some instances.

## Responding to people's needs

On a respiratory ward we found that one nurse was doing a medication round while another was in a multidisciplinary meeting (discharge, progress, support) and that patients were not being turned every hour, as identified on

assessments. Monitoring paperwork had also not been completed. Rounds were made to check patients once, twice or three times an hour, depending on the staffing pressure of individual wards, rather than based on the needs of individual patients.

On one ward, staff were constantly being asked to work bank (overtime) shifts and we found that every shift had at least one bank or agency staff. Staff worked hard to meet people's essential care needs, but did not have enough time for some basic duties, such as talking to patients or repositioning them.

On one ward we found that some patients' mouth care had not been attended to, which had caused them discomfort. Relatives felt that they had provided care to patients that the nurses should have provided.

Patients told us that staff answered their call bell when they needed help and were responsive to their needs. However, some patients also told us that staff "generally missed the little things". People spoke about not having had a shower and missed shaving and being able to look after their hair. It was generally felt that there was less time for communication with patients and families to update them or ask them how they were getting on.

Patients told us that the newspapers trolley did not come up to some of the older people's wards and patients felt the pay television was expensive. This meant that people couldn't read a newspaper or watch television and therefore felt unoccupied.

We did not identify any instances of patients being supported to shower, even where wards were equipped with walk-in shower rooms. Patients were washed in bed and not given the option of a shower.

## Bed occupancy and discharge arrangements

Patients were not always discharged in a timely manner. Medical wards consistently reported to us that patient flow and discharge was negatively affected by the delay in processing and arranging continuing care placements for patients who could not go back home. Applications for continuing care were approved by a local authority funding panel, after which placements were selected. We were given examples where patients had been ready for discharge but the application process had been delayed. In

# Medical care (including older people's care)

some cases, patients had been waiting on medical wards for seven and 10 weeks. The pressure on bed numbers meant that some medical patients were being cared for as 'outlier patients' on surgical wards.

On a cardiology ward there was a weekend medical team (a house officer and consultant) who worked 9am to 5pm to enable weekend discharges. The team reviewed patients who had been identified for discharge and decided whether they were fit to go home. There was also a cardiology registrar available on call for advice. Apart from this, we found that seven-day working for consultants was not in place.

By contrast, we found that, where people had a prognosis of needing end of life care within three months, a 'fast track' process enabled funding and a care package to be arranged in a matter of days from the point of application.

We found a mixed picture when it came to patients being treated according to their individual identified need, which mostly depended on ward organisation and number of staff for each ward. On a cardiology ward and most care of the elderly wards, we found that essential elements such as

nutrition and pressure care were clearly documented and monitored. There were daily multidisciplinary reviews through a 'board round' where all patients' care was reviewed.

## Are medical care services well-led?

Leadership was lacking on some wards and at a senior level in addressing problems. There was a lack of leadership on some wards due to staffing shortages. This meant that some wards did not function as well as they could, which impacted on patient care. Senior management had not resolved some of the problems on the wards, such as a shortage of suitable staff and equipment, and these issues had been ongoing for some time.

Morale was low among staff at all levels. Staff were concerned about the planned changes to staffing levels and the impact these would have on patients. They were also concerned about access to management and escalation arrangements. Nursing staff felt supported by their direct line manager. They said that they did not feel supported by senior management or the trust management generally.

# Surgery

Safe	
Effective	
Caring	
Responsive	
Well-led	

## Information about the service

Whipps Cross Hospital has 12 theatres for surgery and these are supported by surgical wards. We visited the majority of these wards.

We spoke with patients and staff, including doctors, nurses, senior managers and support staff. We observed care and treatment and looked at care records. We received comments from our listening event and from people who contacted us to tell us about their experience. We also reviewed performance information about the trust.

## Summary of findings

Overall, surgical services were safe, effective and caring. However, some improvements needed to be made, particularly to the pre-admission ward arrangements. We saw evidence of safe surgical practice and good use of the World Health Organisation (WHO) surgery checklist, designed to prevent avoidable mistakes. Measures had been implemented to improve safety on the wards and there had been a reduction of incidents, such as patients falling. There were good arrangements in place to manage hospital infections and maintain hygiene.

Patients were very complimentary about staff and said that they were cared for well. Staff worked well together to assess patients' needs.

However, the organisation of pre-admission wards needed to be reviewed. The levels and skills of staff did not always meet people's needs and patients sometimes had to wait a long time on these wards.

A lack of available beds in the hospital impacted on surgical services. As a result, patients sometimes had to wait in recovery after surgery rather than be transferred to a ward. There were some medical patients on the surgical wards. Patients were not always discharged in a timely way and were not always involved in planning their discharge from hospital. Patients did not know how to make a complaint.

There was a lack of appropriate equipment (oxygen and suction) on some wards. Appropriate checks on emergency equipment were not always carried out.

Staff morale was low. Some staff said that, when they raised concerns about patient safety, they felt bullied

# Surgery

and fearful of raising further issues. There was some good leadership at a local level. However, staff were concerned about the effectiveness of the trust's governance system as a whole.

## Are surgery services safe?

Staffing levels on some wards and the lack of some essential equipment put patients at risk, although there was no evidence that patients had come to harm. Safety measures in theatres were effective. A good standard of hygiene was maintained. Overall, improvements are needed.

### Patient safety procedures

Patients were protected from avoidable harm during surgery. At our last inspection in June 2013, we found that the hospital had introduced measures to ensure that the WHO surgical checklist was used at every surgery. At this inspection, we found that the use of the WHO list had become embedded into practice on both the wards and theatres and we saw WHO checklists that had been satisfactorily completed. The WHO list was audited every month and the results fed back to the surgical teams. Staff were able to explain clearly how the WHO surgical checklist was used.

There had not been any 'never events' – serious, preventable patient safety incidents – relating to the use of the WHO checklist in 2013.

### Managing risks

We saw up-to-date patient safety information displayed on each ward visited. This information related to key risks, such as pressure ulcers, falls, hospital acquired infections, staffing levels and use of bank (overtime) staff. This information was provided as part of the trust's 'Because We Care' campaign. Staff were able to explain the campaign, how it affected patient safety and experience, and how it had been embedded into nursing practice since its introduction. On one ward, staff had signed a form to confirm that they had read and supported the campaign. However, not all nursing staff were familiar with the details of the campaign.

Staff told us about acting on safety alerts and learning from incidents. They explained how investigations into pressure ulcers had identified areas for improvement and had changed practice. Staff now discussed patient safety, including pressure ulcers, at daily and monthly meetings. We found that the management of the pressure ulcers we reviewed was appropriate.



# Surgery

Staff knew how to report incidents. However, one ward had a backlog of incident reports, dating back to September 2013, that had not been submitted.

## Hospital infections and hygiene

Patients were protected from the risk of infection. The hospital's rates for *Clostridium difficile* (*C. difficile*) and methicillin-resistant staphylococcus aureus (MRSA) were lower than expected. Staff were seen to adhere to good hand hygiene practice. There were sufficient alcohol hand-gel dispensers available throughout the theatres and wards. Wards were clean. We observed the cleaning of some medical equipment and found this to be satisfactory. Domestic staff maintained cleanliness throughout the day. Patients said that the wards appeared to be clean. Staff were able to explain how they kept wards clean and prevented infections.

## Staffing

On theatres, we found that there were enough suitably qualified and experience surgeons, anaesthetists and nurses to meet patients' needs. Surgical staffing was largely stable. Staff were mostly permanent and agency staff numbers were low. However, we noted that the trust is in the process of changing the nursing bandings on theatres. This is being undertaken after a comparative analysis of theatre nursing levels at other similar hospitals, with reference to national staffing guidance and a staff consultation. While we accept that the trust has assured itself that the evidence base for the changes is robust, there are risks associated with these changes, which we wish to bring to the trust's attention – such as the loss of experienced staff and low staff morale, which could have a negative impact on patients.

Some surgical wards were appropriately staffed. Others did not have enough staff on duty or staff lacked the necessary knowledge, skills and experience to ensure safe patient care. Some wards relied heavily on agency nurses, which impacted on the quality and continuity of care. On some wards, we found a relatively high number of unfilled shifts, meaning that the wards were short-staffed. The pre-admission surgical wards were open for longer than had been intended due to demand, and were reliant on agency staff. Patients reported long waits on these wards.

## Equipment

There was not enough equipment and this potentially put patients at risk. There was no bedside oxygen on one ward and staff relied on portable oxygen. On other wards, oxygen

flow meters were not always available at the bedside. One ward did not have suction equipment. Some wards caring for patients with tracheostomies shared suction equipment. High vacuum suction pumps were found at suction points designed for cavity suction. On one ward, broken suction equipment was not taken out of use. Staff said that they had difficulties in finding bladder scanner machines. Resuscitation trolleys on the wards were supposed to be checked every day in line with the trust's policy. We found that, although checks were regular, they were not made daily. Some trolleys did not have essential resuscitation equipment for several days. Staff on the pre-admission wards had not been trained to use emergency equipment (a defibrillator), which also put patients at risk.

## Patient records

We found some inconsistencies in the way hourly rounds were recorded in patients' notes on some wards. We found that the confidentiality of patients' records was compromised in two instances on two different wards.

## Are surgery services effective? (for example, treatment is effective)

Overall, surgical services were effective.

## Collaborative working

We found that staff collaborated well in multidisciplinary teams on the wards. We observed a multidisciplinary meeting where patients' discharge arrangements were discussed. There were effective arrangements to identify the actions that needed to be taken to ensure that patients were discharged from hospital as soon as possible. The findings from meetings are disseminated to the wards for action. We reviewed the discharge arrangements for five patients who were due to be discharged on the day of the inspection. Four were completed quickly, while one was delayed until the next day, although this was due to the need for an increased care package.

## Audits

We saw evidence of high-impact intervention audits relating to catheters, venflons, central lines, hand washing and methicillin-resistant staphylococcus aureus (MRSA) screening. The results of the audits were fed back to staff so they could improve the quality of the care being provided.



# Surgery

## Are surgery services caring?

Staff in the surgical department provided a caring service.

The majority of patients said they were impressed by the caring attitude of nursing staff and felt they were being well cared for. One patient said that the nurses had been “lovely.” Another had been “really impressed” and thought the nurses were “friendly...I can’t fault them at all”. Most patients said that communication with staff was good, although some patients said that there were occasionally language barriers.

## Patients’ privacy and rights

Patients’ privacy and dignity were maintained. We saw respectful interactions between staff and patients in recovery bays and on the surgical wards. Staff used quiet voices where necessary. Curtains were drawn around beds when necessary. Patients said that staff spoke to them in a respectful way and that their privacy and dignity were respected.

## Food and drink

Patients had adequate nutrition and hydration and, where appropriate, most patients were helped to eat. Patients were given drinks and snacks throughout the day. Protected meal times were in place on the surgical wards to enable patients to eat uninterrupted and be supported to eat if necessary. On one ward in particular, there was a system in place to check that patients needing help were supported to eat. However, on one ward we found that people were not being helped when required. Most patients were satisfied with the food, although few patients were aware that there was an option to order something to eat that was not on the menu.

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

Patients’ needs were not always met and improvements are needed.

## Patient feedback and complaints

We saw evidence that feedback from patient questionnaires had altered practice on several wards. Completion rates of the NHS Friends and Family Test was increasing, although the results were yet to be reflected in patient care.

Some patients were unaware of the Patient Advice and Liaison Service, which gives patients information and helps them with complaints, or they found that the hospital’s on-site office had closed. There was a number for patients to call, although when we tried, we were unable to get through.

Many patients said that they did not know how to make a complaint and there was little or no information displayed on the wards about the complaints process. The trust had produced a new complaints leaflet (dated October 2013), although this had not been widely distributed.

## Responding to patients’ needs

In theatres and on some wards, we found staffing levels to be satisfactory and people’s needs were being met. We looked at medical records and made observations on the wards to check this.

People said that call bells were answered promptly. However, on some wards, staffing levels were either just sufficient to perform necessary tasks or, in some cases, insufficient to meet people’s needs. One member of staff said that, with the staffing levels, “we’ve made it hard to care.” Some patients felt that their medical needs were being met, but that staff were too busy to spend quality time with them. Patients reported long waits on the pre-admission wards (Hope and Poplar). There were 15 patients with medical needs on surgical wards (‘outlier’ patients). While their needs were being met, these wards were not the most suitable environment for these patients.

## Bed occupancy

Even though people were safe and cared for well, some patients were waiting too long in the recovery area before being admitted to a bed in a ward. One patient had stayed overnight in the recovery area before being admitted to a ward. Surgery planning meetings were held two weeks in advance of operations to prevent avoidable cancellations. However, operations were sometimes cancelled or delayed because of a lack of beds within the hospital.

There was an established system in place to review bed occupancy in the hospital on an on-going basis. Bed

# Surgery

occupancy meetings were held several times a day to review the number of beds available, the patients who needed a bed and the patients who were due to be discharged. However, there were systemic problems that these meetings could not easily resolve. There were insufficient beds for patients. There were 15 medical patients on surgical wards. A temporary overflow ward was now open permanently. Patients were not always discharged promptly. This was partly due to delays in the discharge system and the wait for social care packages.

This constant pressure on bed numbers had a negative effect on patients' experiences and the quality of care. We reported on this situation following our last inspection in June 2013. The situation had not improved.

## Patient involvement in care

While some patients said they had been involved in planning their discharge, a number said that they had not been involved and that the discharge process sometimes seemed disjointed. Some patients reported that they had not had any discussions about being discharged, despite having been in hospital for some time.

## Are surgery services well-led?

While some wards were well-led and there was some good leadership at a local level, there were concerns about the trust's governance system overall and issues with low staff morale.

## Governance and leadership

Staff spoke of a governance structure that had become complex. They said that it was difficult to know who to raise issues with and, when they did know, sometimes no action was taken. Staff felt that local innovation was being stifled and that things were being driven from the centre of the

organisation. Shortly before our inspection, the trust had strengthened the role of the site lead to address some of these issues. It is too early to determine whether this will have an impact.

Some senior surgical staff felt that there was a significant disconnect between the views of the leadership and the views of clinicians on what was in patients' best interests. Clinicians were concerned that the decisions of the leadership team would have a detrimental impact on the quality and safety of patient care.

On the theatres and the wards, staff felt that the surgical CAG and hospital nursing leaders were visible and accessible. They also felt that communication was good between these leaders and staff.

Some patients knew who the sister was on these wards. The sister had personally introduced themselves to staff. Patients felt that, on some wards, the nursing teams were well-led by the sisters. Some surgical wards were working effectively and were well-led. Other wards were not working as effectively, partly due to their leadership.

Staff morale was very low. Staff across all specialties were concerned about the staffing review and that experienced staff will leave, having a negative impact on the quality of patient care.

We received many comments about bullying and a lack of an open culture. Staff said they felt bullied by the organisation, particularly where changes to services and/or staffing levels were being implemented. Some people felt afraid to discuss their concerns with the organisation – in some instances about patient safety – for fear of reprisals. Staff felt that they had no voice. They said they used to identify problems and find solutions, but following the merger, they no longer did this.

# Intensive/critical care

Safe

Effective

Caring

Responsive

Well-led

## Information about the service

The critical care service at Whipps Cross University Hospital has a nine-bed intensive care unit (ICU). Two beds are for level-two patients and seven beds are for level-three patients. The hospital does not have a high dependency unit (HDU).

We spoke with staff, including doctors, nurses, senior managers and support staff. We observed care and treatment and looked at care records.

## Summary of findings

Overall, this was a safe, caring, effective and well-led service. Infection control was managed appropriately. There were enough appropriately qualified staff on duty. There was good education support and the unit learned from incidents and applied best practice guidelines. There were systems in place to monitor quality and safety. However, there were some delays to patients being transferred into and out of ICU and occasional single-sex ward breaches, although this was due to the shortage of available beds in the hospital.

# Intensive/critical care

## Are intensive/critical services safe?

The service was focused on safety.

### Patient safety and managing risks

An ICU consultant was the patient safety lead. Serious incidents in the unit were discussed at a hospital patient safety group where, if the incident was serious enough, a root cause analysis and action plan would be developed. Incidents were also discussed at team and unit meetings. Staff explained how they reviewed incidents to improve practice. One example was the prevention of pressure ulcers on patients' noses caused by ventilation masks. Staff used a chart to record the treatment plans and prevention and care observations. As a result, we were told that there had been none of this type of pressure ulcer for some years.

### Hospital infections and hygiene

Patients were protected from the risk of infection. There were appropriate infection control systems in place. The microbiology team visited the unit every day. Guidelines were followed on controlling or minimising the risk to patients from the bacteria *Pseudomonas aeruginosa* to reduce the risk of infection. There were appropriate arrangements for patients admitted to the unit with an infection. The unit looked clean. Hand hygiene facilities were available and we observed staff following infection control guidelines, which were checked for compliance by an infection control link nurse. Appropriate facilities were in place for handling clinical waste.

### Staffing and skills

There were enough appropriately qualified staff to meet patients' needs, including sufficient consultant cover. Nursing staffing levels were in line with national and best practice guidance. The unit had a full-time clinical educator to support its training programme, which was mostly in-house to meet its training needs and to support bedside training. Training attendance rates were 95%.

### Equipment

Some essential equipment was out of use. The ICU had two ventilator trolleys: one had not been working for over six months, leaving the unit reliant on one trolley to transfer patients to the general wards. Staff had raised this issue with senior management and it was on the hospital's risk register, categorised as high. However, no prompt action had been taken and the information on the risk register

was out of date. The arrangements to manage if the trolley was out of use or broken were inadequate. The lack of this essential equipment could have a potentially serious impact on patients.

## Are intensive/critical services effective? (for example, treatment is effective)

The service is effective.

The ICU took part in the Intensive Care National Audit & Research Centre (ICNARC) national audit programme. The ICNARC data highlighted that patient mortality was above average, although the hospital is not an outlier. Unit-acquired MRSA infections were similar to other hospitals, as were non-clinical patient transfers and delayed discharges. Out-of-hours discharges to the ward were much lower than other hospitals. However, unplanned readmissions to the unit within 48 hours were higher than many similar hospitals. The unit had an audit office to support this process.

## Are intensive/critical services caring?

This was a caring service, suitable to the needs of patients requiring critical care.

### Patients' privacy and dignity

Staff were observed to be caring. The atmosphere on the unit was quiet, calm and purposeful. Staff were focused on the patients in the unit. Patients were positioned comfortably. They looked clean and well kept. Their bedclothes were clean and well ordered.

### Patients' rights

The unit had a restraint policy which had been developed in consultation with vulnerable adults and senior nursing, legal and governance teams. The policy considers the ways in which patients can be lawfully and appropriately restrained from removing life-saving equipment – such as the use of mittens, wrist restraints, and medicinal restraints. We observed one patient unconsciously trying to remove their tracheotomy tube. Staff were attending to the patient, but the mittens helped prevent the patient taking out the tube.

# Intensive/critical care

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

While services generally responded to patients' needs, the high demand for hospital beds, and the lack of a high dependency unit (HDU) meant that waiting times and bed transfer times were sometimes inadequate.

### Responding to patients' needs

Patients' welfare was regularly monitored to ensure that changes were responded to in a timely manner. Staff used a daily treatment record to complete all essential checks and observations and to record them in one place. This also provided an efficient way for staff coming on duty to see what had occurred during the last shift. The unit had implemented 'The Golden Hour', where, in the first hour of duty, staff were allowed to concentrate on handover and on completing and signing the shift checklist. This included checking the monitor alarms and other equipment, checking the patient's identification band against notes, reviewing wound and other documentation, damp dusting the bed area, shelves, trolleys and pumps, checking the clinical waste and completing a moving and handling assessment. We saw various care bundles in use on the unit, including bowel, central venous pressure (CVP) lines, spinal care, and palliative care.

The hospital does not have a high dependency unit (HDU). This means that there is a big impact on patients who are transferred from ICU to the wards. The trust has reviewed a business case for a HDU, although it has not been implemented. The trust should ensure that it is satisfied with its justification for not having a HDU.

### Bed occupancy

There were systems in place to monitor the demand for ICU beds and ensure that patients were discharged appropriately. However, the pressure on beds in the hospital impacted on the unit's ability to accept and discharge patients in a timely manner. A site coordinator moves patients to the wards following a decision to transfer out of ICU. The coordinator tries not to move patients from ICU after 8pm. The site coordinator monitored the capacity of external neighbouring hospitals' ICUs so that they can be aware of any potential surges into the emergency department and ICU.

ICU bed occupancy and throughput was high. Where possible, elective patients were allocated a bed in ICU before their operation. However, because of the demand for beds at the hospital, patients sometimes had to remain in the recovery area after their surgery for prolonged periods until ICU beds became available. We also found a female patient who had been waiting for more than 36 hours on ICU for a surgical bed. This had been classified as an unjustified mixed-sex breach and was nationally reportable. The hospital incurred penalty charges as a result.

### Quality care and treatment

The unit took action to improve the quality of treatment. We saw various examples of innovative practice and improvements to patient care. We were given an example of a patient who had airway abnormalities, which had made it difficult to intubate. Staff from all over the hospital had been brought in to help achieve the intubation. A debriefing was held afterwards, examining how to respond to a similar situation in the future.

## Are intensive/critical services well-led?

The unit was well-led, although we identified issues with the trust's clinical governance systems.

### Leadership

We saw evidence of leadership and innovation on the unit. There were clear lines of responsibility and definition of roles. However, some staff reported that, when they needed leadership from the trust, they did not always know who to go to and felt it was difficult to get things done.

### Managing quality and performance

There were systems in place to monitor the safety and quality of care and action was taken to address concerns. There was a comprehensive audit programme and evidence of action taken on the results of audits. There were monthly ICU clinical governance and critical care meetings across three hospitals (Whipps Cross, Royal London and Newham). The critical care group shared ways of doing things, for example, dealing with out-of-hours patient discharge and practice in accordance with National Institute for Health and Care Excellence (NICE) and Intensive Care Society guidelines. However, it was felt that this group could be more effective.

# Maternity and family planning

Safe

Effective

Caring

Responsive

Well-led

## Information about the service

Whipps Cross maternity service delivers more than 5,000 babies annually. The maternity services include an antenatal clinic with nine consulting rooms, a 40-bed antenatal and postnatal ward, including four transitional care cots, a labour ward and a triage area. The site includes a special care baby unit (SCBU) with capacity for 18 cots. The SCBU is a level 2 unit, which means that it has the capabilities to care for 27 week-old newborn infants who are at least 1kg at birth.

We spoke to 16 women, four partners and 40 staff, including midwifery assistants, nursery nurses, midwives, nurses, doctors, consultants and senior managers. We observed care and looked at the records of 12 women and babies. We reviewed comments from our listening event, from comment cards left at the hospital reception and from people who contacted us to tell us about their experiences. We reviewed performance information about the trust from internal and external sources and compared it against national guidelines.

## Summary of findings

We saw that improvements had been made in the maternity department, but further progress was needed. The service was clean, which was not the case at our last visit in June 2013. Reporting of faulty equipment and checking of resuscitation equipment had also improved since our last visit. However, other equipment was found to be faulty and there was still a need to improve the availability of safe equipment. The service had enhanced the way it learned from incidents and this should continue so that the changes are embedded. Women said that they felt staff cared for them well, although on occasions security staff were discourteous. Staffing levels were appropriate and there was sufficient consultant cover, although some staff said that there were times when they were stretched and could not provide one-to-one care to women in established labour. We found that the maternity service did not always respond to people's complaints in a timely manner. Although systems were in place for reporting and reviewing incidents, we did not always see evidence that appropriate action was taken. The risk register and meeting minutes we reviewed did not always demonstrate the sequence of actions taken to minimise the risk. Staff told us that current changes to the staffing structure were affecting morale and left some staff feeling undervalued.



# Maternity and family planning

## Are maternity and family planning services safe?

Patient safety in the maternity service had improved since our last inspection, but further progress was needed. Enhancements were possible, especially regarding equipment, site security and addressing potential risks. Staffing continued to be an area that could potentially create risks to patient safety and welfare.

### Patient welfare and safety

There were procedures in place to assess and manage risks to women or their unborn child at their antenatal appointments. These included both health and social risks, such as diabetes or their vulnerability to abuse. An audit conducted in July 2013 showed that the pathway for women before 18 weeks was not always followed consistently.

There were systems in place to deal with medical emergencies. The service used the Neonatal Early Warning Score (NEWS) to identify and escalate any deterioration. Staff had been trained how to use NEWS and in resuscitation. There were two unexpected admissions to SCBU in October 2013 and these cases were monitored to ensure that causes could be dealt with in the future.

### Equipment

Systems to ensure that essential equipment was available had improved, although further progress is required. At a previous CQC inspection in June 2013, concerns were raised about faulty equipment. During this visit we found that resuscitation checklist audits showed an improvement in adhering to daily resuscitation equipment checks. However, in October there were five incidents relating to parts missing from equipment, failure to check emergency equipment and equipment being inadequate or unavailable. Two people using the service said that there had been faulty cardiotocography equipment during their hospital stay between August and September 2013.

During an unannounced visit we also found that the umbilical cord blood analysis machine on the labour ward was not working. It had been reported and fixed several times. However on 22 November 2013, staff were running upstairs with blood samples to ensure that vital tests could

be completed before the samples clotted. This matter needed to be addressed to ensure monitoring equipment was fit for use and that a blood analysis machine was easily accessible to labour ward staff at all times.

### Safeguarding

Staff demonstrated knowledge on how and where to report safeguarding issues. We spoke to named safeguarding leads for the maternity unit and the SCBU. The safeguarding leads liaised with the women, family, health visitor and other relevant agencies to ensure safe antenatal care and safe discharges. Staff told us they had attended safeguarding training. We saw a training matrix on the SCBU, showing that over 60% of the nursing staff had completed training for safeguarding vulnerable children.

We were told that there is work to improve cross-sector working between local authority, primary care and maternity teams to identify vulnerable families during antenatal care and to minimise any unnecessary delay in processes after birth, which can affect the woman and/or baby's length of stay.

There were security risks at the maternity unit entrance. Although a security guard was in attendance, checks to ensure visitors signed in and out upon entry and exit were inconsistent. We observed several instances over the three days of our visit where visitors entered without signing in and were allowed to leave without proper security checks. During an unannounced visit we observed the reception area for 40 minutes. The security guard failed to ensure that all visitors to the unit signed in.

### Managing risk

The hospital was learning from mistakes, but there were improvements to be made. Staff could describe the system for reporting incidents. They felt lessons to be learned from incidents were disseminated well by management. Monthly "hot topic" newsletters were displayed and included details of incidents and any subsequent changes to policies and procedures. Security issues had been identified as a risk on the maternity risk register. We also found that the way the midwife rota system was configured was difficult to understand and did not always reflect if staff had been moved to other maternity departments.

# Maternity and family planning

The trust had identified that delays in the induction of labour was a contributory factor in some cases leading to high caesarean section rates. A redesign of the induction of labour suite was due to be completed by September 2013, although this was yet to be implemented.

## Infection control

Patients were protected from the risk of infection. At a previous inspection, concerns were raised about the cleanliness of the environment. On this visit, the premises were clean. Clinical waste bins were not overfilled and communal facilities were visibly clean. Cleaning schedules and cleaning audits were completed and showed improvement. We observed staff using hand gel before and after patient care. Hand gels were available and hand gel dispensers were working properly, which was not the case at the last CQC visit. However, during our 40 minute observation of the maternity main entrance, we saw some staff leaving the premises wearing theatre scrubs but no covering protective overalls.

## Staffing levels

On occasions, staffing levels did not meet the needs of patients. At the time of our inspection there were sufficient numbers of staff to meet the needs of women on the unit. The midwife-to-birth ratio was one midwife for every 32 births, which was higher than the national guideline of 1:28 but within the trust's target. We reviewed midwifery and medical staff rotas and found that the rotas corresponded with the hospital's establishment most of the time. Consultants were available on the labour ward 60 hours a week, including weekends, as recommended by the Royal College of Obstetricians and Gynaecologists. Nursing staff told us that weekends were difficult as there was reduced cover on the SCBU.

According to the performance report for October 2013, there were only six workload-related incidents or understaffing issues recorded. However, staff seemed to think this happened more than reported. We were told that the procedure to book bank (overtime) staff took too long and sometimes resulted in shifts remaining unfilled. Women who shared their experience with us also highlighted that they had waited for a midwife to attend to them during labour and were left alone for lengthy periods. It will be useful for the provider to note that the rotas were

not always amended when staff moved to other departments. We also saw that, on the night shift of 6 November 2013, there were more staff on duty than required by the trust.

There were two obstetric theatres. However, only one was used due to staffing issues. Staff told us that if a patient required an emergency caesarean section, it was difficult to get staff to enable a second theatre to operate. This was a potential risk to patient safety.

## Are maternity and family planning services effective? (for example, treatment is effective)

The maternity service at Whipps Cross provided effective treatment to the majority of women using the service. Where there had been shortcomings in care, the service had identified risks and was in the process of responding to them. However, changes to staffing structures were impacting on the ability of staff to consistently provide effective care.

## Benchmarking and national guidelines

The service's mortality rates were within expected ranges. The service's caesarean-section rate was 27.02%, higher than the national average. The trust had identified links between failed induction of labour and the unplanned caesarean section rate, and the service was in the process of redesigning induction of labour suites to address this. Although it had been planned to open in September, the new suite was not yet in operation at the time of the inspection.

We saw that there were up-to-date policies and protocols which were available to staff on the trust's intranet. However, staff told us that they could not always access a computer and showed us printed guidelines which did not always correspond with the online guidelines.

There was a programme of clinical audit to ensure the service was providing effective care. The outcomes of these audits were shared with staff and training was provided where necessary for the SCBU. However, staff were not able to explain whether the recommendations resulting from an audit of the gynaecology pathway for hemiparesis in July 2013 had been implemented.



# Maternity and family planning

## Collaborative working

Staff collaborated with each other in the interests of patients. We observed a staff handover on the labour ward and postnatal ward. On the labour ward, handover was attended by consultants and doctors in addition to the midwives. The SCBU and maternity service, including fetal medicine, worked closely together to ensure that any potential admissions to the SCBU were identified as earlier as possible.

## Staff skills

There were enough appropriately trained staff to meet patients' needs. Midwives had statutory supervision of their practice and met a supervisor of midwives formally every year. They could approach the supervisor of midwives for advice. We were told that 14 midwives had attended a critical care course and the service aimed to enable at least one midwife on the labour ward to attend the course annually to improve critical care skills. Staff working on the SCBU were all up to date with mandatory training. Appraisals were almost completed and there were clear developmental plans for each staff member. We reviewed rotas dated between August and October 2013 and found a good skills mix. There were plans in place to start a rotational programme across the site to enable staff to gain varied experience.

## IT and administrative support

Some staff told us the service's IT systems were being changed in line with the rest of Barts Health NHS Trust and an IT consultant had been contracted on a sessional basis to support this process. They sometimes had problems with accessing IT and administration staff were undergoing training. As there was to be a reduction in administrative support, midwives felt they would spend more time on administrative tasks which would affect their ability to provide effective care.

### Are maternity and family planning services caring?

Most women told us they felt they had been well cared for. We reviewed comment cards, completed by women during our visit, and found that most had a positive experience. There was some negative feedback about the care for women who had emergency caesarean sections as they felt they did not always know what was happening and became more anxious when they saw staff rushing them to

theatre. While most people were positive about the attitude of staff, four women we spoke with told us they had been waiting for discharge but had not been kept informed.

We spoke to some parents whose baby was being cared for in the SCBU. They were satisfied with the quality of care being provided. We saw rooming-in facilities for parents to use to gain more confidence in caring for their baby before discharge.

However, we heard the security staff at reception speak to members of the public discourteously.

## Privacy and dignity

Women's privacy and dignity were maintained most of the time. We observed staff speaking to women and their partners in a compassionate and professional manner. Delivery rooms on the labour ward had en suite toilet and shower facilities. The antenatal and postnatal wards had a mixture of shared bays and private rooms. On the antenatal clinic, doors were kept closed during consultation, with the exception of one episode where a midwife was giving advice loudly while the door on the staff side of the consulting rooms was kept open.

There were systems in place to provide psychological support, including a bereavement service. There were two dedicated rooms for bereaved families where people could spend the night if they wished and a separate room in the scanning department which could be used to break bad news.

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

Improvements were needed to ensure that services were responsive to women's needs.

## Accessible services

Women felt that their needs had been met at each stage of their pregnancy. A home-birth service was available, which was provided by the community midwife team. However, the team told us that they were struggling to cope as their hours and working arrangements had been changed. This meant that women had to wait for long periods before a second midwife arrived to assist with a home birth.

# Maternity and family planning

## Accessible information

Women were provided with sufficient information about their care and the service. Women kept their medical notes in relation to their pregnancy up until they delivered their baby. We saw that their antenatal notes included information on who to contact if they were concerned about anything. There was a range of information leaflets available on various topics, including tests, breastfeeding and stopping smoking. Women were given a pack when they attended antenatal clinic which also included information such as posture and antenatal classes. Although all information was in English, staff told us they used Language Line document translators and the pictures in the leaflets to bridge language barriers. It would be useful for the provider to note that the packs were of a poor photocopy quality and contained information relating to legacy sites.

## Continuity of care

Women did not always receive a continuity of care. We found that, for twin pregnancies and women who had medical conditions which prevented them from having a normal birth, there was a lack of continuity of care. This was because women saw the midwife at booking and then were cared by the obstetrician without any midwife input. It would be useful for the provider to note that continuity was also an issue for women from outside the borough, as it meant that they saw their local midwife after the birth but saw the hospital antenatal team before birth.

Women who had twin pregnancies and women with medical conditions told us that they did not experience continuity of care and did not have information or a discussion about choices such as mode of birth, breastfeeding or parenting during pregnancy. This was because although they had first booked with a midwife in the community, once they were referred onto a 'complex' pathway they were cared for a team at the hospital led by an obstetrician and would not have any contact with the community maternity team until after the birth. It would be useful for the provider to note that continuity was also an issue for women from outside the borough as they also saw the hospital team during pregnancy and their local midwife after birth.

## Patients' feedback and complaints

Patients' experiences and complaints were used to improve the service and the effectiveness of treatment, although improvements were needed. The trust was in the

process of using women's experiences of care to improve the service through patient surveys, complaints and comments. The 'Great Expectations' programme was launched in August 2013 to improve women's experiences. We reviewed four staff files on the labour ward and saw evidence of how the matrons had attempted to address poor staff attitudes towards the women and colleagues. It would be useful for the provider to note that not all staff were aware of this programme.

It was concerning to note that the trust was not working in partnership with the Maternity Services Liaison Committee (MSLC). The MSLC had not been consulted or involved in the Great Expectations Programme or any other initiatives to respond to and improve women's experiences.

Staff were able to explain the complaints policy and procedure but could not always show us where complaints leaflets were kept. Staff told us that, if someone made a verbal complaint, they would attempt to resolve this at the time. All complaints were escalated to the ward manager or matron.

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

The service was mostly well-led, but there were issues to address to ensure that leadership and working across all hospitals in the trust contributed to better services for patients.

Changes to the staffing structure were causing anxieties among staff at all levels. They felt supported to a certain extent. However, the hospital needed to involve staff at all levels to a greater degree in the proposed changes.

## Leadership

The leadership of the maternity department was evolving. There was a new head of midwifery post for the hospital, and they had had four different people in this post over the last 18 months. We found that there were champions (or staff who were passionate about aspects of care) for areas such as breastfeeding and fetal medicine. However, there seemed to be no clear structure in place in order to allow for continuity in the absence of the named lead.

Some staff across all disciplines were anxious about proposed staffing changes and were uncertain of how the governance structure would work. Other staff felt that there was a lack of consultation or staff involvement regarding

# Maternity and family planning

proposed changes. They reported that messages were shared with staff once decisions had already been made by senior management. Another group felt that Whipps Cross was told what to do by Barts Health without any explanation. Integration and joint working across sites was still fragmented.

Some staff told us that any concerns they raised were not always dealt with but others felt the opposite. Some staff felt victimised for speaking out about poor care. Others said they were told not to say much at the CQC inspection or felt that, if they told us anything negative, they would be victimised.

## **Managing quality and performance**

Quality of care and safety was monitored using monthly performance dashboards – an online performance reporting and tracking system. The dashboard showed (at

31 August 2013) low rates of natural birth at 57%, while caesarean-section rates were slightly high at 27.02%. Only 93.8% of venous thromboembolism (VTE) – blood clot assessments were completed within 24 hours of admission (95% was the benchmark).

It was difficult to establish whether lessons were learned from incidents as root cause analyses following incidents were not made available to us. Staff received a newsletter covering ‘hot topics’ to ensure that they were aware of the latest incidents, although this had only recently been introduced. However, for the SCBU, there was evidence that the neonatal governance dashboard was reviewed by senior staff. They were aware of the top five risks on the risk register and what action was being taken. Senior staff went back to the wards on ‘clinical Fridays’ to observe and evaluate care.

# Services for children & young people

Safe

Effective

Caring

Responsive

Well-led

## Information about the service

Whipps Cross University Hospital provides medical and surgical services for children on an unplanned and planned attendance. This includes a general inpatient service, medical and surgical day case services and a dedicated 24-hour children's A&E service.

A&E facilities provide a five-bed children's observation bay, four children's treatment rooms and a children's resuscitation bay allocated within the main A&E resuscitation area. A designated children's ward accommodates 27 inpatient beds (16 cubicles and 11 bays), a 10-bed day case surgery unit and a four-bed medical day case unit.

We spoke with patients and staff, including doctors, nurses, senior managers and support staff. We observed care and treatment and looked at care records. We also reviewed performance information about the trust.

## Summary of findings

Overall, children's care at Whipps Cross was caring, effective and well-led. However, there were some issues around equipment checks, record-keeping and communication with families.

Parents and children were generally happy with the care they had received and felt they had been supported by caring and considerate staff. There were systems in place to ensure patients' safety and minimise risks in relation to medication management, although the effectiveness of the measures in place had yet to be determined. Equipment checks of resuscitation trolleys and records of medication expiry dates were not consistently completed. Children's care and treatment was monitored through participation in local and national clinical effectiveness audits. Facilities were appropriate to provide holistic care to children and young people, including developmental play and educational support.

Communication and information provided to families was not always responsive to their needs.

# Services for children & young people

## Are services for children & young people safe?

Services were mostly safe, but some improvements were required.

### Staffing

There were enough trained staff to meet patients' needs. There was a dedicated team of paediatric trained nurses on the children's ward. Current nursing staff levels met national guidelines. Consistent agency staff were used to fill any gaps in rotas. Nursing staff numbers were increased during winter months in children's A&E with an additional two posts for part of the night-shift period. Some A&E nursing staff raised concerns about being under pressure when gaps in the rota could not be filled or when the department was busy. Medical staffing in A&E included paediatric consultant cover during the day and on-call support out of hours.

### Safeguarding children

Staff were trained in safeguarding children and had good links with the trust's designated safeguarding team. Supervision sessions were conducted by the safeguarding team to provide staff a platform for reflective learning from reported safeguarding incidents. Staff we spoke with were familiar with the escalation and reporting process if safeguarding concerns were suspected. The patient administration system automatically notified staff if a child was on the child protection register.

### Medication risk management

Systems were in place to identify medication prescribing errors. A designated paediatric pharmacist provided daily specialist input and support. This included clinical checks of medication charts. However, we noted a medication prescribing frequency error that appeared not to have been identified through the system check process. We brought this to the attention of clinical staff.

A teaching programme for junior doctors about children's medication prescribing had recently been initiated. This was to include 'before and after' audits of medication prescribing errors to monitor training effectiveness. Outcome data had yet to be collated. Training records demonstrated that nursing staff were required to pass medication competency assessment tests.

There were inconsistencies in the monitoring of medications. We saw that reconstitution dates of medical suspensions were recorded on bottles stored in the fridge on the children's ward. This meant that expiry dates could be monitored to ensure medication efficacy. In contrast, monitoring records did not appear to be consistently maintained in children's A&E. We observed that medication expiry checklists reported to be completed monthly had not been recorded on five occasions between February 2013 and October 2013.

### Equipment

Equipment checks were not always consistently monitored or documented in all areas. Staff on the children's ward reported that the resuscitation trolley was checked at least daily but we did not see documentation to support this. Missed checks or incomplete records were also noted on daily resuscitation trolley checklists in children's A&E. The checklist approach did not make it easy to identify if corrective actions had been taken to address any deficiencies found.

### Hygiene and environment

The children's wards and the A&E department were visibly clean. We observed examples of good hand hygiene and infection control procedures. We saw staff cleaning clinical areas including beneath the beds and patient bathrooms in accordance with cleaning schedules. Single-occupancy rooms were available for children who required barrier nursing. Disposable bedside curtains were in use and dated. Monthly infection control audit records for the department demonstrated high standards of cleanliness.

## Are services for children & young people effective? (for example, treatment is effective)

Overall, children's services were effective.

### Clinical management and guidelines

Children's care and treatment was monitored. We saw that the paediatric clinical audit programme for 2013/14 was regularly updated in line with National Institute for Health and Care Excellence (NICE) professional guidelines. Records demonstrated that Children's A&E participated in a number of College of Emergency Medicine (CEM) clinical effectiveness audits, which measured the department against national standards. The Paediatric Early Warning

# Services for children & young people

Score (PEWS) system was used in the assessment and monitoring of children in A&E. An internal audit by the department to assess compliance with PEWS guidelines had been carried out in May 2013.

## Are services for children & young people caring?

Overall, children were well cared for by staff.

### Patient feedback

Most of the families and children we spoke with told us that they had been supported by caring and considerate staff and that they felt well looked after. Comments included: “Well looked after”; “Very well cared for and informed”; and “Hundred per cent happy”.

### Support for children and their families

We observed many examples of compassionate and sensitive care from staff at all levels. Medical staff interacted with children and explained treatment processes at an age-appropriate level. Pre-admission clinics to prepare children and families for planned surgery were operated weekly. Facilities were available to allow parents to stay overnight with their children on the inpatient ward and parents were allowed to stay in the anaesthetic room when their child was taken to theatre. Provision was made to assist people with concessionary car parking charges when children were admitted as inpatients and when children’s A&E waiting lengths were prolonged.

### Food and drink

Food and drink was provided to children attending A&E when needed and was available day and night.

Children had adequate nutrition and hydration, but some children went without food for a long time while waiting for an operation. We observed lunchtime meals being served on the inpatient ward. A limited menu was available, including alternative options to meet specific dietary requirements and cultural needs. Some parents expressed concerns about the length of time their children had food and drink withdrawn when theatre lists were delayed.

### Bereavement

Effective bereavement arrangements were in place. The hospital had a bereavement care policy and pathway to support families in the event of a child’s death. Clear guidelines were documented for staff to

follow with a checklist of actions to take. Bereavement support information and details of support services for parents and siblings were provided at the point of need. Private rooms were available for bereaved families to use. The trust’s chaplaincy service accommodated all faiths and was accessible day and night.

## Are services for children & young people responsive to people’s needs? (for example, to feedback?)

Improvements are needed to ensure that staff and services are responsive to children’s needs.

### Assessment and care plans

Children were not always monitored. Children on the inpatient ward were assessed regularly by the medical team to update management plans according to progress. Nursing teams completed care plan documentation on admission to the ward, which was maintained during the patient’s stay. Nursing staff used an age-appropriate pain management guidance system. A young person we spoke with on the inpatient ward described being in pain after a tonsillectomy. We noted that pain score assessments had not been recorded for this patient and pain relief had not been given as prescribed. We raised this with clinical staff. Other parents and children we spoke with on the day surgery unit reported to be happy with their child’s clinical management. They told us that nursing staff had checked their child’s temperature, blood pressure, pain relief and nutritional needs.

### Transition

Arrangements were in place for the transfer of critically ill children to specialist paediatric specialist centres by the Children’s Acute Transport Service (CATS).

### Communication and information

Information for families in the urgent care assessment unit was inadequate and led to confusion and anxiety. On arrival, patients were given coloured cards that triaged people to either children’s A&E or a GP-led service. This led to confusion as red cards used to stream patients to children’s A&E were interpreted by some people to indicate urgent priority. One parent told us, “We had to wait 30 minutes despite the red card and had to make a fuss to be seen”. Parents also said they were not made aware by



# Services for children & young people

triage staff of the family room available in the urgent care waiting area. This meant that children may wait to be seen in an adult urgent care environment which was inappropriate to their age.

## Education and developmental needs

Effective education arrangements were in place for children. School facilities provided in partnership with the local authority and a children's play area was available for use on the inpatient ward. The team managing the service included qualified teachers, play specialists and nursery staff. Teaching was provided during term time and educational needs determined through liaison with children's regular schools to provide supportive and appropriate educational lessons through to GCSE level. We observed that the play area was well equipped with a variety of age appropriate play equipment. Parents we spoke with commented positively on the play facilities provided. Separate facilities for older children on the inpatient ward were restricted. Staff told us that efforts were made to facilitate for children's maturity.

## Consent to treatment

Parents and children told us they were provided with enough information to give informed consent to treatment. This included information about the associated, risks, benefits and alternative options. One parent and young person described the risks of the procedure they had undergone. This correlated with the signed consent documentation in the patients file. Another child awaiting surgery said, "The doctors have told me about the risks – bleeding, vomiting, neck pain, joint pain – but it is only one percent so I should be okay".

## Are services for children & young people well-led?

Children's services were well-led.

## Managing quality and performance

Safety and quality of care were monitored and action taken to improve performance. Senior managers had a clear vision for service improvement and development of children's services. Paediatric improvement programme groups had been established to encourage service development in children's inpatient and emergency care services. We saw records of quality improvement projects which examined issues such as length of inpatient stay and discharge delays. Patient Reported Experience Measure (PREM) surveys were undertaken to provide patient feedback on specific quality of care improvements that could be made. These included the Young Inpatients Survey 2103 and Your Child's Emergency Care.

## Leadership

Children's services were well-led. However, many staff expressed their concerns about future leadership and support especially at an operational level.

Staff worked together as a team and there was good communication between A&E and the inpatient ward. Staff records demonstrated that nursing staff received annual appraisals and had access to mandatory and professional development training relevant to their roles. A comprehensive in-house training programme for A&E nursing staff had been developed by the department's practice development team. Training included skill competency assessments.

Nursing staff meetings were held regularly and provided a platform to discuss issues and provide feedback about incidents that had occurred. Minutes of the inpatient ward nursing staff meetings documented problems with use of patient-controlled analgesia pumps. We saw that instruction was provided to staff to prevent re-occurrence, pending the outcome of formal investigation by the trust. An issue relating to discharge medication and the correct procedure to follow was also circulated to staff.

# End of life care

Safe

Effective

Caring

Responsive

Well-led

## Information about the service

Palliative care is provided in the 11-bed Margaret Centre. There is also a bereavement service, mortuary and Macmillan cancer support shop front. Staff from the Margaret Centre provide end of life care services within the hospital.

We spoke with staff in the Margaret Centre, bereavement service, mortuary and Macmillan staff on site.

## Summary of findings

We found that the service was generally safe, effective and caring. Staff worked together well to deliver end of life care in a compassionate and effective way. The hospital was following national guidelines in relation to end of life care and had stopped using the Liverpool Care Pathway. Patients said that they felt well cared for by staff. However, the unit where end of life care was delivered was in need of refurbishment as it compromised patients' privacy and safety. In particular, there were no bathing facilities available. There was no out-of-hours palliative medical cover or speciality specific advice, although the hospital plans to put this in place in 2014.



# End of life care

## Are end of life care services safe?

Improvements are required to ensure people are cared for in a safe environment.

### Patient safety

Patients on medical wards who were on end of life care pathways were also supported by the palliative care team based at the Margaret Centre and we found examples of safe and effective care. On one ward, we found incorrect information on a 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) form.

### Buildings and environments

The environment at the Margaret Centre was in need of updating. Staff told us that, before our announced visit, the trust was considering the possibility of a refurbishment as they recognised it was in need of attention. The Margaret Centre was located to the rear of the main hospital building. There was no covered route between the two buildings and we observed one patient in a critical condition being transferred in the rain. The floors had started to lift in places and the decoration was tired and worn through natural wear and tear.

## Are end of life care services effective? (for example, treatment is effective)

Care and effective treatment results in the best quality of life.

### National guidelines

The centre adhered to government guidelines. The Liverpool Care Pathway was no longer in use and the service was using a 'comfort care plan' which placed emphasis on nursing observations. This was in place at the Margaret Centre, but not on medical wards. A matron spoke to us about managing the treatment of symptoms, pain management, dignity and involvement of relatives through the comfort care plan.

### Collaborative working

We found Margaret Centre staff collaborated well with staff on the wards. As well as meeting the needs of inpatients at the centre, the team also worked with end of life patients on the wards in the main hospital. We sat in on the weekly multidisciplinary team meeting comprised of two consultants, two nurses and a psychologist. The team

discussed new referrals and on-going cases they provided support for. A set format for discussions ensured that individual needs were met, including diagnosis, prognosis, family, spiritual and psychological needs. Plans of action were agreed, based on identified needs.

## Are end of life care services caring?

Staff were caring towards patients. However, the layout of the premises compromised patients' privacy and dignity.

Staff based at the Margaret Centre went onto the wards, offering support, advice and medical input to hospital ward staff delivering care to patients at the end of their life. We observed compassionate and patient-centred care provided by the team, who spoke with patients and key ward staff about patient care. All of the patients and relatives spoke very highly of the service provided by the Margaret Centre and also very highly of the staff. One patient said, "they do things when they say they will and with such willingness. The care is outstanding". People had a genuine affection for the centre because of the care they had experienced.

We observed two good examples of end of life care on medical wards. Where a patient had recently died, we observed the Senior Sister contact the patient's spouse and deal with the situation in a personalised and dignified manner. Patients were supported by other ward staff and there were plans in place to follow up patients to reassure them. Staff were debriefed on the same day. In another example, we found a patient was at end stage of cancer but had made the decision to stay on the ward rather than be transferred to the Margaret Centre. The ward and palliative care team supported these wishes and worked to care for the patient on the ward.

The bereavement service was committed and compassionate. The service was contracted to a private funeral company which was staffed from Monday to Friday with an on-call service available. The bereavement officer offered support, advice and guidance as well as assisting with viewing of the body.

### Privacy and dignity

The layout of the premises compromised patients' privacy and dignity. There was no reception area and all visitors

# End of life care

had to wait outside while their enquiry was dealt with by staff. On entry to the building, visitors would immediately enter a clinical area. Staff walked past people's open bedrooms to get to offices.

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

(for example, to feedback?)

The service was responsive to patients' needs, although improvements were needed to the ward environment.

### Meeting patients' needs

The environment did not meet patients' needs. All accommodation at the Margaret Centre was in single rooms which did not have en suite toilet facilities. The building contained only two toilets, neither of which were accessible to wheelchairs, and only one shower. All patients used commodes due to the lack of toilet facilities rather than because of levels of independence or support needs.

There were no arrangements in place to enable medical and surgical wards to access end of life care at weekends, although there were informal arrangements. The hospital had plans to provide end of life care to wards at weekends from April 2014.

There was a clear and unimpeded pathway to the mortuary for relatives to follow when they wished to view the body. This respected people's dignity. In the event of a death on a ward, the body was taken from the ward to the basement, which was not accessible to the public, by lift.

We reviewed the end of life pathway on one ward. Staff appeared clear about the procedures to be followed at end of life stage. An extra side room had been allocated for use in emergencies which included patients who were dying. Ward staff told us that they were happy to involve relatives in end of life decisions which they felt had been restrictive under the previously used Liverpool Care Pathway.

Where people had a prognosis of end of life within three months, a 'fast track' process enabled funding and a care package to be arranged in a matter of days from the point of application. We traced some cases that had followed this

pathway and found people had been swiftly enabled to go home or to a nursing home. This was in contrast to applications for non-end of life continuing care, where people experienced delays.

### Patient records and consent

The majority of the 'do not attempt cardio-pulmonary resuscitation (DNA CPR) forms we reviewed had been fully completed.

### Patient feedback

There were mechanisms in place to obtain feedback from patients and their families. The service told us that they felt the NHS Friends and Family Test was not the most suitable form of gaining feedback from people who were bereaved.

The service also distributed comment cards. We saw a lot of complimentary comments about the Margaret Centre from both of these sources. People had made negative comments about the centre's accessibility from the community and the state of the ward environment.

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

Improvements were needed to the way that the service was led.

### Leadership

The Margaret Centre's itself was well-led and patients were cared for well by staff. However, there was a lack of support for palliative and end of life care from the senior management. Staff felt 'done to' by Barts senior management. We found that 80% of referrals came from the main hospital and 20% from the community. Due to a high hospital mortality rate and beds in the Margaret Centre being controlled by hospital bed managers, patients from the community had difficulty accessing a bed for palliative care. There were also cases where patients without palliative care or end of life needs were inappropriately placed in the centre by bed managers.

### Managing quality and performance

Quality and performance was being monitored. The trust data collection returns were submitted, but the centre did not receive feedback on performance from the trust. Staff at the Margaret Centre viewed the trust as unresponsive to the needs and challenges faced by the service.

# Outpatients

Safe

Effective

Caring

Responsive

Well-led

## Information about the service

A wide range of outpatient services were available at Whipps Cross Hospital. Adult services were split across five teams: medical; surgical; orthopaedic; ear, nose and throat (ENT); and oral. Children's outpatient services were also provided.

We visited the main outpatients department and spoke with patients and staff across a number of specialities. We observed care and treatment and looked at care records.

## Summary of findings

Overall, improvements are needed. Outpatient services at Whipps Cross Hospital were caring and well-led with some issues around waiting times, information governance and over-crowded clinics. Transformation projects were in place to improve waiting times and patients' experiences. The department was generally clean and hygienic but waiting rooms were overcrowded. There were long waiting times for many clinics. However, the trust was aware of these issues and had strategies in place to address them. Patients were pleased with the treatment they received and felt well informed and involved in decisions about their care. Patients' dignity and respect were maintained by staff in the outpatients department. There was evidence the department had made efforts to ensure its services were accessible and responsive to people's needs. Some people reported difficulty in re-arranging appointments that had been made for them.

# Outpatients

## Are outpatients services safe?

Services were mostly safe, although some improvements were needed.

### Safeguarding

Staff we spoke with had received safeguarding training and were aware of the processes to follow if any concerns were suspected.

### Hygiene and infection control

The whole outpatient area appeared clean and well maintained with cleaning staff clearly visible in the department. Cleaning audits were maintained and daily spot checks performed by facilities management. Hand sanitiser was available for patients and visitors to the department with dispensers kept in each clinic reception area and spaced around various locations. The department had an infection control link nurse. Cleaning date labels on equipment and furniture in treatment rooms were visible across the department. It was noted that a changing mat in the children's outpatient area was ripped and would be difficult to clean.

### Buildings and environment

The outpatient service was provided in an accessible environment suitable for wheelchair access. We noted that some waiting areas were overcrowded with insufficient seating for people, posing potential trip hazards. We also observed an overspill of adult patients into the children's waiting area in one clinic.

### Equipment

Staff did not always have access to the equipment that they needed. Resuscitation trollies and equipment were available in the department. Some trollies were shared between outpatient areas. Staff in children's outpatients told us that they did not always have access to equipment to meet children's needs. There was no electrocardiogram (ECG) equipment in the general outpatient department. This meant that children who required ECG tests had to be directed to children's A&E. There was no trained paediatric nurse in the clinic on Thursdays, which meant children would have to go to the ward if they required an injection.

### Patients' records

Patients' records were appropriately stored, with one exception. We observed over 30 boxes of archived patient medical records stored in a corridor accessible to the

public. This raised issues with both fire safety and information security. We raised this with senior staff who informed us that the issue had been formally escalated and a solution only recently identified. We were told records were due to be removed the following day for safe storage. We returned to this department a week later and observed that these records had been removed.

## Are outpatients services effective? (for example, treatment is effective)

Improvements were needed to the effectiveness of outpatient services.

### Operative function

We learned that there were long waiting times for first appointments in some outpatient clinics. The trust was aware of the issues and measures were in place to address them. Senior staff informed us that extra clinic lists had been added, including sessions in the evening and on a Saturday. Locum staff had been recruited to cover sickness and reduce waiting times. There were plans to start telephone clinics from December 2013 to further reduce waiting times.

Outpatient sessions frequently ran late. Staff told us that one of the reasons for delays was that new patient appointments, which require more time, were being allocated the same time slot length as follow-up appointments. Delays were also caused by missing information from patient records – for example, referral letters and discharge letters missing on the day of clinic. We observed that there was an escalation process in place for reporting missing information so that this could be tracked through to the relevant department.

We discussed with a clinical lead how effectiveness was monitored. We were told that clinical outcome audits were used to monitor performance against national standards.

## Are outpatients services caring?

Outpatient services were caring.

Many patients we spoke with talked about caring and approachable nurses and doctors. They were given appropriate information and support regarding treatment and felt involved in decisions about their care. One patient said, "Doctors are fine and nurses are fine – they give good

# Outpatients

information and explanations". Another person said, "The doctors and nurses are brilliant. They discuss treatment and care and speak my language not medical jargon" and "Cardiology is out of this world, fantastic".

## Dignity and respect

Patients' privacy and dignity were respected. We saw that consultations took place in private rooms with closed doors. Nurses were seen assisting patients into the clinic rooms. Conversations between staff took place in private clinical areas to maintain patient confidentiality. A lead nurse told us that attitudes on respect and dignity were a key focus at recruitment and nursing appraisal.

## Communication

Patients told us that staff kept them informed if there were delays to appointments. We observed staff updating information boards with the expected appointment delay time. Reception staff also informed people on arrival of waiting times. There was an information desk manned by volunteers to provide direction to the relevant outpatient clinic area. We observed a colour-coded department guide to assist patients in finding their way to different access points within the department and wider hospital. Information about potential outpatient clinic waiting time was provided in appointment letters. Leaflets on the complaints procedure were available in 34 different languages. Language Line, an external translation service, was used to provide interpreters for patients as needed.

## Patient support

A number of initiatives had been put in place to improve patients' experiences while waiting for their clinic appointment slots. These included a refreshment trolley providing tea and coffee free of charge, twice a day and student beauticians who visited the clinic waiting rooms twice weekly to give hand massages.

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

Improvements were needed to ensure that the outpatient department was responsive to people's needs.

## Waiting times

People we spoke with reported long waiting times in the outpatient department. Several people described that the wait could be two to three hours. Someone said, "You wait

for ages if you need blood tests". A specific issue was raised regarding the orthopaedic clinic and x-ray department. One patient described an hour wait to be seen by the orthopaedic team only to find they required an x-ray for the consultation to continue. They then had a further half-an-hour wait in x-ray before returning to the clinic.

## Appointments

Staff informed us there were additional appointment slots available in clinics to allow urgent referrals to be seen promptly. Some people we spoke to found it difficult to re-arrange their appointments. One patient said they tried to call five times to re-arrange an appointment which clashed with a holiday but could not make contact with the outpatient department. We noted that one of the standards in the transformation project which was in progress aimed to ensure in the future that every patient has a telephone number for every specialist department.

## Patients' experiences

During our visit we were told by a senior member of staff about a unique project the trust had been engaged in called 'Patients as People'. The project sees patients annotate photographs taken of them with prior consent, to illustrate their hospital experiences and reaction to these. This could provide an insight for staff about the emotional experiences of people attending the hospital.

## Are outpatients services well-led?

Outpatient services were well-led.

## Managing quality and performance

There were appropriate systems in place to monitor quality and performance. Senior managers had a clear vision for service improvement and development of outpatients services. A transformation project was in progress to shape future service delivery which set out clear standards of improvement and how these were to be achieved. These standards included reducing waiting room times and the time taken for outpatient summary notes to reach GPs. A similar transformation project was also in progress to address children's outpatient services.

Some clinics had issues with patients missing appointments which meant there were vacant slots that could have been used by other people. The trust addressed this issue by sending patients a reminder letter two weeks before their appointment was due. We were told that a text

# Outpatients

messaging reminder system was also planned for the future. To reduce late clinic list cancellations, doctors are required to give six weeks' notice before their clinic can be cancelled.

# Good practice and areas for improvement

## Areas of good practice

Our inspection team highlighted the following areas of good practice:

- Staff were compassionate, caring and committed in all areas of the hospital.
- The intensive care unit (ICU) was safe, met patients' needs and demonstrated how improvements could be made through learning from incidents.
- Improvements have been made in both accident and emergency and maternity services since our last inspection and we saw some good practice in these departments.
- Palliative care was compassionate and held in high regard by staff, patients and friends and family.
- We saw some good practice in children's services, particularly in relation to education and activities for children while in hospital.
- The hospital was clean and staff adhered to good infection control practice. Staff worked well together in multidisciplinary teams.

## Areas in need of improvement

### Action the hospital MUST take to improve

- Ensure staffing levels meet people's needs on all medical and surgical wards.

- Address delays to providing care. Patients' discharge from hospital is sometimes delayed. This impacts on other areas of the hospital and its effective functioning.
- Ensure that equipment on the medical and surgical wards and in ICU is always available, appropriately maintained and checked in accordance with the trust's policies and safety guidelines.
- Improve staff morale is low across all grades.
- Make changes to the culture of the organisation. There is a lack of an open culture. Staff feel bullied and unable to raise safety issues without fear.
- Make changes to the hospital environment. Some parts of the hospital do not meet patients' care needs. The hospital environment in the Margaret Centre and outpatients compromises patients' privacy, dignity and safety.
- Ensure that patients know how to make a complaint. Changes are needed to ensure that the hospital learns effectively from complaints.
- Strengthen governance arrangements. Currently, these are not always effective. Staff do not feel empowered to make changes and the governance structures hinder them at times.
- Ensure that the hospital's risk register is managed more effectively.



This section is primarily information for the provider

## Compliance actions

### Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures	<p>Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.</p> <p>Improvements are needed to ensure that patients receive appropriate levels of care and welfare.</p> <p>This relates to the issues with the way patients were cared for on the medical and surgical wards and the delays to their care and/or discharge from hospital.</p>
Regulated activity	Regulation
Maternity and midwifery services	<p>Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.</p> <p>Improvements are needed to ensure that patients receive appropriate levels of care and welfare.</p> <p>This relates to the issues with the way patients were cared for on the medical and surgical wards and the delays to their care and/or discharge from hospital.</p>
Regulated activity	Regulation
Surgical procedures	<p>Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.</p> <p>Improvements are needed to ensure that patients receive appropriate levels of care and welfare.</p> <p>This relates to the issues with the way patients were cared for on the medical and surgical wards and the delays to their care and/or discharge from hospital.</p>



This section is primarily information for the provider

## Compliance actions

### Regulated activity

### Regulation

Treatment of disease, disorder or injury

Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Improvements are needed to ensure that patients receive appropriate levels of care and welfare.

This relates to the issues with the way patients were cared for on the medical and surgical wards and the delays to their care and/or discharge from hospital.

### Regulated activity

### Regulation

Diagnostic and screening procedures

Regulation 15(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Improvements are needed to ensure that the patient environments (or 'premises') are safe and meet patients' needs.

This relates to the environment in the Margaret Centre, outpatients and on some medical wards.

### Regulated activity

### Regulation

Surgical procedures

Regulation 15(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Improvements are needed to ensure that the patient environments (or 'premises') are safe and meet patients' needs.

This relates to the environment in the Margaret Centre, outpatients and on some medical wards.

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Treatment of disease, disorder or injury

Regulation 15(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

This section is primarily information for the provider

## Compliance actions

Improvements are needed to ensure that the patient environments (or 'premises') are safe and meet patients' needs.

This relates to the environment in the Margaret Centre, outpatients and on some medical wards.

### Regulated activity

### Regulation

Treatment of disease, disorder or injury

Regulation 16(1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Improvements are needed to ensure that equipment is appropriately maintained and available for use.

This relates to a lack of low-rise beds on medical wards, bedside oxygen on one ward, oxygen flow meters and suction on the surgical wards, equipment in maternity, ensuring resuscitation equipment is fit for use and the lack of a spare ventilator trolley in ITU.

### Regulated activity

### Regulation

Maternity and midwifery services

Regulation 16(1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Improvements are needed to ensure that equipment is appropriately maintained and available for use.

This relates to a lack of low-rise beds on medical wards, bedside oxygen on one ward, oxygen flow meters and suction on the surgical wards, equipment in maternity, ensuring resuscitation equipment is fit for use and the lack of a spare ventilator trolley in ITU.

### Regulated activity

### Regulation

Surgical procedures

Regulation 16(1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

This section is primarily information for the provider

## Compliance actions

Improvements are needed to ensure that equipment is appropriately maintained and available for use.

This relates to a lack of low-rise beds on medical wards, bedside oxygen on one ward, oxygen flow meters and suction on the surgical wards, equipment in maternity, ensuring resuscitation equipment is fit for use and the lack of a spare ventilator trolley in ITU.

### Regulated activity

### Regulation

Treatment of disease, disorder or injury

Regulation 16(1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Improvements are needed to ensure that equipment is appropriately maintained and available for use.

This relates to a lack of low-rise beds on medical wards, bedside oxygen on one ward, oxygen flow meters and suction on the surgical wards, equipment in maternity, ensuring resuscitation equipment is fit for use and the lack of a spare ventilator trolley in ITU.

### Regulated activity

### Regulation

Diagnostic and screening procedures

Regulation 19(1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Improvements are needed to ensure that patients know how to make a complaint and that complaints are dealt with appropriately.

### Regulated activity

### Regulation

Maternity and midwifery services

Regulation 19(1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Improvements are needed to ensure that patients know how to make a complaint and that complaints are dealt with appropriately.

This section is primarily information for the provider

## Compliance actions

### Regulated activity

### Regulation

Surgical procedures

Regulation 19(1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Improvements are needed to ensure that patients know how to make a complaint and that complaints are dealt with appropriately.

### Regulated activity

### Regulation

Treatment of disease, disorder or injury

Regulation 19(1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Improvements are needed to ensure that patients know how to make a complaint and that complaints are dealt with appropriately.